

SERFF Tracking Number: AMFL-128005588 State: Arkansas
Filing Company: AMERICAN FIDELITY LIFE INSURANCE State Tracking Number:
Company Tracking Number: 60429
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: UL2008 LIFE RDR
Project Name/Number: TERM LIFE INSURANCE RIDER/60429

Filing at a Glance

Company: AMERICAN FIDELITY LIFE INSURANCE

Product Name: UL2008 LIFE RDR

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMFL-128005588 State: Arkansas

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

Co Tr Num: 60429

Author: Rita Enderson

Date Submitted: 01/19/2012

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 01/23/2012

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: TERM LIFE INSURANCE RIDER

Project Number: 60429

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Rita Enderson

Filing Description:

UL2008 LIFE RDR (TERM LIFE INSURANCE RIDER) TO BE ISSUED WITH PREVIOUSLY APPROVED POLICY
UL2008

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 11/09/2011

Domicile Status Comments: FILED AND
APPROVED IN FLORIDA

Market Type: Individual

Individual Market Type:

Filing Status Changed: 01/23/2012

State Status Changed: 01/23/2012

Created By: Rita Enderson

Corresponding Filing Tracking Number: 60429

Company and Contact

Filing Contact Information

RITA ENDERSON, SR VICE PRESIDENT

4060 BARRANCAS AVE

PENSACOLA, FL 32507

RITAE@AMFILIFE.COM

850-456-7041 [Phone]

850-457-9901 [FAX]

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Filing Company Information

AMERICAN FIDELITY LIFE INSURANCE CoCode: 60429 State of Domicile: Florida
4060 BARRANCAS AVENUE Group Code: 60429 Company Type: LIFE
PENSACOLA, FL 32507 Group Name: AMFI State ID Number:
(850) 456-7401 ext. [Phone] FEIN Number: 59-0787372

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AMERICAN FIDELITY LIFE INSURANCE	\$150.00	01/19/2012	55615978

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/23/2012	01/23/2012

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Disposition Date: 01/23/2012

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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	MIL APP UL/CR		Yes
Supporting Document	ACTUARIAL		No
Form	TERM LIFE INSURANCE RIDER		Yes
Form	APPLICATION CIVILIAN		Yes
Form	APPLICATION MILITARY		Yes

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Form Schedule

Lead Form Number: UL2008 LIFE RDR

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	UL2008 LIFE RDR	Policy/Cont ract/Fraternal Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.500	UL LIFE RDR AF.pdf
	CIV APP UL/CR	Application/ Enrollment Form CIVILIAN	Initial		50.000	ARK AMFI CIV APP.pdf
	MIL APP UL/CR	Application/ Enrollment Form MILITARY	Initial		50.000	ARK AMFI MIL APP.pdf

TERM LIFE INSURANCE RIDER

EFFECTIVE DATE. Coverage under this rider will go into effect on the Policy Date of the policy to which it is attached.

RIDER DEATH BENEFIT. The death benefit payable under this rider is in the form of a monthly benefit to the Insured's Beneficiary. The amount and period of payments varies with the age of the Insured at the time of the Insured's death:

Attained Age of Insured at time of Death	0-34	35-44	45-55	56-70
Monthly Payment to Beneficiary First 60 Months	\$1,000	\$ 750	\$ 500	0
Monthly Payment to Beneficiary Second 60 Months	1,500	1,000	0	0
Lump Sum*	0	0	0	\$1,000
Total of All Payments	\$150,000	\$105,000	\$ 30,000	\$1,000

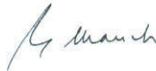
Any payments remaining unpaid at the death of the Beneficiary will be paid as they become due to the Contingent Beneficiary. In event that no Contingent Beneficiary survives the Beneficiary, any remaining payments due will be commuted to a lump sum and the commuted value will be paid to the Estate of the Beneficiary.

*When the Insured reaches age 56, the monthly payment feature will no longer apply. The benefit will automatically revert to a lump sum death benefit. The amount of the Monthly Deduction will remain the same as the amount prior to age 56.

COST OF RIDER. The monthly charge for this Coverage is shown on page 3a of the Policy. It will be included in the Monthly Deduction while this rider is in force.

TERMINATION OF BENEFIT. Coverage under this rider will end on the earliest of the following dates:

1. The Date that the Policy to which this rider is attached terminates.
2. The Policy Anniversary corresponding to the Insured's age 70.
3. The Date that the owner instructs us in a written request to terminate coverage under this rider.



President

AMERICAN FIDELITY LIFE INSURANCE COMPANY

LIFE INSURANCE APPLICATION

PERSONAL INFORMATION

1. PROPOSED INSURED

NAME: _____ SOCIAL SECURITY NO: _____

GENDER: FEMALE MALE BIRTHPLACE (STATE,COUNTRY) _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE NUMBER: _____ U.S. CITIZEN YES NO

Cell Phone Number: _____ e-mail address: _____

EMPLOYER: _____ ADDRESS: _____

TELEPHONE: _____

EXACT DUTIES: _____

2. COMPLETE IF PROPOSED INSURED IS NOT OWNER:

OWNER'S NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY/STATE _____ ZIP: _____

RELATIONSHIP TO PROPOSED INSURED: _____ TELEPHONE: _____

POLICY INFORMATION

3. PLAN OF INSURANCE: _____ INITIAL AMOUNT OF DEATH BENEFIT:\$ _____

Initial Target Monthly Premium Amount \$ _____ Initial Excess Premium \$ _____ Total:\$ _____

DATE OF ISSUE: _____ Mode of Payment: Direct Bill: Monthly Quarterly Semi Annual Annual Other: _____

Riders: _____

PREMIUM PAYOR IF OTHER THAN PROPOSED INSURED OR OWNER:

NAME: _____ SOCIAL SECURITY NUMBER: _____

RELATIONSHIP TO PROPOSED INSURED: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

BENEFICIARY

4. PRIMARY BENEFICIARY(S): (FIRST BENEFICIARY(S))

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

CONTINGENT BENEFICIARY: (SECOND BENEFICIARY(S) In the event the Primary Beneficiary(s) predecease me:

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

CHARITABLE BENEFIT RIDER BENEFICIARY DESIGNATION: (Will receive 1% additional death benefit, if applicable)

NAME: _____ ADDRESS: _____ City: _____ State: _____ Zip: _____

PHYSICIAN INFORMATION

NAME OF PHYSICIAN OR FACILITY THAT HAS CURRENT RECORDS: _____

ADDRESS: _____

TELEPHONE:(_____) _____ STREET _____ CITY _____ STATE _____ ZIP _____

DATE OF LAST VISIT: _____

LIFE INSURANCE APPLICATION CONTINUED
MEDICAL AND NON MEDICAL QUESTIONS

5. TO THE BEST OF MY KNOWLEDGE HAS THE PROPOSED INSURED EVER BEEN DIAGNOSED BY, OR RECEIVED TREATMENT FROM A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR ANY OF THE FOLLOWING DURING THE LAST 10 YEARS?: IF YES, PLEASE CHECK AND PROVIDE DETAILS BELOW:

	YES	NO
A. HAD MEDICAL, SURGICAL OR OTHER TREATMENT OR ADVICE IN THE PAST 10 YEARS?		
B. HAD AN OPERATION, USE OF HEART, BLOOD PRESSURE OR DIABETES MEDICATION?		
C. HAD OR HAVE DISEASE IN THE LAST TEN (10) YEARS OF THE:		
1. LUNGS/RESPIRATORY SYSTEM, HEART, BLOOD, HIGH OR LOW BLOOD PRESSURE, DIABETES?		
2. DIGESTIVE SYSTEM, LIVER, PANCREAS, KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, OR PROSTATE		
3. STROKE, TIA, PARALYSIS, SEIZURES, NERVOUS DISEASE, MULTIPLE SCLEROSIS, PARKINSONS DISEASE, ALZHEIMER'S DISEASE, MEMORY LOSS?		
4. HEPATITIS, LUPUS, CIRRHOSIS, COLITIS, IMMUNE SYSTEM, THYROID, NERVOUS OR PSYCHOLOGICAL DISEASE?		
5. CANCER, TUMOR, POLYP?		
6. ANY OTHER SICKNESS, INJURY LAST 10 YEARS OR TAKING ANY PRESCRIPTION MEDICATIONS?		
7. GAINED OR LOST MORE THAN 5 POUNDS IN PAST YEAR?		
8. HAVE YOU EVER BEEN TREATED OR DIAGNOSED BY A MEMBER OF THE MEDICAL PROFESSION FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)?		
9. HAS THE PROPOSED INSURED EVER SOUGHT, BEEN ADVISED TO SEEK, OR RECEIVED COUNSELING OR TREATMENT FOR THE USE OF ALCOHOL OR DRUGS FROM A LICENSED MEMBER OF THE MEDICAL PROFESSION ?		
10. HEIGHT: _____ WEIGHT: _____		

6. HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO, IF YES GIVE DATES AND DETAILS: _____
7. DO YOU PARTICIPATE IN MOTOR SPORTS RACING, BOAT RACING, PARACHUTING, HANG GLIDING, ROCK OR MOUNTAIN CLIMBING, OR SKYDIVING? YES NO
8. HAVE YOU BEEN CONVICTED OF DRIVING UNDER THE INFLUENCE OF ALCOHOL OR DRUGS OR HAD DRIVING VIOLATIONS? YES NO
 DRIVER'S LICENSE NUMBER AND STATE ISSUED: _____
9. HAVE YOU MADE OR DO YOU CONTEMPLATE MAKING FLIGHTS AS A PILOT, STUDENT PILOT OR AIR CREW MEMBER DURING THE NEXT TWO YEARS?: YES NO

DETAILS AND REMARKS FOR ABOVE 5-9: _____

10. DO YOU HAVE EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS? YES NO
11. DO YOU INTEND THE REPLACEMENT OR CHANGE OF ANY OF YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS IN CONNECTION WITH THIS APPLICATION FOR NEW LIFE INSURANCE? YES NO

I declare to the best of my knowledge and belief that all of the statements in the application, including any attachments, are complete, true and accurate. All questions were asked of me.

I understand that no licensed insurance agent is authorized to: make or modify contracts; waive any Insurer rights or requirements; or waive any information the Insurer requests.

The policy will become effective when all of the following conditions are met:

- the policy is issued by the Insurer
- the policy is delivered to, and accepted by the policy owner
- there have been no changes in the application that I have not notified the Insurer prior to delivery
- the first premium has been paid in full.

Fraud Notice: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. (Not applicable in CO,FL,HI,MD,NE, OK, OR, TN, VA or WA)

In CALIFORNIA, For your protection, California law requires that you be made aware of the following: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In COLORADO, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

In VIRGINIA, any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application for insurance or files a claim containing a false or deceptive statement may be violated state law.

In OKLAHOMA, WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. MAINE/TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. NEW MEXICO: 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 civil fines and criminal penalties.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I do do not want to have federal income tax withheld from my periodic or non-periodic withdrawals. I reserve the right to change this option. I understand that this insurance agent has no authority to give any legal, tax, or other advice, on behalf of this company. You are entitled to receive a copy of this form upon request. This application remains valid for twenty four (24) months.

Signature of Proposed Insured: _____ Date: _____

Signature of Owner if other than Insured: _____ Date: _____

Signed at: _____

Agents: Does the proposed insured have any existing life insurance policies or annuity contracts? Yes No
 (If "yes", complete replacement form)

To the best of your knowledge, will any existing life insurance policies or annuity contract be replaced or will values from another insurance policy or annuity contracts (through loans, surrenders or otherwise) be used to pay premiums for the policy applied for? Yes No
 If "yes", complete replacement form.

AGENT NAME AND SIGNATURE: _____	AGENT CODE NUMBER: _____
STATE LICENSE NUMBER: _____	
GENERAL AGENT: _____	

LIFE INSURANCE APPLICATION
MILITARY APPLICANTS
PERSONAL INFORMATION

1. PROPOSED INSURED

NAME: _____ SOCIAL SECURITY NO: _____

GENDER: FEMALE MALE BIRTHPLACE (STATE,COUNTRY) _____ DATE OF BIRTH: _____ AGE: _____

MILITARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE NUMBER: _____ U.S. CITIZEN YES NO ACTIVE DUTY / RETIRED / DEPENDENT

Cell Phone Number: _____ e-mail address: _____

BRANCH OF SERVICE: _____ RANK: _____ DUTIES: _____ DISCHARGE DATE: _____

PERMANENT ADDRESS : _____

CITY _____ STATE _____ ZIP: _____ Telephone Number(_____) _____

MAIL POLICY TO: _____ MILITARY ADDRESS OR _____ PERMANENT ADDRESS

2. COMPLETE IF PROPOSED INSURED IS NOT OWNER:

OWNER'S NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY/STATE _____ ZIP: _____

RELATIONSHIP TO PROPOSED INSURED: _____ TELEPHONE: _____

POLICY INFORMATION

3. PLAN OF INSURANCE: _____ INITIAL AMOUNT OF DEATH BENEFIT:\$ _____

Initial Monthly Target Premium Amount \$ _____ Initial Excess Premium Amount \$ _____ Total:\$ _____

Date of Issue: _____ Riders: _____

PREMIUM PAYOR IF OTHER THAN PROPOSED INSURED OR OWNER:

NAME: _____ SOCIAL SECURITY NUMBER: _____

RELATIONSHIP TO PROPOSED INSURED: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

BENEFICIARY

4. PRIMARY BENEFICIARY(S): (FIRST BENEFICIARY(S))

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

CONTINGENT BENEFICIARY: (SECOND BENEFICIARY(S) In the event the Primary Beneficiary(s) predecease me:

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

CHARITABLE BENEFIT RIDER BENEFICIARY DESIGNATION: (Will receive 1% additional death benefit, if applicable)

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

LIFE INSURANCE APPLICATION CONTINUED

MEDICAL AND NON MEDICAL QUESTIONS

5. TO THE BEST OF MY KNOWLEDGE HAS THE PROPOSED INSURED EVER BEEN DIAGNOSED BY, OR RECEIVED TREATMENT FROM A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR ANY OF THE FOLLOWING?: IF YES, PLEASE CHECK AND PROVIDE DETAILS BELOW:

YES NO

A. HAD MEDICAL, SURGICAL OR OTHER TREATMENT OR ADVICE IN THE PAST 10 YEARS?		
B. HAD AN OPERATION, USE OF HEART, BLOOD PRESSURE OR DIABETES MEDICATION?		
C. HAD OR HAVE DISEASE IN THE LAST TEN (10) YEARS OF THE:		
1. LUNGS/RESPIRATORY SYSTEM, HEART, BLOOD, HIGH OR LOW BLOOD PRESSURE, DIABETES?		
2. DIGESTIVE SYSTEM, LIVER, PANCREAS, KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, OR PROSTATE		
3. STROKE, TIA, PARALYSIS, SEIZURES, NERVOUS DISEASE, MULTIPLE SCLEROSIS, PARKINSONS DISEASE, ALZHEIMER'S DISEASE, MEMORY LOSS?		
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5. CANCER, TUMOR, POLYP?		
6. ANY OTHER SICKNESS, INJURY LAST 10 YEARS OR TAKING ANY PRESCRIPTION MEDICATIONS?		
7. GAINED OR LOST MORE THAN 5 POUNDS IN PAST YEAR?		
8. HAVE YOU EVER BEEN TREATED OR DIAGNOSED BY A MEMBER OF THE MEDICAL PROFESSION FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)?		
9. HAS THE PROPOSED INSURED EVER SOUGHT, BEEN ADVISED TO SEEK, OR RECEIVED COUNSELING OR TREATMENT FOR THE USE OF ALCOHOL OR DRUGS FROM A LICENSED MEMBER OF THE MEDICAL PROFESSION?		
10. ARE YOU NOW OR HAVE YOU EVER BEEN CONSIDERED FOR DISCHARGE FROM MILITARY SERVICE FOR MEDICAL REASONS?		
11. HEIGHT: _____ WEIGHT: _____		

6. HAVE YOU EVER BEEN CONVICTED OF A FELONY?: YES NO, IF YES GIVE DATES AND DETAILS: _____
7. DO YOU PARTICIPATE IN MOTOR SPORTS RACING, BOAT RACING, PARACHUTING, HANG GLIDING, ROCK OR MOUNTAIN CLIMBING, OR SKYDIVING? YES NO
8. HAVE YOU BEEN CONVICTED OF DRIVING UNDER THE INFLUENCE OF ALCOHOL OR DRUGS OR HAD DRIVING VIOLATIONS? YES NO
DRIVER'S LICENSE NUMBER AND STATE ISSUED: _____
9. HAVE YOU MADE OR DO YOU CONTEMPLATE MAKING FLIGHTS AS A PILOT, STUDENT PILOT OR AIR CREW MEMBER?: YES NO
10. DO YOU HAVE EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS? YES NO
11. DO YOU INTEND THE REPLACEMENT OR CHANGE OF ANY OF YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS IN CONNECTION WITH THIS APPLICATION FOR NEW LIFE INSURANCE? YES NO

DETAILS AND REMARKS FOR ABOVE: _____

I declare to the best of my knowledge and belief that all of the statements in the application, including any attachments, are complete, true and accurate. All questions were asked of me.

I understand that no licensed insurance agent is authorized to: make or modify contracts; waive any Insurer rights or requirements; or waive any information the Insurer requests.

The policy will become effective when all of the following conditions are met:

- the policy is issued by the Insurer
- the policy is delivered to, and accepted by the policy owner
- there have been no changes in the application that I have not notified the Insurer prior to delivery
- the first premium has been paid in full.

Fraud Notice: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. (Not applicable in CO,FL,HI,MD,NE, OK, OR, TN, VA or WA)

In CALIFORNIA, For your protection, California law requires that you be made aware of the following: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
 In COLORADO, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages, Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
 In VIRGINIA and WASHINGTON, any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application for insurance or files a claim containing a false or deceptive statement may be violated state law.
 In OKLAHOMA, WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony
 MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. WASHINGTON/TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. NEW MEXICO: 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 civil fines and criminal penalties.

I do do not want to have federal income tax withheld from my periodic or non-periodic withdrawals. I reserve the right to change this option. I understand that this insurance agent has no authority to give any legal, tax, or other advice, on behalf of this company.

You are entitled to receive a copy of this form upon request. This application remains valid for twenty four (24) months.

Signature of Proposed Insured: _____ Date: _____

Signature of Owner if other than Insured: _____ Date: _____

Signed at: _____

Agents: Does the proposed insured have any existing life insurance policies or annuity contracts? Yes No
 If "yes", complete replacement form.

To the best of your knowledge, will any existing life insurance policies or annuity contract be replaced or will values from another insurance policy or annuity contracts (through loans, surrenders or otherwise) be used to pay premiums for the policy applied for? Yes No
 If "yes", complete replacement form.

AGENT NAME AND SIGNATURE: _____	AGENT CODE NUMBER: _____
STATE LICENSE NUMBER: _____	
GENERAL AGENT NAME: _____	GENERAL AGENT CODE NUMBER: _____

SERFF Tracking Number: AMFL-128005588 State: Arkansas
Filing Company: AMERICAN FIDELITY LIFE INSURANCE State Tracking Number:
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Product Name: UL2008 LIFE RDR
Project Name/Number: TERM LIFE INSURANCE RIDER/60429

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: ARK FLESCH.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: CIV APP UL/CR APPLICATION CIV Attachment: ARK AMFI CIV APP.pdf		

	Item Status:	Status Date:
Satisfied - Item: MIL APP UL/CR Comments: APPLICATION MIL Attachment: ARK AMFI MIL APP.pdf		

	Item Status:	Status Date:
Satisfied - Item: ACTUARIAL Comments: Attachment: UL AMFI LRDR ACTUARIAL.pdf		

12.	Filing Submission Date	1/16/12	
13.	Filing Fee (If required)	Amount _____	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval	CA	

15.	Filing Description: TERM LIFE INSURANCE RIDER
<p>Re: Form UL2007 LIFE RDR</p> <p>Dear Department:</p> <p>Submitted for your review and approval is the above mentioned rider. This rider will be available on new issues only attached to our previously approved policy UL2007 approved in your state.</p> <p>This is to certify that the above mentioned rider has a Flesch Score of 50.5.</p> <p>This policy will be marketed by our General Agency system to the general public including military members.</p> <p>We have reviewed this rider and believe to the best of our knowledge it is in compliance with the laws and regulations of the State of Arkansas.</p> <p>The Actuarial Memorandum is included in this filing.</p> <p>Please let us know if you have any questions.</p> <p>Rita Enderson</p> <p>Administrator</p>	

16.	Certification (If required)
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.</p> <p>Print Name <u> RITA ENDERSON </u> Title <u> Administrator </u></p> <p>Signature <u>  </u> Date: <u> 1/16/12 </u></p>	

LIFE INSURANCE APPLICATION

PERSONAL INFORMATION

1. PROPOSED INSURED

NAME: _____ SOCIAL SECURITY NO: _____

GENDER: FEMALE MALE BIRTHPLACE (STATE,COUNTRY) _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE NUMBER: _____ U.S. CITIZEN YES NO

Cell Phone Number: _____ e-mail address: _____

EMPLOYER: _____ ADDRESS: _____

TELEPHONE: _____

EXACT DUTIES: _____

2. COMPLETE IF PROPOSED INSURED IS NOT OWNER:

OWNER'S NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY/STATE _____ ZIP: _____

RELATIONSHIP TO PROPOSED INSURED: _____ TELEPHONE: _____

POLICY INFORMATION

3. PLAN OF INSURANCE: _____ INITIAL AMOUNT OF DEATH BENEFIT:\$ _____

Initial Target Monthly Premium Amount \$ _____ Initial Excess Premium \$ _____ Total:\$ _____

DATE OF ISSUE: _____ Mode of Payment: Direct Bill: Monthly Quarterly Semi Annual Annual Other: _____

Riders: _____

PREMIUM PAYOR IF OTHER THAN PROPOSED INSURED OR OWNER:

NAME: _____ SOCIAL SECURITY NUMBER: _____

RELATIONSHIP TO PROPOSED INSURED: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

BENEFICIARY

4. PRIMARY BENEFICIARY(S): (FIRST BENEFICIARY(S))

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

CONTINGENT BENEFICIARY: (SECOND BENEFICIARY(S) In the event the Primary Beneficiary(s) predecease me:

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

CHARITABLE BENEFIT RIDER BENEFICIARY DESIGNATION: (Will receive 1% additional death benefit, if applicable)

NAME: _____ ADDRESS: _____ City: _____ State: _____ Zip: _____

PHYSICIAN INFORMATION

NAME OF PHYSICIAN OR FACILITY THAT HAS CURRENT RECORDS: _____

ADDRESS: _____

TELEPHONE:(_____) _____ CITY STATE ZIP

DATE OF LAST VISIT: _____

LIFE INSURANCE APPLICATION CONTINUED
MEDICAL AND NON MEDICAL QUESTIONS

5. TO THE BEST OF MY KNOWLEDGE HAS THE PROPOSED INSURED EVER BEEN DIAGNOSED BY, OR RECEIVED TREATMENT FROM A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR ANY OF THE FOLLOWING DURING THE LAST 10 YEARS?: IF YES, PLEASE CHECK AND PROVIDE DETAILS BELOW:

	YES	NO
A. HAD MEDICAL, SURGICAL OR OTHER TREATMENT OR ADVICE IN THE PAST 10 YEARS?		
B. HAD AN OPERATION, USE OF HEART, BLOOD PRESSURE OR DIABETES MEDICATION?		
C. HAD OR HAVE DISEASE IN THE LAST TEN (10) YEARS OF THE:		
1. LUNGS/RESPIRATORY SYSTEM, HEART, BLOOD, HIGH OR LOW BLOOD PRESSURE, DIABETES?		
2. DIGESTIVE SYSTEM, LIVER, PANCREAS, KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, OR PROSTATE		
3. STROKE, TIA, PARALYSIS, SEIZURES, NERVOUS DISEASE, MULTIPLE SCLEROSIS, PARKINSONS DISEASE, ALZHEIMER'S DISEASE, MEMORY LOSS?		
4. HEPATITIS, LUPUS, CIRRHOSIS, COLITIS, IMMUNE SYSTEM, THYROID, NERVOUS OR PSYCHOLOGICAL DISEASE?		
5. CANCER, TUMOR, POLYP?		
6. ANY OTHER SICKNESS, INJURY LAST 10 YEARS OR TAKING ANY PRESCRIPTION MEDICATIONS?		
7. GAINED OR LOST MORE THAN 5 POUNDS IN PAST YEAR?		
8. HAVE YOU EVER BEEN TREATED OR DIAGNOSED BY A MEMBER OF THE MEDICAL PROFESSION FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)?		
9. HAS THE PROPOSED INSURED EVER SOUGHT, BEEN ADVISED TO SEEK, OR RECEIVED COUNSELING OR TREATMENT FOR THE USE OF ALCOHOL OR DRUGS FROM A LICENSED MEMBER OF THE MEDICAL PROFESSION ?		
10. HEIGHT: _____ WEIGHT: _____		

6. HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO, IF YES GIVE DATES AND DETAILS: _____
7. DO YOU PARTICIPATE IN MOTOR SPORTS RACING, BOAT RACING, PARACHUTING, HANG GLIDING, ROCK OR MOUNTAIN CLIMBING, OR SKYDIVING? YES NO
8. HAVE YOU BEEN CONVICTED OF DRIVING UNDER THE INFLUENCE OF ALCOHOL OR DRUGS OR HAD DRIVING VIOLATIONS? YES NO
 DRIVER'S LICENSE NUMBER AND STATE ISSUED: _____
9. HAVE YOU MADE OR DO YOU CONTEMPLATE MAKING FLIGHTS AS A PILOT, STUDENT PILOT OR AIR CREW MEMBER DURING THE NEXT TWO YEARS?: YES NO

DETAILS AND REMARKS FOR ABOVE 5-9: _____

10. DO YOU HAVE EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS? YES NO
11. DO YOU INTEND THE REPLACEMENT OR CHANGE OF ANY OF YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS IN CONNECTION WITH THIS APPLICATION FOR NEW LIFE INSURANCE? YES NO

I declare to the best of my knowledge and belief that all of the statements in the application, including any attachments, are complete, true and accurate. All questions were asked of me.

I understand that no licensed insurance agent is authorized to: make or modify contracts; waive any Insurer rights or requirements; or waive any information the Insurer requests.

The policy will become effective when all of the following conditions are met:

- the policy is issued by the Insurer
- the policy is delivered to, and accepted by the policy owner
- there have been no changes in the application that I have not notified the Insurer prior to delivery
- the first premium has been paid in full.

Fraud Notice: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. (Not applicable in CO,FL,HI,MD,NE, OK, OR, TN, VA or WA)

In CALIFORNIA, For your protection, California law requires that you be made aware of the following: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In COLORADO, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

In VIRGINIA, any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application for insurance or files a claim containing a false or deceptive statement may be violated state law.

In OKLAHOMA, WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. MAINE/TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NEW MEXICO: 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 civil fines and criminal penalties. WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I do do not want to have federal income tax withheld from my periodic or non-periodic withdrawals. I reserve the right to change this option. I understand that this insurance agent has no authority to give any legal, tax, or other advice, on behalf of this company. You are entitled to receive a copy of this form upon request. This application remains valid for twenty four (24) months.

Signature of Proposed Insured: _____ Date: _____

Signature of Owner if other than Insured: _____ Date: _____

Signed at: _____

Agents: Does the proposed insured have any existing life insurance policies or annuity contracts? Yes No
 (If "yes", complete replacement form)

To the best of your knowledge, will any existing life insurance policies or annuity contract be replaced or will values from another insurance policy or annuity contracts (through loans, surrenders or otherwise) be used to pay premiums for the policy applied for? Yes No
 If "yes", complete replacement form.

AGENT NAME AND SIGNATURE: _____	AGENT CODE NUMBER: _____
STATE LICENSE NUMBER: _____	
GENERAL AGENT: _____	

LIFE INSURANCE APPLICATION
MILITARY APPLICANTS
PERSONAL INFORMATION

1. PROPOSED INSURED

NAME: _____ SOCIAL SECURITY NO: _____

GENDER: FEMALE MALE BIRTHPLACE (STATE,COUNTRY) _____ DATE OF BIRTH: _____ AGE: _____

MILITARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE NUMBER: _____ U.S. CITIZEN YES NO ACTIVE DUTY / RETIRED / DEPENDENT

Cell Phone Number: _____ e-mail address: _____

BRANCH OF SERVICE: _____ RANK: _____ DUTIES: _____ DISCHARGE DATE: _____

PERMANENT ADDRESS : _____

CITY _____ STATE _____ ZIP: _____ Telephone Number(_____) _____

MAIL POLICY TO: _____ MILITARY ADDRESS OR _____ PERMANENT ADDRESS

2. COMPLETE IF PROPOSED INSURED IS NOT OWNER:

OWNER'S NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY/STATE _____ ZIP: _____

RELATIONSHIP TO PROPOSED INSURED: _____ TELEPHONE: _____

POLICY INFORMATION

3. PLAN OF INSURANCE: _____ INITIAL AMOUNT OF DEATH BENEFIT:\$ _____

Initial Monthly Target Premium Amount \$ _____ Initial Excess Premium Amount \$ _____ Total:\$ _____

Date of Issue: _____ Riders: _____

PREMIUM PAYOR IF OTHER THAN PROPOSED INSURED OR OWNER:

NAME: _____ SOCIAL SECURITY NUMBER: _____

RELATIONSHIP TO PROPOSED INSURED: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

BENEFICIARY

4. PRIMARY BENEFICIARY(S): (FIRST BENEFICIARY(S))

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

CONTINGENT BENEFICIARY: (SECOND BENEFICIARY(S) In the event the Primary Beneficiary(s) predecease me:

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

NAME: _____ RELATIONSHIP: _____ SHARE: _____ %

ADDRESS: _____

CHARITABLE BENEFIT RIDER BENEFICIARY DESIGNATION: (Will receive 1% additional death benefit, if applicable)

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

LIFE INSURANCE APPLICATION CONTINUED

MEDICAL AND NON MEDICAL QUESTIONS

5. TO THE BEST OF MY KNOWLEDGE HAS THE PROPOSED INSURED EVER BEEN DIAGNOSED BY, OR RECEIVED TREATMENT FROM A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR ANY OF THE FOLLOWING?: IF YES, PLEASE CHECK AND PROVIDE DETAILS BELOW:

YES NO

A. HAD MEDICAL, SURGICAL OR OTHER TREATMENT OR ADVICE IN THE PAST 10 YEARS?		
B. HAD AN OPERATION, USE OF HEART, BLOOD PRESSURE OR DIABETES MEDICATION?		
C. HAD OR HAVE DISEASE IN THE LAST TEN (10) YEARS OF THE:		
1. LUNGS/RESPIRATORY SYSTEM, HEART, BLOOD, HIGH OR LOW BLOOD PRESSURE, DIABETES?		
2. DIGESTIVE SYSTEM, LIVER, PANCREAS, KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, OR PROSTATE		
3. STROKE, TIA, PARALYSIS, SEIZURES, NERVOUS DISEASE, MULTIPLE SCLEROSIS, PARKINSONS DISEASE, ALZHEIMER'S DISEASE, MEMORY LOSS?		
4. HEPATITIS, LUPUS, CIRRHOSIS, COLITIS, IMMUNE SYSTEM, THYROID, NERVOUS OR PSYCHOLOGICAL DISEASE?		
5. CANCER, TUMOR, POLYP?		
6. ANY OTHER SICKNESS, INJURY LAST 10 YEARS OR TAKING ANY PRESCRIPTION MEDICATIONS?		
7. GAINED OR LOST MORE THAN 5 POUNDS IN PAST YEAR?		
8. HAVE YOU EVER BEEN TREATED OR DIAGNOSED BY A MEMBER OF THE MEDICAL PROFESSION FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)?		
9. HAS THE PROPOSED INSURED EVER SOUGHT, BEEN ADVISED TO SEEK, OR RECEIVED COUNSELING OR TREATMENT FOR THE USE OF ALCOHOL OR DRUGS FROM A LICENSED MEMBER OF THE MEDICAL PROFESSION?		
10. ARE YOU NOW OR HAVE YOU EVER BEEN CONSIDERED FOR DISCHARGE FROM MILITARY SERVICE FOR MEDICAL REASONS?		
11. HEIGHT: _____ WEIGHT: _____		

6. HAVE YOU EVER BEEN CONVICTED OF A FELONY?: YES NO, IF YES GIVE DATES AND DETAILS: _____
7. DO YOU PARTICIPATE IN MOTOR SPORTS RACING, BOAT RACING, PARACHUTING, HANG GLIDING, ROCK OR MOUNTAIN CLIMBING, OR SKYDIVING? YES NO
8. HAVE YOU BEEN CONVICTED OF DRIVING UNDER THE INFLUENCE OF ALCOHOL OR DRUGS OR HAD DRIVING VIOLATIONS? YES NO
DRIVER'S LICENSE NUMBER AND STATE ISSUED: _____
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11. DO YOU INTEND THE REPLACEMENT OR CHANGE OF ANY OF YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS IN CONNECTION WITH THIS APPLICATION FOR NEW LIFE INSURANCE? YES NO

DETAILS AND REMARKS FOR ABOVE: _____

I declare to the best of my knowledge and belief that all of the statements in the application, including any attachments, are complete, true and accurate. All questions were asked of me.

I understand that no licensed insurance agent is authorized to: make or modify contracts; waive any Insurer rights or requirements; or waive any information the Insurer requests.

The policy will become effective when all of the following conditions are met:

- the policy is issued by the Insurer
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- there have been no changes in the application that I have not notified the Insurer prior to delivery
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In CALIFORNIA, For your protection, California law requires that you be made aware of the following: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
 In COLORADO, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages, Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
 In VIRGINIA and WASHINGTON, any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application for insurance or files a claim containing a false or deceptive statement may be violated state law.
 In OKLAHOMA, WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony
 MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. WASHINGTON/TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. NEW MEXICO: 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 civil fines and criminal penalties.

I do do not want to have federal income tax withheld from my periodic or non-periodic withdrawals. I reserve the right to change this option. I understand that this insurance agent has no authority to give any legal, tax, or other advice, on behalf of this company.

You are entitled to receive a copy of this form upon request. This application remains valid for twenty four (24) months.

Signature of Proposed Insured: _____ Date: _____

Signature of Owner if other than Insured: _____ Date: _____

Signed at: _____

Agents: Does the proposed insured have any existing life insurance policies or annuity contracts? Yes No
 If "yes", complete replacement form.

To the best of your knowledge, will any existing life insurance policies or annuity contract be replaced or will values from another insurance policy or annuity contracts (through loans, surrenders or otherwise) be used to pay premiums for the policy applied for? Yes No
 If "yes", complete replacement form.

AGENT NAME AND SIGNATURE: _____	AGENT CODE NUMBER: _____
STATE LICENSE NUMBER: _____	
GENERAL AGENT NAME: _____	GENERAL AGENT CODE NUMBER: _____