

<i>SERFF Tracking Number:</i>	<i>FRTH-127705890</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Forethought Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50594</i>
<i>Company Tracking Number:</i>	<i>A4150-01</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.111 Single Premium - Single Life</i>
<i>Product Name:</i>	<i>Whole Life Insurance Application</i>		
<i>Project Name/Number:</i>	<i>A4150-01 Freedom/A4150-01</i>		

Filing at a Glance

Company: Forethought Life Insurance Company

Product Name: Whole Life Insurance SERFF Tr Num: FRTH-127705890 State: Arkansas

Application

TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- State Tr Num: 50594
Closed

Sub-TOI: L071.111 Single Premium - Single Life Co Tr Num: A4150-01 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird
Author: Beth Witte Disposition Date: 01/04/2012
Date Submitted: 12/30/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: A4150-01 Freedom

Project Number: A4150-01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 11/04/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 01/04/2012

State Status Changed: 01/04/2012

Created By: Beth Witte

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Beth Witte

Filing Description:

Attached for your review and approval are life insurance application forms. These application forms are to be used with individual whole life insurance policy forms that are being marketed by fully licensed life insurance agents and are not to be used to fund prearranged funerals. These policy forms were originally approved by your office on August 8, 2008, SERFF tracking #FRTH-125742828.

Application A4150-01-AR is an application that includes personal information and medical questions. This application will be used by agents who prefer to complete the medical questionnaire with their client prior to having a phone interview completed.

SERFF Tracking Number: FRTH-127705890 State: Arkansas
 Filing Company: Forethought Life Insurance Company State Tracking Number: 50594
 Company Tracking Number: A4150-01
 TOI: L071 Individual Life - Whole Sub-TOI: L071.111 Single Premium - Single Life
 Product Name: Whole Life Insurance Application
 Project Name/Number: A4150-01 Freedom/A4150-01

Application forms A4151-01-AR and A4152-01 include the same wording as application A4150-01-AR. A4150-01-AR is being divided into two parts, personal information and medical questionnaire, to create these two forms.

Application A4151-01-AR is an application that does not include medical questions. This application will be used by agents who prefer to have a third party interviewer complete the medical questionnaire with their client. For this purpose, we would like to have the medical questionnaire as a separate document with a different form number, form A4152-01.

These application forms contain no unusual or controversial features or language that deviate from normal insurance industry standards.

Company and Contact

Filing Contact Information

Kasey Poettker, Compliance Analyst kasey_poettker@forethought.com
 1 Forethought Center 812-933-6748 [Phone]
 Batesville, IN 47006 812-933-6348 [FAX]

Filing Company Information

Forethought Life Insurance Company CoCode: 91642 State of Domicile: Indiana
 1 Forethought Center Group Code: 1266 Company Type: Insurance
 Batesville, IN 47006 Group Name: State ID Number:
 (800) 648-0075 ext. [Phone] FEIN Number: 06-1016329

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: 3 APPLICATIONS X \$50.00 EACH = \$150.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Forethought Life Insurance Company	\$150.00	12/30/2011	54939446

SERFF Tracking Number: FRT-127705890 State: Arkansas
Filing Company: Forethought Life Insurance Company State Tracking Number: 50594
Company Tracking Number: A4150-01
TOI: L071 Individual Life - Whole Sub-TOI: L071.111 Single Premium - Single Life
Product Name: Whole Life Insurance Application
Project Name/Number: A4150-01 Freedom/A4150-01

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/04/2012	01/04/2012

SERFF Tracking Number: *FRTH-127705890* *State:* *Arkansas*
Filing Company: *Forethought Life Insurance Company* *State Tracking Number:* *50594*
Company Tracking Number: *A4150-01*
TOI: *L071 Individual Life - Whole* *Sub-TOI:* *L071.111 Single Premium - Single Life*
Product Name: *Whole Life Insurance Application*
Project Name/Number: *A4150-01 Freedom/A4150-01*

Disposition

Disposition Date: 01/04/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *FRTH-127705890* State: *Arkansas*
 Filing Company: *Forethought Life Insurance Company* State Tracking Number: *50594*
 Company Tracking Number: *A4150-01*
 TOI: *L071 Individual Life - Whole* Sub-TOI: *L071.111 Single Premium - Single Life*
 Product Name: *Whole Life Insurance Application*
 Project Name/Number: *A4150-01 Freedom/A4150-01*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Form	APPLICATION FOR LIFE INSURANCE		Yes
Form	APPLICATION FOR LIFE INSURANCE PART 1		Yes
Form	MEDICAL QUESTIONNAIRE		Yes

SERFF Tracking Number: FRTH-127705890 State: Arkansas
 Filing Company: Forethought Life Insurance Company State Tracking Number: 50594
 Company Tracking Number: A4150-01
 TOI: L071 Individual Life - Whole Sub-TOI: L071.111 Single Premium - Single Life
 Product Name: Whole Life Insurance Application
 Project Name/Number: A4150-01 Freedom/A4150-01

Form Schedule

Lead Form Number: A4150-01

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	A4150-01-AR	Application/ Enrollment Form APPLICATION FOR LIFE INSURANCE	Initial		54.000	A4150-01-AR Application for LI Freedom 1011.pdf
	A4151-01-AR	Application/ Enrollment Form APPLICATION FOR LIFE INSURANCE PART 1	Initial		54.000	A4151-01-AR Application for LI Part 1 Freedom 1011.pdf
	A4152-01	Application/ Enrollment Form MEDICAL QUESTIONNAIRE	Initial		51.000	A4152-01 Application for LI Part 2 Freedom 1011.pdf

Forethought Life Insurance Company One Forethought Center Batesville, IN 47006-0148

1. PROPOSED INSURED

(Please Print Using Black Ink)

First Name		Middle Initial	Last Name	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Age	State of Birth	Social Security Number - .
Are You a U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No IF NO, PROVIDE PERMANENT RESIDENT CARD NUMBER OR VISA TYPE				
Mailing Address			Residential Address (if different than Mailing Address)	
City		State	Zip Code	Occupation
Phone Number (home) ()		Phone Number (work) ()		E-mail Address
Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				

2. OWNER *(Complete only if the Owner and Proposed Insured are different.)*

First Name		Middle Initial	Last Name	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Proposed Insured		Social Security Number - .	
Are You a U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No IF NO, PROVIDE PERMANENT RESIDENT CARD NUMBER OR VISA TYPE				
Mailing Address			Residential Address (if different than Mailing Address)	
City		State	Zip Code	
Phone Number (home) ()		Phone Number (work) ()		E-mail Address

3. BENEFICIARY INFORMATION *(Beneficiary proceeds will be split equally if no percentages are provided.)*

Primary

First Name		Middle Initial	Last Name	
Age	Relationship to Proposed Insured		Social Security Number - .	Percentage

First Name		Middle Initial	Last Name	
Age	Relationship to Proposed Insured		Social Security Number - .	Percentage

Contingent

First Name		Middle Initial	Last Name	
Age	Relationship to Proposed Insured		Social Security Number - .	Percentage

First Name		Middle Initial	Last Name	
Age	Relationship to Proposed Insured		Social Security Number - .	Percentage

4. INSURANCE PLAN INFORMATION

Plan of Insurance: <input type="checkbox"/> Level Death Benefit <input type="checkbox"/> Graded Death Benefit	Billing Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT
Face Amount \$ _____	
Riders: { <input type="checkbox"/> _____ } { <input type="checkbox"/> _____ } { <input type="checkbox"/> _____ }	
Initial Premium \$ _____	<input type="checkbox"/> Check with Application <i>Make check payable to Forethought Life Insurance Company</i> <input type="checkbox"/> Draft First Premium <i>Draft EFT account for initial premium on _____</i>

5. BANK DRAFT AUTHORIZATION – Please attach a voided personal check

Electronic Funds Transfer (EFT) <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Custom Date _____ (1 st thru 28 th of the month) Account # _____ ABA Routing/Transit # _____ ()	
Name of Financial Institution _____	Phone # of Financial Institution _____	
Social Security Number of Account Holder _____		
<p>Automatic Payment Authorization – Must be completed for EFT I authorize Forethought Life Insurance Company (“FLIC”) to charge/deduct my insurance premium from my account. This authorization is to remain in effect until I revoke my automatic monthly premium payment by notifying FLIC.</p>		
Payor’s Signature – <i>as it appears on the bank account</i> _____		Date _____

6. REPLACEMENT INFORMATION

1. Does the proposed insured currently have any life insurance in force?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Will this insurance replace any life insurance in force? If Yes, complete #3 and submit replacement forms required by your state.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Company Name _____ _____	Face Amount _____ _____	Policy Number _____ _____

7. ELIGIBLE GRANDCHILDREN (to be covered by Grandchildren’s Benefit)

Grandchild’s Full Name	Date of Birth	Grandchild’s Full Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

8. HEALTH QUESTIONS

1.	What is your current Height? _____ ft _____ in: Weight? _____ lbs		
2.	Do you require assistance in performing the Activities of Daily Living (ADL's) of eating, bathing, toileting, transferring or dressing or are you confined to a wheelchair?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
3.	Are you currently:		
	a. Hospitalized or confined to a bed, nursing home, psychiatric facility, receiving home health care or hospice care or are you currently incarcerated?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	b. Receiving kidney dialysis, chemotherapy or radiation, or using oxygen equipment to assist in breathing (other than for sleep apnea)?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
4.	Have you:		
	a. Been medically diagnosed as having a life expectancy of 12 months or less?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	b. Had a heart, lung, liver or kidney transplant or has one been recommended to you?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	c. Within the last 12 months, been advised to have any medical procedure, diagnostic test or surgery that has not yet been done or for which the results have not been received?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	d. Been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
5.	Have you been medically diagnosed, treated for, advised to have treatment for, taken medication, or been prescribed medication for:		
	a. Alzheimer's disease, dementia, chronic memory loss?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	b. Lou Gehrig's disease (ALS), kidney or liver failure, or end stage kidney disease?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	c. Congestive heart failure or cardiomyopathy within the last 24 months?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
6.	In the last 12 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:		
	a. Coronary artery disease, heart attack, angina, heart surgery (including bypass, angioplasty and stent placement) or heart valve replacement?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	b. Stroke or transient ischemic attack (TIA), carotid artery surgery or aneurysm?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
7.	In the last 24 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:		
	a. Any internal cancer, brain tumor, leukemia, melanoma, Hodgkin's disease or other lymphoma, cirrhosis of the liver or alcohol or drug dependency?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	b. Diabetes with complications including, eye or kidney disorders, diabetic coma, insulin shock or amputation due to disease?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
8.	Do you have diabetes in combination with a stroke, TIA, or heart disease (including heart attack and heart surgery); have you had multiple strokes, TIA's or heart attacks, or do you have heart disease with a history of a stroke or TIA?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
9.	In the last 24 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:		
	a. Coronary artery disease, heart attack, angina, heart surgery (including bypass, angioplasty and stent placement) or heart valve replacement?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	b. Stroke or transient ischemic attack (TIA), carotid artery surgery, aneurysm or any irregular heartbeat, such as atrial fibrillation (including a pacemaker or defibrillator)?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	c. Depression, bipolar disorder, schizophrenia or other psychosis?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	d. Parkinson's disease, multiple sclerosis or chronic hepatitis?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
	e. Emphysema, chronic obstructive pulmonary disease (COPD), asthma or chronic bronchitis?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
10.	Do you have diabetes that has required insulin treatment within the last 5 years?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
11.	In the last 12 months, have you had a seizure or convulsion?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
12.	Have you been hospitalized 2 or more times in the last 12 months for any reason?	<input type="checkbox"/>	Yes <input type="checkbox"/> No

9. STATE REQUIRED NOTICES

AR Residents

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.

10. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the Proposed Insured, authorize Forethought Life Insurance Company to obtain protected health information including prescription history, for the purpose of determining my eligibility for insurance, from any licensed physician, medical practitioner, hospital, clinic, the Veteran's administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the Medical Information Bureau, Inc. (MIB), insurance companies, consumer reporting agencies and authorize said persons, firms or entities to furnish such information to Forethought Life Insurance Company.

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may not be protected under federal privacy rules.

A photographic copy of this authorization shall be as valid as the original. I have a right to receive a copy of this authorization upon request. This authorization shall be valid for two years from the date of my signature below, and may be revoked by sending written notice to Forethought Life Insurance Company at the address listed above.

11. AGREEMENT

I agree that no insurance shall be in effect until: (a) a policy has been issued, and (b) the first premium is paid while I am living and my insurability remains unchanged and then only if I am actually in the state of health represented in this application.

I state that the answers set forth in this application are full, complete and true to the best of my knowledge and belief. The answers are the basis of any insurance issued.

I acknowledge that I have received the Notice of Information Practices and the MIB disclosure notice.

I agree that a verbal confirmation may be requested for this application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

All statements made by me or on behalf of me shall be deemed to be representations and not warranties.

Proposed Insured Signature

Date

Signed At (City, State)

Owner Signature (if other than Proposed Insured)

Date

Signed At (City, State)

Licensed Agent Signature

Date

Signed At (City, State)

12. AGENT DECLARATIONS AND SIGNATURES

Primary Agent Name (Print)			
Address	City	State	Zip Code
Phone Number (home) ()	E-mail Address		
Business or Institution Name	Business or Institution Phone Number ()		
License Number	Agent Number		

I declare that: (a) the application was signed and dated by the Proposed Insured and by the Owner, if not the Proposed Insured, after all answers and information were recorded herein; and (b) I have truly and accurately recorded on this form all of the information provided by the Proposed Insured and the Owner, if not the Proposed Insured.

1. Did you personally see the Proposed Insured? Yes
 If yes, what type of photo ID was used to verify identity? No

Drivers license Passport Other _____

2. Will this policy replace or change any existing life insurance or annuities? If yes, complete the appropriate state Replacement form and submit it with the application. Yes
 No

3. Did you give the Proposed Insured a copy of the Information Practices and MIB Disclosure? Yes
 No

If the Owner is other than the Proposed Insured, what type of photo ID was used to verify the Owner's identity?

Drivers license Passport Other _____

What is the best time and phone number to contact the Proposed Insured?

Time _____ Phone Number () _____ Time Zone _____

Mail completed policy to: Agent Policyowner

_____ Primary Agent Signature	_____ Date	_____ Signed At (City, State)
_____ Print Name	_____ Commission %	
_____ Agent Signature	_____ Date	_____ Signed at (City, State)
_____ Print Name	_____ Commission %	_____ Agent Number

FORETHOUGHT LIFE INSURANCE COMPANY HOME OFFICE USE ONLY

Application for Life Insurance
 Forethought Life Insurance Company
 One Forethought Center
 P.O. Box 148
 Batesville, IN 47006-0148

Forethought Life Insurance Company One Forethought Center Batesville, IN 47006-0148

1. PROPOSED INSURED

(Please Print Using Black Ink)

First Name		Middle Initial	Last Name	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Age	State of Birth
Social Security Number - -				
Are You a U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No IF NO, PROVIDE PERMANENT RESIDENT CARD NUMBER OR VISA TYPE				
Mailing Address			Residential Address (if different than Mailing Address)	
City		State	Zip Code	Occupation
Phone Number (home) ()		Phone Number (work) ()		E-mail Address
Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				

2. OWNER *(Complete only if the Owner and Proposed Insured are different.)*

First Name		Middle Initial	Last Name	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Relationship to Proposed Insured		Social Security Number - -
Are You a U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No IF NO, PROVIDE PERMANENT RESIDENT CARD NUMBER OR VISA TYPE				
Mailing Address			Residential Address (if different than Mailing Address)	
City		State	Zip Code	
Phone Number (home) ()		Phone Number (work) ()		E-mail Address

3. BENEFICIARY INFORMATION *(Beneficiary proceeds will be split equally if no percentages are provided.)*

Primary

First Name		Middle Initial	Last Name	
Age	Relationship to Proposed Insured		Social Security Number - -	Percentage

First Name		Middle Initial	Last Name	
Age	Relationship to Proposed Insured		Social Security Number - -	Percentage

Contingent

First Name		Middle Initial	Last Name	
Age	Relationship to Proposed Insured		Social Security Number - -	Percentage

First Name		Middle Initial	Last Name	
Age	Relationship to Proposed Insured		Social Security Number - -	Percentage

4. INSURANCE PLAN INFORMATION

Plan of Insurance: <input type="checkbox"/> Level Death Benefit <input type="checkbox"/> Graded Death Benefit	Billing Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT
Face Amount \$ _____	
Riders: { <input type="checkbox"/> _____ } { <input type="checkbox"/> _____ } { <input type="checkbox"/> _____ }	
Initial Premium \$ _____	
<input type="checkbox"/> Check with Application <i>Make check payable to Forethought Life Insurance Company</i> <input type="checkbox"/> Draft First Premium <i>Draft EFT account for initial premium on _____</i>	

5. BANK DRAFT AUTHORIZATION – Please attach a voided personal check

Electronic Funds Transfer (EFT) <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Custom Date _____ (1 st thru 28 th of the month) Account # _____ ABA Routing/Transit # _____ ()	
Name of Financial Institution _____		Phone # of Financial Institution _____
Social Security Number of Account Holder _____		
Automatic Payment Authorization – Must be completed for EFT I authorize Forethought Life Insurance Company (“FLIC”) to charge/deduct my insurance premium from my account. This authorization is to remain in effect until I revoke my automatic monthly premium payment by notifying FLIC.		
Payor’s Signature – <i>as it appears on the bank account</i> _____		Date _____

6. REPLACEMENT INFORMATION

1. Does the proposed insured currently have any life insurance in force?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Will this insurance replace any life insurance in force? If Yes, complete #3 and submit replacement forms required by your state.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Company Name _____ _____	Face Amount _____ _____	Policy Number _____ _____

7. ELIGIBLE GRANDCHILDREN (to be covered by Grandchildren’s Benefit)

Grandchild’s Full Name	Date of Birth	Grandchild’s Full Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

8. STATE REQUIRED NOTICES

AR Residents

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.

9. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the Proposed Insured, authorize Forethought Life Insurance Company to obtain protected health information including prescription history, for the purpose of determining my eligibility for insurance, from any licensed physician, medical practitioner, hospital, clinic, the Veteran's administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the Medical Information Bureau, Inc. (MIB), insurance companies, consumer reporting agencies and authorize said persons, firms or entities to furnish such information to Forethought Life Insurance Company.

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may not be protected under federal privacy rules.

A photographic copy of this authorization shall be as valid as the original. I have a right to receive a copy of this authorization upon request. This authorization shall be valid for two years from the date of my signature below, and may be revoked by sending written notice to Forethought Life Insurance Company at the address listed above.

10. AGREEMENT

I agree that no insurance shall be in effect until: (a) a policy has been issued, and (b) the first premium is paid while I am living and my insurability remains unchanged and then only if I am actually in the state of health represented in this application.

I state that the answers set forth in this application are full, complete and true to the best of my knowledge and belief. The answers are the basis of any insurance issued.

I acknowledge that I have received the Notice of Information Practices and the MIB disclosure notice.

I agree that a verbal confirmation may be requested for this application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

All statements made by me or on behalf of me shall be deemed to be representations and not warranties.

Proposed Insured Signature

Date

Signed At (City, State)

Owner Signature (if other than Proposed Insured)

Date

Signed At (City, State)

Licensed Agent Signature

Date

Signed At (City, State)

11. AGENT DECLARATIONS AND SIGNATURES

Primary Agent Name (Print)			
Address	City	State	Zip Code
Phone Number (home) ()	E-mail Address		
Business or Institution Name	Business or Institution Phone Number ()		
License Number	Agent Number		

I declare that: (a) the application was signed and dated by the Proposed Insured and by the Owner, if not the Proposed Insured, after all answers and information were recorded herein; and (b) I have truly and accurately recorded on this form all of the information provided by the Proposed Insured and the Owner, if not the Proposed Insured.

1. Did you personally see the Proposed Insured? Yes
 If yes, what type of photo ID was used to verify identity? No
 Drivers license Passport Other _____

2. Will this policy replace or change any existing life insurance or annuities? If yes, complete the appropriate state Replacement form and submit it with the application. Yes
 No

3. Did you give the Proposed Insured a copy of the Information Practices and MIB Disclosure? Yes
 No

If the Owner is other than the Proposed Insured, what type of photo ID was used to verify the Owner's identity?

Drivers license Passport Other _____

What is the best time and phone number to contact the Proposed Insured?

Time _____ Phone Number () _____ Time Zone _____

Mail completed policy to: Agent Policyowner

Primary Agent Signature

Date

Signed At (City, State)

Print Name

Commission %

Agent Signature

Date

Signed at (City, State)

Print Name

Commission %

Agent Number

FORETHOUGHT LIFE INSURANCE COMPANY HOME OFFICE USE ONLY

Application for Life Insurance

Forethought Life Insurance Company
 One Forethought Center
 P.O. Box 148
 Batesville, IN 47006-0148

Forethought Life Insurance Company One Forethought Center Batesville, IN 47006-0148

1. PROPOSED INSURED

(Please Print Using Black Ink)

Name (First, Middle Initial, Last)		Date of birth (mm/dd/yyyy)
Mailing Address		
City	State	Social Security Number - -

2. HEALTH QUESTIONS

1. What is your current Height? _____ ft _____ in: Weight? _____ lbs	
2. Do you require assistance in performing the Activities of Daily Living (ADL's) of eating, bathing, toileting, transferring or dressing or are you confined to a wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you currently:	
a. Hospitalized or confined to a bed, nursing home, psychiatric facility, receiving home health care or hospice care or are you currently incarcerated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Receiving kidney dialysis, chemotherapy or radiation, or using oxygen equipment to assist in breathing (other than for sleep apnea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you:	
a. Been medically diagnosed as having a life expectancy of 12 months or less?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Had a heart, lung, liver or kidney transplant or has one been recommended to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Within the last 12 months, been advised to have any medical procedure, diagnostic test or surgery that has not yet been done or for which the results have not been received?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been medically diagnosed, treated for, advised to have treatment for, taken medication, or been prescribed medication for:	
a. Alzheimer's disease, dementia, chronic memory loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Lou Gehrig's disease (ALS), kidney or liver failure, or end stage kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Congestive heart failure or cardiomyopathy within the last 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the last 12 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:	
a. Coronary artery disease, heart attack, angina, heart surgery (including bypass, angioplasty and stent placement) or heart valve replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Stroke or transient ischemic attack (TIA), carotid artery surgery or aneurysm?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. In the last 24 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:	
a. Any internal cancer, brain tumor, leukemia, melanoma, Hodgkin's disease or other lymphoma, cirrhosis of the liver or alcohol or drug dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes with complications including, eye or kidney disorders, diabetic coma, insulin shock or amputation due to disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you have diabetes in combination with a stroke, TIA, or heart disease (including heart attack and heart surgery); have you had multiple strokes, TIA's or heart attacks, or do you have heart disease with a history of a stroke or TIA?	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. In the last 24 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:
- a. Coronary artery disease, heart attack, angina, heart surgery (including bypass, angioplasty and stent placement) or heart valve replacement? Yes No
 - b. Stroke or transient ischemic attack (TIA), carotid artery surgery, aneurysm or any irregular heartbeat, such as atrial fibrillation (including a pacemaker or defibrillator)? Yes No
 - c. Depression, bipolar disorder, schizophrenia or other psychosis? Yes No
 - d. Parkinson's disease, multiple sclerosis or chronic hepatitis? Yes No
 - e. Emphysema, chronic obstructive pulmonary disease (COPD), asthma or chronic bronchitis? Yes No
10. Do you have diabetes that has required insulin treatment within the last 5 years? Yes No
11. In the last 12 months, have you had a seizure or convulsion? Yes No
12. Have you been hospitalized 2 or more times in the last 12 months for any reason? Yes No

3. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the Proposed Insured, authorize Forethought Life Insurance Company to obtain protected health information including prescription history, for the purpose of determining my eligibility for insurance, from any licensed physician, medical practitioner, hospital, clinic, the Veteran's administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the Medical Information Bureau, Inc (MIB), insurance companies, consumer reporting agencies and authorize said persons, firms or entities to furnish such information to Forethought Life Insurance Company.

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may not be protected under federal privacy rules.

A photographic copy of this authorization shall be as valid as the original. I have a right to receive a copy of this authorization upon request. This authorization shall be valid for two years from the date of my signature below, and may be revoked by sending written notice to Forethought Life Insurance Company at the address listed above.

4. AGREEMENT

I agree that no insurance shall be in effect until: (a) a policy has been issued, and (b) the first premium is paid while living and my insurability remains unchanged and then only if I am actually in the state of health represented in this application.

I state that the answers set forth in this application are full, complete and true to the best of my knowledge and belief. The answers are the basis of any insurance issued.

I acknowledge that I have received the Notice of Information Practices and the MIB disclosure notice.

I agree that a verbal confirmation may be requested for this application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

All statements made by me or on behalf of me shall be deemed to be representations and not warranties.

Proposed Insured Signature

Date

Proposed Insured Printed Name

Examiner/Interviewer Signature

SERFF Tracking Number: FRTH-127705890

State: Arkansas

Filing Company: Forethought Life Insurance Company

State Tracking Number: 50594

Company Tracking Number: A4150-01

TOI: L071 Individual Life - Whole

Sub-TOI: L071.111 Single Premium - Single Life

Product Name: Whole Life Insurance Application

Project Name/Number: A4150-01 Freedom/A4150-01

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

A4150-01 Readability Cert 1011.pdf

Item Status:

Status

Date:

Bypassed - Item: Application

Bypass Reason: N/A

Comments:

Item Status:

Status

Date:

Bypassed - Item: Life & Annuity - Acturial Memo

Bypass Reason: N/A

Comments:

CERTIFICATION OF READABILITY

FORM #	FORM NAME	FLESCH SCORE
A4150-01	APPLICATION FOR LIFE INSURANCE	54.0
A4151-01	APPLICATION FOR LIFE INSURANCE – PART 1	54.0
A4152-01	APPLICATION FOR LIFE INSURANCE – PART 2 MEDICAL QUESTIONNAIRE	51.0

Forethought Life Insurance Company hereby certifies that these forms achieve the Flesch reading ease score listed.



David K. Mullen, Senior Vice President

October 11, 2011