

<i>SERFF Tracking Number:</i>	<i>METF-127892200</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Texas Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>11M009 R 11/12</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Applications</i>		
<i>Project Name/Number:</i>	<i>/11M009 R 11/12</i>		

Filing at a Glance

Company: Texas Life Insurance Company

Product Name: Applications

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate
Premium - Single Life

Filing Type: Form

SERFF Tr Num: METF-127892200 State: Arkansas

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

Co Tr Num: 11M009 R 11/12

State Status: Approved-Closed

Author: Jan Spoede

Date Submitted: 01/04/2012

Reviewer(s): Linda Bird

Disposition Date: 01/06/2012

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number: 11M009 R 11/12

Requested Filing Mode: Informational

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 12/19/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 01/06/2012

State Status Changed: 01/06/2012

Created By: Jan Spoede

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Jan Spoede

Filing Description:

11M009 R 12/11, Application

11M010 R 12/11 R 12/11, Supplement to Application

11M009-E R 12/11, Electronic Application

11N060 R 12/11, Amendment to Application

<i>SERFF Tracking Number:</i>	<i>METF-127892200</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Texas Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>11M009 R 11/12</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Applications</i>		
<i>Project Name/Number:</i>	<i>/11M009 R 11/12</i>		

A few revisions have been made to the previously approved applications listed above. These revisions were made to keep these applications consistent with the approved ICC applications.

On the paper apps (11M009 R 12/11 and 11M010 R 12/11) the following revisions were made: On 11M009 R 12/11, the tier 2 lead-in question was revised; question 1a on the supplement to application, 11M010 R 12/11; and the revision revision dates were added to the both form numbers.

On the electronic application, 11M009-E R 12/11 the tier 2 lead-in question - 3 and question 4a were revised and the revision dates were added to the form number.

The following revisions were made to the Amendment:

1. the lead-in question to a.-j.
2. question 1.a.
3. revised form #.

Red Lined copies of the forms are attached to the Supporting Documents Tab.

No other changes were made to these forms.

Company and Contact

Filing Contact Information

Jan Spoede, Senior Associate, Product Development	jspoede@texaslife.com
P.O. Box 830	800-283-9233 [Phone] 6371 [Ext]
Waco, TX 76703	254-745-6389 [FAX]

Filing Company Information

Texas Life Insurance Company	CoCode: 69396	State of Domicile: Texas
P.O. Box 830	Group Code:	Company Type: Life
Waco, TX 76703	Group Name:	State ID Number:
(800) 283-9233 ext. [Phone]	FEIN Number: 74-0940890	

Filing Fees

SERFF Tracking Number: METF-127892200 State: Arkansas
Filing Company: Texas Life Insurance Company State Tracking Number:
Company Tracking Number: 11M009 R 11/12
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Applications
Project Name/Number: /11M009 R 11/12

Fee Required? Yes
Fee Amount: \$200.00
Retaliatory? No
Fee Explanation: AR charges \$50.00 per form. There are 4 forms.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Texas Life Insurance Company	\$200.00	01/04/2012	55025507

SERFF Tracking Number: METF-127892200

State: Arkansas

Filing Company: Texas Life Insurance Company

State Tracking Number:

Company Tracking Number: 11M009 R 11/12

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Applications

Project Name/Number: /11M009 R 11/12

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/06/2012	01/06/2012

SERFF Tracking Number: *METF-127892200* *State:* *Arkansas*
Filing Company: *Texas Life Insurance Company* *State Tracking Number:*
Company Tracking Number: *11M009 R 11/12*
TOI: *L071 Individual Life - Whole* *Sub-TOI:* *L071.101 Fixed/Indeterminate Premium - Single*
Product Name: *Applications* *Life*
Project Name/Number: */11M009 R 11/12*

Disposition

Disposition Date: 01/06/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: METF-127892200 State: Arkansas
 Filing Company: Texas Life Insurance Company State Tracking Number:
 Company Tracking Number: 11M009 R 11/12
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Applications
 Project Name/Number: /11M009 R 11/12

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Red-lined forms.		Yes
Form	Application		Yes
Form	Supplement to Application		Yes
Form	Electronic Application		Yes
Form	Amendment to Application		Yes

SERFF Tracking Number: METF-127892200 State: Arkansas
 Filing Company: Texas Life Insurance Company State Tracking Number:
 Company Tracking Number: 11M009 R 11/12
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Applications
 Project Name/Number: /11M009 R 11/12

Form Schedule

Lead Form Number: 11M009 R 11/12

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	11M009 R 12/11	Application/ Enrollment Form	Revised	Replaced Form #: 11M009 Previous Filing #: METF-127318429	56.600	11M009 R 12-11 _AR_CT_DC_DE_ND_SD[1].pdf
	11M010 R 12/11	Application/ Supplement to Enrollment Application Form	Revised	Replaced Form #: 11M010 Previous Filing #: METF-127318429	56.600	11M010 R 11-12 _AR_CT_DC_DE_ND_SD[1].pdf
	11M009-E R 12/11	Application/ Electronic Enrollment Form	Revised	Replaced Form #: 11M009-E Previous Filing #: METF-127339952	56.600	11M009-E R12-11 RED LINED_AR_DC_DE_ND_SD[1].pdf
	11N060 R12/11	Policy/Cont Amendment to ract/Fratern Application al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: 11N060 Previous Filing #: METF-127311344	55.800	AAWappAme nd2011_AR_CT_DC_DE_ND_SD Rev 12-11pdf.pdf

1st Deduction Date: _____ Employer: _____ Policy Number: _____

Proposed Insured Personal Information

Last Name	<input type="text"/>	SSN	<input type="text"/>
First Name	<input type="text"/>	Birth Date	<input type="text"/> Age ⁽¹⁾ <input type="text"/>
MI	<input type="text"/>	Sex	<input type="text"/> Hire Date <input type="text"/>

Tier 1 Questions

Within the last 12 months have you used tobacco in any form? Yes No
 Are you at work on a full-time basis, performing your usual duties? Yes No

Street/PO Box City State Zip

Phone: Day Evening Email

Beneficiary Name: Relationship:

Will proposed coverage replace or change any existing insurance or annuity policy? Yes No
 (if "Yes" identify and complete replacement form.) Company Policy Number

Do you have existing insurance or annuities (including coverage with Texas Life)? Yes No If "Yes" complete the Existing Insurance Form *even if replacement is not contemplated.*

Coverage Information

Face Amount ⁽²⁾	<input type="text"/>	Plan of Insurance: _____ [One To One] _____
Premium	<input type="text"/>	Select Riders to be Added: <input type="checkbox"/> Family Term Rider <input type="checkbox"/> Accidental Death ⁽³⁾ <input type="checkbox"/> Waiver Premium ⁽³⁾ [<input type="checkbox"/> Rider] [<input type="checkbox"/> Rider]
Rider Premium	<input type="text"/>	Payroll is per: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Skip _____
Total Premium	<input type="text"/>	<input type="checkbox"/> I elect the Automatic Contract Loan provision to pay a premium overdue 30 days or more, if my policy has sufficient cash value.

Tier 2 Questions

(If answered "Yes" no coverage is offered, except as available under Tier 1 questions.)

During the last 24 months have you been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following: a. Cancer (excluding non-melanoma skin cancer)? b. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy? c. Alcohol or drug abuse? d. Diabetes for which the recommended treatment is insulin? e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)? f. Stroke or transient ischemic attack (TIA)? g. Chronic kidney disease or kidney failure (excluding kidney stones)? h. Parkinson's disease or paralysis? i. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)? j. Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?	Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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(1) Age on Issue Date (2) or Face Amount purchased by premium shown, if less (3) Proposed insured (employee) issue ages 17-59

Additional Statements

For residents of [AL, DC, IN, and OR]: I received a summary description of the accelerated death benefit and Important Notice regarding Accelerated Death Benefit.

For residents of Arkansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.

For residents of Washington, DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment, and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

Proposed Insured
(Owner) Signature _____ Date _____ City _____ State _____

Agent Only: To the best of my knowledge the insurance applied for is is not to replace existing insurance or annuity. I have delivered to the Proposed Insured the applicable forms and information described in Additional Statements above.

Enroller
Signature _____ Print
Enroller Name _____ Agent # _____

Interim Insurance

Interim insurance will be in force on the application date if these conditions are met: (1) the insurance is purchased through payroll deduction or through your membership in a union or association; (2) you sign a Salary Deduction Authorization or Bank Draft Authorization Form (union and association members only); and, (3) you are insurable at standard rates under Our rules and usual practice. Interim insurance remains in effect until the earlier of: (a) the Policy Date; (b) the date We decline the application; (c) the date We notify you that you are ineligible for interim insurance; or, (d) the 180th day after the application date.

Supplement to Application from (Employee): _____
 Employee Social Security: _____ Application Date: _____

1. Within the past five years, have you: a. been treated by a member of the medical profession, been an inpatient or outpatient at a hospital or clinic, or been advised to have a surgical operation? b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)? c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician? d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past ten years, have you been diagnosed with or been treated for: a. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys? b. Cancer, tumor, diabetes, or disorder of the blood? c. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder? d. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details below.	<input type="checkbox"/>	<input type="checkbox"/>

4. What is your height, weight, and birth state?	Hgt.	Wgt.	Birth State
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5. Your personal physician (if none, enter "None")

Physician Name: _____

Address: _____ City: _____ State: _____

6. Details, including date, diagnosis, type of treatment, and current condition		Name, address and phone # of physician(s)
Ques No.	Details	

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

X _____
 Proposed Insured (Owner) Signature

X _____
 Enroller/Agent Signature Print Enroller/Agent Name Agt No. Date City State

Proposed Insured

NAME	STATUS	SEX	SOCIAL SECURITY NO.	BIRTH DATE	AGE	BENEFICIARY/RELATIONSHIP
John Q. AR	EMP	M	111111111	03-01-1976	35	Primary: Gary Doe, Child (100%) /

Employee Information (applicant and policy owner):

NAME: John Q. Doe SOCIAL SECURITY NO: 111111111
 ADDRESS: 123 Main Street, Waco, TX 76710
 PERSONAL EMAIL ADDRESS: www.jdoe.mybook.com DAYTIME PHONE: 254-666-1111 EVENING PHONE: 254-333-1111
 EMPLOYER: ABC GROUP HIRE DATE: 01-01-2001 PAYROLL FREQUENCY: 12

Coverages and Premium

PLAN NAME: [Texas Life SOLUTION Series 321] POLICY FORM: [WLSTO-11]

NAME	FACE AMOUNT	ADB AMOUNT	WAIVER BENEFIT	FAMILY TERM RIDER	[CHILD TERM AMOUNT]	[UNION STRIKE RIDER]	TOTAL PREMIUM
John Q. AR	250000.00	250000.00	No	Yes	[0]	[No]	
Payroll Frequency Premium	154.00	20.00	15.40	2.00	[0.00]	[0.00]	189.40

I elect the **Automatic Premium Loan** provision to pay premium overdue 30 days or more, if my policy has sufficient cash value. Yes

REPLACEMENT

Will proposed coverage replace or change any existing insurance or annuity policy? [Detail here for Yes responses] No

[Do you have existing insurance or annuities (including coverage with Texas Life)? If "Yes" complete the Existing Insurance Form even if replacement is not contemplated.] No

QUESTION No.	PROPOSED INSURED
(1) Within the last 12 months have you used tobacco in any form?	No
(2) Are you at work on a full-time basis, performing your usual duties?	Yes
[(3) <u>During the last 24 months have you been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following:</u> a. Cancer (excluding non-melanoma skin cancer)? b. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy? c. Alcohol or drug abuse? d. Diabetes for which the recommended treatment is insulin? e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)? f. Stroke or transient ischemic attack (TIA)? g. Chronic kidney disease or kidney failure (excluding kidney stones)? h. Parkinson's disease or paralysis? i. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)? j. Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?	No]
[(4a) <u>Within the past five years, have you been treated by a member of the medical profession, been an inpatient or outpatient at a hospital or clinic, or been advised to have a surgical operation?</u> [Detail here for Yes responses]	No]

QUESTION No.**PROPOSED
INSURED**

- | | | |
|--------|--|-----|
| [(4b) | Within the past five years, have you had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)?
<i>[Detail here for Yes responses]</i> | No] |
| [(4c) | Within the past five years, have you used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician?
<i>[Detail here for Yes responses]</i> | No] |
| [(4d) | Within the past five years, have you been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?
<i>[Detail here for Yes responses]</i> | No] |
| [(5a) | Within the past ten years, have you been diagnosed with or been treated for heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?
<i>[Detail here for Yes responses]</i> | No] |
| [(5b) | Within the past ten years, have you been diagnosed with or been treated for alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys?
<i>[Detail here for Yes responses]</i> | No] |
| [(5c) | Within the past ten years, have you been diagnosed with or been treated for cancer, tumor, diabetes, or disorder of the blood?
<i>[Detail here for Yes responses]</i> | No] |
| [(5d) | Within the past ten years, have you been diagnosed with or been treated for asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder?
<i>[Detail here for Yes responses]</i> | No] |
| [(6) | Are you taking any prescribed medication at regular intervals?
<i>[Detail here for Yes responses]</i> | No] |
| [(7) | What is your height, weight, and birth state?
<i>John Q. Doe - Height: 5'10" Weight: 180 lbs Birth State: VA</i> |] |
| [(8) | Your Personal physician:
<i>John Q. Doe - Dr Phylis Smith, 123 Main Waco, TX</i> |] |

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

E-SIGNATURE RECORDED

20110301 19:11:45 IDQ _____

PROPOSED INSURED (AND POLICY OWNER) SIGNATURE

Agent Only: To the best of my knowledge the insurance applied for **[IS NOT]** to replace existing insurance or annuity.

<u>KOLT AGENT</u>	<u>9999994</u>	<u>20110301</u>	<u>WACO</u>	<u>AR</u>
PRINT ENROLLER/AGENT NAME	AGT. NO.	DATE	CITY	STATE

E-SIGNATURE RECORDED

ELEC SIGNATURE 201103011090301 _____

ENROLLER / AGENT SIGNATURE

Interim Insurance

Interim insurance will be in force on the application date if these conditions are met: (1) the insurance is purchased through payroll deduction or through your membership in a union or association; (2) you sign a Salary Deduction Authorization or Bank Draft Authorization Form (union and association members only); and, (3) you are insurable at standard rates under Our rules and usual practice. Interim insurance remains in effect until the earlier of: (a) the Policy Date; (b) the date We decline the application; (c) the date We notify you that you are ineligible for interim insurance; or, (d) the 180th day after the application date.

Amendment to Application on Proposed Insured: [(INSURED'S NAME HERE)]
File Number: [00100000]

- | | | |
|--|--|---------------------------------------|
| [Within the last 12 months have you used tobacco in any form?] | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| [Are you at work on a full-time basis, performing your usual duties?] | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--|---------------------------------------|
| [During the last 24 months have you been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following:?] | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
|---|--|---------------------------------------|
- [a. Cancer (excluding non-melanoma skin cancer)?]
 - [b. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy?]
 - [c. Alcohol or drug abuse?]
 - [d. Diabetes for which the recommended treatment is insulin?]
 - [e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)?]
 - [f. Stroke or transient ischemic attack (TIA)?]
 - [g. Chronic kidney disease or kidney failure (excluding kidney stones)?]
 - [h. Parkinson's disease or paralysis?]
 - [i. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)?]
 - [j. Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?]

- | | | |
|--|------------|-----------|
| [1. Within the past five years, have you:] | Yes | No |
|--|------------|-----------|
- [a. been treated by a member of the medical profession, been an inpatient or outpatient at a hospital or clinic, or been advised to have a surgical operation?]
 - [b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)?]
 - [c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician?]
 - [d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?]

- | | | |
|---|--------------------------|--------------------------|
| [2. Within the past ten years, have you been diagnosed with or been treated for:] | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|
- [a. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys?]
 - [b. Cancer, tumor, diabetes, or disorder of the blood?]
 - [c. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder?]
 - [d. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?]

[3. Are you taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details in No. 6. below.]	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------

[4. What is your height, weight, and birth state? Height:_____ Weight:_____ Birth State:_____]

[5. Your personal physician (if none, enter "None")

Physician Name:_____ Address:_____

City:_____ State/Zip:_____

]

Continued Next Page

[6. Details, including date, diagnosis, type of treatment, and current condition

Ques. #	Details	Name/address/phone of physician(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this amendment to application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

X _____
Signature (Insured's Name Here) Date

SERFF Tracking Number: METF-127892200 State: Arkansas
 Filing Company: Texas Life Insurance Company State Tracking Number:
 Company Tracking Number: 11M009 R 11/12
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Applications
 Project Name/Number: /11M009 R 11/12

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachments:		
WLSTO-NI-11 & apps R 12-11_Read_Cert.pdf		
11N060 Amendment_Read_Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
This filing is for applications.		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: These forms are all applications.		
Comments:		

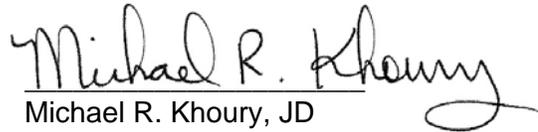
	Item Status:	Status Date:
Satisfied - Item: Red-lined forms.		
Comments:		
Attachments:		
AAWappAmend2011_AR_CT_DC_DE_ND_SD Rev 12-11 RED LINEDpdf.pdf		
11M009 R 12-11 RED LINED_AR_CT_DC_DE_ND_SD[1].pdf		
11M009-E R12-11 RED LINED_AR_DC_DE_ND_SD[1].pdf		
11M010 R 11-12 RED LINED_AR_CT_DC_DE_ND_SD[1].pdf		

TEXASLIFE

INSURANCE COMPANY

CERTIFICATION OF READABILITY
FORM: WLSTO-NI-11, 11M009 R 12/11, 11M010 R 12/11, & 11M009-E R 12/11

This is to certify that Texas Life Insurance Company Form WLSTO-NI-11, 11M009 R 12/11, 11M010 R 12/11, and 11M009-E R 12/11 has achieved a Flesch Reading Ease Score of 56.60.



Michael R. Khoury, JD
Director
Compliance

Texas Life Insurance Company
Waco, Texas

Date: 14 December 2011

TEXASLIFE

INSURANCE COMPANY

**CERTIFICATION OF READABILITY
FORM: 11N060 Amendment**

This is to certify that Texas Life Insurance Company Form 11N060 Amendment has achieved a Flesch Reading Ease Score of 55.80.



Michael R. Khoury, JD
Director
Compliance

Texas Life Insurance Company
Waco, Texas

Date: 6 July 2011

Amendment to Application on Proposed Insured: [(INSURED'S NAME HERE)]
File Number: [00100000]

- | | |
|--|--|
| [Within the last 12 months have you used tobacco in any form?] | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| [Are you at work on a full-time basis, performing your usual duties?] | <input type="checkbox"/> <input type="checkbox"/> |

[During the last 24 months have you been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following:] **Yes** **No**

- [a. Cancer (excluding non-melanoma skin cancer)?]
- [b. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy?]
- [c. Alcohol or drug abuse?]
- [d. Diabetes for which the recommended treatment is insulin?]
- [e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)?]
- [f. Stroke or transient ischemic attack (TIA)?]
- [g. Chronic kidney disease or kidney failure (excluding kidney stones)?]
- [h. Parkinson's disease or paralysis?]
- [i. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)?]
- [j. Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?]

- [1. **Within the past five years, have you:**] **Yes** **No**
- [a. been treated by a member of the medical profession, been an inpatient or outpatient at a hospital or clinic, or been advised to have a surgical operation?]
 - [b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)?]
 - [c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician?]
 - [d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?]

- [2. **Within the past ten years, have you been diagnosed with or been treated for:**]
- [a. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys?]
 - [b. Cancer, tumor, diabetes, or disorder of the blood?]
 - [c. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder?]
 - [d. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?]

[3. Are you taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details in No. 6. below.]

[4. What is your height, weight, and birth state? Height:_____ Weight:_____ Birth State:_____]

[5. Your personal physician (if none, enter "None")

Physician Name:_____ Address:_____

City:_____ State/Zip:_____

]

Continued Next Page

[6. Details, including date, diagnosis, type of treatment, and current condition

Ques. #	Details	Name/address/phone of physician(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this amendment to application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

X _____ Date
Signature (Insured's Name Here)

1st Deduction Date: _____ Employer: _____ Policy Number: _____

Proposed Insured Personal Information

Last Name	<input type="text"/>	SSN	<input type="text"/>
First Name	<input type="text"/>	Birth Date	<input type="text"/> Age ⁽¹⁾ <input type="text"/>
MI	<input type="text"/>	Sex	<input type="text"/> Hire Date <input type="text"/>

Tier 1 Questions

Within the last 12 months have you used tobacco in any form? Yes No
Are you at work on a full-time basis, performing your usual duties? Yes No

Street/PO Box City State Zip
 Phone: Day Evening Email
 Beneficiary Name: Relationship:

Will proposed coverage replace or change any existing insurance or annuity policy? Yes No
 (if "Yes" identify and complete replacement form.) Company Policy Number

Do you have existing insurance or annuities (including coverage with Texas Life)? Yes No If "Yes" complete the Existing Insurance Form *even if replacement is not contemplated.*

Coverage Information

Face Amount ⁽²⁾	<input type="text"/>	Plan of Insurance: _____ [One To One] _____
Premium	<input type="text"/>	Select Riders to be Added: <input type="checkbox"/> Family Term Rider <input type="checkbox"/> Accidental Death ⁽³⁾ <input type="checkbox"/> Waiver Premium ⁽³⁾ [<input type="checkbox"/> Rider] [<input type="checkbox"/> Rider]
Rider Premium	<input type="text"/>	Payroll is per: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Skip _____
Total Premium	<input type="text"/>	<input type="checkbox"/> I elect the Automatic Contract Loan provision to pay a premium overdue 30 days or more, if my policy has sufficient cash value.

Tier 2 Questions

(If answered "Yes" no coverage is offered, except as available under Tier 1 questions.)

<p><u>During the last 24 months have you been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following:</u></p> <p>a. Cancer (excluding non-melanoma skin cancer)?</p> <p>b. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy?</p> <p>c. Alcohol or drug abuse?</p> <p>d. Diabetes for which the recommended treatment is insulin?</p> <p>e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)?</p> <p>f. Stroke or transient ischemic attack (TIA)?</p> <p>g. Chronic kidney disease or kidney failure (excluding kidney stones)?</p> <p>h. Parkinson's disease or paralysis?</p> <p>i. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)?</p> <p>j. Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?</p>	<table border="1"> <tr> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No				
<input type="checkbox"/>	<input type="checkbox"/>				

(1) Age on Issue Date (2) or Face Amount purchased by premium shown, if less (3) Proposed insured (employee) issue ages 17-59

Additional Statements

For residents of [AL, DC, IN, and OR]: I received a summary description of the accelerated death benefit and Important Notice regarding Accelerated Death Benefit.

For residents of Arkansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.

For residents of Washington, DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment, and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

Proposed Insured
(Owner) Signature _____ Date _____ City _____ State _____

Agent Only: To the best of my knowledge the insurance applied for is is not to replace existing insurance or annuity. I have delivered to the Proposed Insured the applicable forms and information described in Additional Statements above.

Enroller
Signature _____ Print
Enroller Name _____ Agent # _____

Interim Insurance

Interim insurance will be in force on the application date if these conditions are met: (1) the insurance is purchased through payroll deduction or through your membership in a union or association; (2) you sign a Salary Deduction Authorization or Bank Draft Authorization Form (union and association members only); and, (3) you are insurable at standard rates under Our rules and usual practice. Interim insurance remains in effect until the earlier of: (a) the Policy Date; (b) the date We decline the application; (c) the date We notify you that you are ineligible for interim insurance; or, (d) the 180th day after the application date.

Proposed Insured

NAME	STATUS	SEX	SOCIAL SECURITY NO.	BIRTH DATE	AGE	BENEFICIARY/RELATIONSHIP
John Q. AR	EMP	M	111111111	03-01-1976	35	Primary: Gary Doe, Child (100%) /

Employee Information (applicant and policy owner):

NAME: John Q. Doe SOCIAL SECURITY NO: 111111111
 ADDRESS: 123 Main Street, Waco, TX 76710
 PERSONAL EMAIL ADDRESS: www.jdoe.mybook.com DAYTIME PHONE: 254-666-1111 EVENING PHONE: 254-333-1111
 EMPLOYER: ABC GROUP HIRE DATE: 01-01-2001 PAYROLL FREQUENCY: 12

Coverages and Premium

PLAN NAME: [Texas Life SOLUTION Series 321] POLICY FORM: [WLSTO-11]

NAME	FACE AMOUNT	ADB AMOUNT	WAIVER BENEFIT	FAMILY TERM RIDER	[CHILD TERM AMOUNT]	[UNION STRIKE RIDER]	TOTAL PREMIUM
John Q. AR	250000.00	250000.00	No	Yes	[0]	[No]	
Payroll Frequency Premium	154.00	20.00	15.40	2.00	[0.00]	[0.00]	189.40

I elect the **Automatic Premium Loan** provision to pay premium overdue 30 days or more, if my policy has sufficient cash value. Yes

REPLACEMENT

Will proposed coverage replace or change any existing insurance or annuity policy? [Detail here for Yes responses] No

[Do you have existing insurance or annuities (including coverage with Texas Life)? If "Yes" complete the Existing Insurance Form even if replacement is not contemplated.] No

QUESTION No.	PROPOSED INSURED
(1) Within the last 12 months have you used tobacco in any form?	No
(2) Are you at work on a full-time basis, performing your usual duties?	Yes
[(3) <u>During the last 24 months have you been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following:</u> a. Cancer (excluding non-melanoma skin cancer)? b. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy? c. Alcohol or drug abuse? d. Diabetes for which the recommended treatment is insulin? e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)? f. Stroke or transient ischemic attack (TIA)? g. Chronic kidney disease or kidney failure (excluding kidney stones)? h. Parkinson's disease or paralysis? i. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)? j. Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?	No]
[(4a) <u>Within the past five years, have you been treated by a member of the medical profession, been an inpatient or outpatient at a hospital or clinic, or been advised to have a surgical operation?</u> [Detail here for Yes responses]	No]

QUESTION No.**PROPOSED
INSURED**

- | | | |
|--------|--|-----|
| [(4b) | Within the past five years, have you had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)?
<i>[Detail here for Yes responses]</i> | No] |
| [(4c) | Within the past five years, have you used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician?
<i>[Detail here for Yes responses]</i> | No] |
| [(4d) | Within the past five years, have you been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?
<i>[Detail here for Yes responses]</i> | No] |
| [(5a) | Within the past ten years, have you been diagnosed with or been treated for heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?
<i>[Detail here for Yes responses]</i> | No] |
| [(5b) | Within the past ten years, have you been diagnosed with or been treated for alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys?
<i>[Detail here for Yes responses]</i> | No] |
| [(5c) | Within the past ten years, have you been diagnosed with or been treated for cancer, tumor, diabetes, or disorder of the blood?
<i>[Detail here for Yes responses]</i> | No] |
| [(5d) | Within the past ten years, have you been diagnosed with or been treated for asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder?
<i>[Detail here for Yes responses]</i> | No] |
| [(6) | Are you taking any prescribed medication at regular intervals?
<i>[Detail here for Yes responses]</i> | No] |
| [(7) | What is your height, weight, and birth state?
<i>John Q. Doe - Height: 5'10" Weight: 180 lbs Birth State: VA</i> |] |
| [(8) | Your Personal physician:
<i>John Q. Doe - Dr Phylis Smith, 123 Main Waco, TX</i> |] |

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

E-SIGNATURE RECORDED

20110301 19:11:45 IDQ _____

PROPOSED INSURED (AND POLICY OWNER) SIGNATURE

Agent Only: To the best of my knowledge the insurance applied for **[IS NOT]** to replace existing insurance or annuity.

<u>KOLT AGENT</u>	<u>9999994</u>	<u>20110301</u>	<u>WACO</u>	<u>AR</u>
PRINT ENROLLER/AGENT NAME	AGT. NO.	DATE	CITY	STATE

E-SIGNATURE RECORDED

ELEC SIGNATURE 201103011090301 _____

ENROLLER / AGENT SIGNATURE

Interim Insurance

Interim insurance will be in force on the application date if these conditions are met: (1) the insurance is purchased through payroll deduction or through your membership in a union or association; (2) you sign a Salary Deduction Authorization or Bank Draft Authorization Form (union and association members only); and, (3) you are insurable at standard rates under Our rules and usual practice. Interim insurance remains in effect until the earlier of: (a) the Policy Date; (b) the date We decline the application; (c) the date We notify you that you are ineligible for interim insurance; or, (d) the 180th day after the application date.

Supplement to Application from (Employee): _____
 Employee Social Security: _____ Application Date: _____

<p>1. Within the past five years, have you:</p> <p>a. <u>been treated by a member of the medical profession, been an inpatient or outpatient at a hospital or clinic, or been advised to have a surgical operation?</u></p> <p>b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)?</p> <p>c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician?</p> <p>d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?</p>	Yes	No
<p>2. Within the past ten years, have you been diagnosed with or been treated for:</p> <p>a. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys?</p> <p>b. Cancer, tumor, diabetes, or disorder of the blood?</p> <p>c. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder?</p> <p>d. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. Are you taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details below.</p>	<input type="checkbox"/>	<input type="checkbox"/>

<p>4. What is your height, weight, and birth state?</p>	Hgt.	Wgt.		Birth State
---	-------------	-------------	--	--------------------

5. Your personal physician (if none, enter "None")

Physician Name: _____

Address: _____ City: _____ State: _____

6. Details, including date, diagnosis, type of treatment, and current condition		Name, address and phone # of physician(s)
Ques No.	Details	

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

X _____
 Proposed Insured (Owner) Signature

X _____
 Enroller/Agent Signature Print Enroller/Agent Name Agt No. Date City State