

State: Arkansas **Filing Company:** Government Personnel Mutual Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: MIB 2013 Authorization Change
Project Name/Number: Life Application/SM42012/SM45M12

Filing at a Glance

Company: Government Personnel Mutual Life Insurance Company
Product Name: MIB 2013 Authorization Change
State: Arkansas
TOI: L071 Individual Life - Whole
Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Filing Type: Form
Date Submitted: 10/02/2012
SERFF Tr Num: GPML-128693492
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: SM42012/SM45M12
Implementation: On Approval
Date Requested:
Author(s): Linda Boydston, Norma Castillo
Reviewer(s): Linda Bird (primary)
Disposition Date: 10/05/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Government Personnel Mutual Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
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General Information

Project Name: Life Application Status of Filing in Domicile:
Project Number: SM42012/SM45M12 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 10/05/2012
State Status Changed: 10/05/2012
Deemer Date: Created By: Norma Castillo
Submitted By: Linda Boydston Corresponding Filing Tracking Number:

Filing Description:

This filing contains no unusual or controversial items from normal Company or industry standards.

Application forms SM45MAR12 and SM420AR12 are being submitted for your approval. Forms will replace the previously approved form shown below.

1. SM45MAR10, approved 4/26/2010 SERFF Tracking # GPML-126557922.
2. SM420AR10, approved 4/26/2010 SERFF Tracking # GPML-126557922.

The form was created in order to comply with the MIB 2013 Authorization change by adding, "I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB" to the authorization section in both of the applications.

The difference between SM45MAR12,SM420AR12 and SM45MAR10,SM420AR10 is limited to:

1. the above MIB authorization
2. the deletion of Amyotrophic Lateral Sclerosis (ALS) from question 27d in form SM420AR12 and from question 28e in form SM45MAR12
3. the form number.

No other changes were made.

These forms are in final print format; however, we reserve the right to change the format due to technological advances.

Company and Contact

Filing Contact Information

Norma Castillo, Regulatory Filing Assistant anc@gpmlife.com
2211 N.E. Loop 410 800-938-4765 [Phone] 2724 [Ext]
P.O. Box 659567 210-357-6722 [FAX]
San Antonio, TX 78217

State: Arkansas **Filing Company:** Government Personnel Mutual Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: MIB 2013 Authorization Change
Project Name/Number: Life Application/SM42012/SM45M12

Filing Company Information

Government Personnel Mutual Life Insurance Company	CoCode: 63967	State of Domicile: Texas
2211 N.E. Loop 410	Group Code: 4712	Company Type: LAH
P.O. Box 659567	Group Name:	State ID Number:
San Antonio, TX 78217	FEIN Number: 74-0651020	
(800) 938-4765 ext. 2814[Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? Yes
 Fee Explanation: Texas retaliatory fee is \$100 for approval per form
 Per Company: No

Company	Amount	Date Processed	Transaction #
Government Personnel Mutual Life Insurance Company	\$200.00	10/02/2012	63313915

SERFF Tracking #:

GPML-128693492

State Tracking #:

Company Tracking #:

SM42012/SM45M12

State:

Arkansas

Filing Company:

Government Personnel Mutual Life Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

MIB 2013 Authorization Change

Project Name/Number:

Life Application/SM42012/SM45M12

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/05/2012	10/05/2012

State: Arkansas **Filing Company:** Government Personnel Mutual Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: MIB 2013 Authorization Change
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Disposition

Disposition Date: 10/05/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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	Statement of Variability		Yes
Form	Life Application		Yes
Form	Life Application		Yes

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Form Schedule

Lead Form Number: SM420AR12

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		SM420AR12	AEF	Life Application	Initial:	59.000	SM420AR12.pdf
2		SM45MAR12	AEF	Life Application	Initial:	59.000	SM45MAR12.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

APPLICATION FOR LIFE INSURANCE - Part 1

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

1 2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222 2

www.gpmlife.com] 3

For Ages 20 through 49, Age Last Birthday

Mail Policy to:
<input type="checkbox"/> Agent
<input type="checkbox"/> Policyholder

1. Name of Proposed Insured (First, M.I., Last)				
2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Birthdate	4. Birthplace		
5. US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Social Security #	7. Height	8. Weight	
9. Home Address of Proposed Insured	City	State/Country	Zip	Telephone Number

Best time to call _____ A.M. _____ P.M. Time Zone: Eastern Central Mountain Pacific

10. Policy: <input type="checkbox"/> SECURE-Mark 4 - WL (WL Only) <input type="checkbox"/> Accidental Death Benefit - ADB (WL Only) <input type="checkbox"/> \$5,000 Child Insurance Rider - CIR (Part 2 Required)	11. Amount Applied for:\$	12. Premium Amount: \$
	13. Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> SemiAnnual <input type="checkbox"/> Monthly EFT	14. Automatic Premium Loan (if available) <input type="checkbox"/> Yes <input type="checkbox"/> No

15. Beneficiary Primary _____ Contingent _____	Social Security # _____	Relationship _____	16. Proposed Insured's Occupation
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17. Owner/Applicant, if other than the Proposed Insured:
Name _____ Social Security # _____ Relationship to Proposed Insured _____ DOB _____
Address: _____

18. Physician(s) name, address and phone number: _____

19. a. List Life insurance in force on Proposed Insured: Company _____ Issue Year _____ ADB _____
b. Will the policy applied for replace or change any existing life or annuity policy or contract in any company? Yes No
20. Has the Proposed Insured used tobacco in any form in the past 12 months? Yes No

If questions 21 through 28 are correctly answered "No", the Proposed Insured may be eligible for SECURE-Mark 4 - WL (Whole Life, Full Death Benefit).

	YES	NO		YES	NO
21. a. Is the Proposed Insured currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care, kidney dialysis, or oxygen?..	<input type="checkbox"/>	<input type="checkbox"/>	24. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:		
b. Has the Proposed Insured ever been diagnosed by a physician as having Congestive Heart Failure or Cardiomyopathy or been told (s)he has less than 12 months to live?.....	<input type="checkbox"/>	<input type="checkbox"/>	a. Stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	<input type="checkbox"/>	<input type="checkbox"/>
22. In the past 10 years, has the Proposed Insured been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	<input type="checkbox"/>	<input type="checkbox"/>	b. Organ transplant or recommendation to have an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
23. Does the Proposed Insured need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet, independently dressing, taking medications, or walking independently without the use of supportive devices?	<input type="checkbox"/>	<input type="checkbox"/>	c. Melanoma, internal cancer, or leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
			d. Alzheimer's disease, dementia, Amyotropic Lateral Sclerosis (ALS), or Parkinson's Disease?	<input type="checkbox"/>	<input type="checkbox"/>
			e. Emphysema, liver disease, kidney disease, or kidney failure?	<input type="checkbox"/>	<input type="checkbox"/>
			f. Alcohol and/or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
			g. Diabetes requiring insulin or any diabetic complications including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	<input type="checkbox"/>	<input type="checkbox"/>
			25. During the past 5 years, has the Proposed Insured been convicted of a felony, been incarcerated, or been on parole or probation for any offense?	<input type="checkbox"/>	<input type="checkbox"/>

Circle each condition resulting in a "Yes" answer for questions 26 through 28.

	YES	NO		YES	NO
<p>26. During the past 12 months, has the Proposed Insured:</p> <p>a. Been admitted to or confined in a hospital two or more times? <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Been told by a medical professional that (s)he needs a medical procedure, surgery, hospitalization, or nursing facility care that has not yet been completed?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Been confined to a nursing facility or received home health care? <input type="checkbox"/> <input type="checkbox"/></p> <p>27. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:</p> <p>a. Seizures or other neurological disorder, Major Depression, Schizophrenia, Psychosis, Bipolar Disorder or other psychiatric disorder? . <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Irregular heart rhythm, enlarged heart, or any other heart disorder?..... <input type="checkbox"/> <input type="checkbox"/></p>			<p>c. Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)? <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Lupus (SLE), Muscular Dystrophy, Multiple Sclerosis or other neuromuscular disorder? <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Diabetes requiring medication other than insulin? <input type="checkbox"/> <input type="checkbox"/></p> <p>28. During the past 24 months, has the Proposed Insured had a suspended or revoked driver's license or had 3 or more moving violations?..... <input type="checkbox"/> <input type="checkbox"/></p>		
<p>For Home Office Endorsements:</p>			<p>Special Instructions/Requests:</p>		

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable period. It is agreed that:

- A. This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.
- B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.
- C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.
- D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement 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 such person to criminal and civil penalties.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): Photo ID verified Type of ID _____

(REQUIRED)

To the best of your knowledge:	Yes	No
A. Has the Proposed Insured any existing life insurance or annuity policy or contract?	<input type="checkbox"/>	<input type="checkbox"/>
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X			/	
Writing Agent's Signature	Date	Agent's Name (Please Print)	State / License #	GPM Life Agent #

RECEIPT FOR PAYMENT

Received from _____ Date _____
the sum of \$ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • [San Antonio, Texas 78265] ¹

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is ⁴ [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660]. ⁵ Information for consumers about MIB may be obtained on its website at [www.mib.com]. ⁶ We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

APPLICATION FOR LIFE INSURANCE - Part 1
GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

Mail Policy to: <input type="checkbox"/> Agent <input type="checkbox"/> Policyholder
--

1] 2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222 2]
www.gpmlife.com] 3] **For Ages 50 through 85, Age Last Birthday**

1. Name of Proposed Insured (First, M.I., Last)			
2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Birthdate	4. Birthplace	
5. US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Social Security #	7. Height	8. Weight
9. Home Address of Proposed Insured	City	State/Country	Zip Telephone Number

Best time to call _____ A.M. _____ P.M. Time Zone: Eastern Central Mountain Pacific

10. Policy: <input type="checkbox"/> SECURE-Mark 4 - WL (WL Only) <input type="checkbox"/> Accidental Death Benefit - ADB (WL Only) <input type="checkbox"/> \$5,000 Child Insurance Rider - CIR (Part 2 Required)	11. Amount Applied for:\$	12. Premium Amount: \$
	13. Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> SemiAnnual <input type="checkbox"/> Monthly EFT	14. Automatic Premium Loan (if available) <input type="checkbox"/> Yes <input type="checkbox"/> No

15. Beneficiary	Social Security #	Relationship
Primary _____		
Contingent _____		

16. Proposed Insured's Occupation

17. Owner/Applicant, if other than the Proposed Insured:

Name _____ Social Security # _____ Relationship to Proposed Insured _____ DOB _____

Address: _____

18. Physician(s) name, address and phone number: _____

19. a. List Life insurance in force on Proposed Insured: Company _____ Issue Year _____ ADB _____

b. Will the policy applied for replace or change any existing life or annuity policy or contract in any company? Yes No

20. Has the Proposed Insured used tobacco in any form in the past 12 months? Yes No

If questions 21 through 29 are correctly answered "No", the Proposed Insured may be eligible for SECURE-Mark 4 - WL (Whole Life, Full Death Benefit).

	YES	NO		YES	NO
21. Is the Proposed Insured currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care or kidney dialysis, or been diagnosed by a physician as having Alzheimer's Disease, dementia, or Amyotropic Lateral Sclerosis (ALS) or been told (s)he have less than 12 months to live?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. In the past 10 years, has the Proposed Insured been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	<input type="checkbox"/>	<input type="checkbox"/>
23. During the past 5 years, has the Proposed Insured been convicted of a felony, been incarcerated, or been on parole or probation for any offense?	<input type="checkbox"/>	<input type="checkbox"/>	24. Is the Proposed Insured currently receiving or been recommended to receive oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
25. Has the Proposed Insured ever been diagnosed by a physician as having Congestive Heart Failure or cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>	26. Does the Proposed Insured need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet independently, dressing, taking medications, or walking independently without the use of supportive devices?	<input type="checkbox"/>	<input type="checkbox"/>

Circle each condition resulting in a "Yes" answer for questions 27 through 29.

	YES	NO		YES	NO
<p>27. During the past 12 months, has the Proposed Insured:</p> <p>a. Been admitted to or confined in a hospital two or more times? <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Been told by a medical professional that (s)he needs a medical procedure, surgery, hospitalization or nursing facility care that has not been completed? <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Been confined to a nursing facility or received home health care? <input type="checkbox"/> <input type="checkbox"/></p> <p>28. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:</p> <p>a. Stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain? <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Organ transplant, or recommendation to have an organ transplant? <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Melanoma, internal cancer, or leukemia? <input type="checkbox"/> <input type="checkbox"/></p>			<p>d. Parkinson's Disease, seizure, neurological disorder, Major Depression, Schizophrenia, Psychosis, Bipolar Disorder, or other psychiatric disorder? <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Liver disease, kidney disease, kidney failure or Lupus (SLE)? <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Irregular heart rhythm, enlarged heart, or any other heart disorder? <input type="checkbox"/> <input type="checkbox"/></p> <p>g. Alcohol and/or drug abuse? <input type="checkbox"/> <input type="checkbox"/></p> <p>h. Diabetes requiring more than 80 units of insulin, or any diabetic complications, including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars? <input type="checkbox"/> <input type="checkbox"/></p> <p>i. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)? <input type="checkbox"/> <input type="checkbox"/></p> <p>29. During the past 24 months, has the Proposed Insured had a suspended or revoked driver's license or had 3 or more moving violations? <input type="checkbox"/> <input type="checkbox"/></p>		
<p>For Home Office Endorsements:</p>			<p>Special Instructions/Requests:</p>		

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable period. It is agreed that:

- A. This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.
- B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.
- C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.
- D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement 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 such person to criminal and civil penalties.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (if other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): Photo ID verified Type of ID _____

(REQUIRED)

To the best of your knowledge:	Yes	No
A. Has the Proposed Insured any existing life insurance or annuity policy or contract?	<input type="checkbox"/>	<input type="checkbox"/>
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X _____ Writing Agent's Signature	_____ Date	_____ Agent's Name (Please Print)	_____ State / License #	_____ GPM Life Agent #
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RECEIPT FOR PAYMENT

Received from _____ Date _____
the sum of \$ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • [San Antonio, Texas 78265] 1

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 4 [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660]. Information for consumers about MIB may be obtained on its website at [www.mib.com]. 8 We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted. 5

SERFF Tracking #:

GPML-128693492

State Tracking #:

Company Tracking #:

SM42012/SM45M12

State:

Arkansas

Filing Company:

Government Personnel Mutual Life Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

MIB 2013 Authorization Change

Project Name/Number:

Life Application/SM42012/SM45M12

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Bulletin 15-2009.pdf			
Regulation 19.pdf			
Regulation 49.pdf			
Readability Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Applications filed under Form Schedule Tab		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
Memorandum of Variability-SM45M.pdf			
Memorandum of Variability-SM420.pdf			

AR certification1

ARKANSAS

SUBJECT - Individual Life X Individual Annuity _____

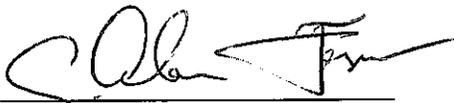
INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

SM45MAR12

SM420AR12

This submission meets the provisions of Rule and Regulation 19, "Unfair sex discrimination in the sale of insurance" as well as all applicable requirements of this Department.



C. Alan Ferguson, Senior VP, General Counsel
& Secretary

AR certification3

ARKANSAS

SUBJECT -

Individual Life

X

Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

SM45MAR12

SM420AR12

On behalf of Government Personnel Mutual Life Insurance Company, I hereby certify that the company is in compliance with Regulation 49 in that we will issue a Life and Health notice to each policy owner.



C. Alan Ferguson, Senior VP, General Counsel
& Secretary

02AR

ARKANSAS

SUBJECT - Individual Life X Individual Annuity

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

FLESCH SCORE

SM45MAR12

59 This form was scored as part of the policy with which it may be used.

SM420AR12

59 This form was scored as part of the policy with which it may be used.

This is to certify that the above referenced form has achieved a Flesch Reading Ease Score, as indicated, and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Sean Staggs, FSA, MAAA
Assistant Vice President & Associate Actuary

Memorandum of Variability
Explanation of Variable Statements and Fields
For Government Personnel Mutual Life Insurance Company
Form SM45MAR12

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in RED. The explanations below follow the order in which the variable fields appear in the form.

<i>Variable Statements/Fields</i>	<i>How or When Used</i>
Page 1	
1. [2211 N.E. loop 410, San Antonio, TX 78217]	This is the company's address
2. [800—929-4765, 210-357-2222]	This is the company's toll free and local phone numbers.
3. [www.gpmlife.com]	This is the company's website address.
4. [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734]	This is MIB's address.
5. [617-426-3660]	This is MIB's phone number.
6. [www.mib.com]	This is the website for MIB.

Memorandum of Variability
Explanation of Variable Statements and Fields
For Government Personnel Mutual Life Insurance Company
Form SM420AR12

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in RED. The explanations below follow the order in which the variable fields appear in the form.

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