

State: Arkansas **Filing Company:** Puritan Life Insurance Company of America
TOI/Sub-TOI: L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life
Product Name: Puritan Beacon SPWL
Project Name/Number: Puritan Beacon SPWL/

Filing at a Glance

Company: Puritan Life Insurance Company of America
Product Name: Puritan Beacon SPWL
State: Arkansas
TOI: L071 Individual Life - Whole
Sub-TOI: L071.311 Current Assumption - Single Premium - Single Life
Filing Type: Form
Date Submitted: 10/07/2012
SERFF Tr Num: PLCA-128706630
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: 01/01/2013
Date Requested:
Author(s): Eric Johansson
Reviewer(s): Linda Bird (primary)
Disposition Date: 10/11/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life
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Filing Company: Puritan Life Insurance Company of America

General Information

Project Name: Puritan Beacon SPWL
Project Number:
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Eric Johansson

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: This submission is pending approval in our domicile state, Arizona.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/11/2012
State Status Changed: 10/11/2012
Created By: Eric Johansson
Corresponding Filing Tracking Number:

Filing Description:

We are submitting the attached numbered forms for your consideration for approval. These forms have not previously been filed by PLICA with Arkansas and do not replace any current forms. They are submitted in final print format. (It is worth noting that this product is a copy of the policy and ADB rider submitted by another carrier that we are working with, Investors Heritage Life. Only the names have been changed on those two documents. The IHL product was approved under SERFF Tracking Number: IHLI-126652310).

Form AR-PLICA-SPWL100 is a single premium non-participating whole life insurance policy with level death benefits. In addition to having access to the cash value through policy loans, this policy allows the owner to take partial withdrawals after the first policy year. This policy will be marketed to potential insureds aged 50-85 using face-to-face contact, and normal underwriting methods. There are no non-guaranteed elements, so this policy will not be illustrated.

Form AR-PLICA-SPWL100-ADB is an Accelerated Death Benefit Payment Rider. This rider will be attached to form AR-PLICA-SPWL100 if the face amount is greater than or equal to \$10,000. There is no premium for this rider. Form AR-PLICA-SPWL100-ADBDISC is a disclosure form to be used at point of sale. Form AR-PLICA-SPWL100-ADBCLDISC is the disclosure required on or before a claim for benefits is paid.

Form AR-PLICA-SPWL100-APP is the application that will be used to apply for the policy and rider above.

Company and Contact

Filing Contact Information

Eric Johansson, VP
16801 Addison Road, Suite 400
Addison, TX 75001

e johansson@puritanlife.com
214-716-5911 [Phone]

Filing Company Information

Puritan Life Insurance Company of America
168010 Addison Road, Suite 400
Addison, TX 75001
(214) 716-5911 ext. [Phone]

CoCode: 71390
Group Code:
Group Name:
FEIN Number: 41-6041001

State of Domicile: Arizona
Company Type: Life / Health
State ID Number:

State: Arkansas **Filing Company:** Puritan Life Insurance Company of America
TOI/Sub-TOI: L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life
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Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Arkansas filing fee (per filing) \$50
 Per Company: No

Company	Amount	Date Processed	Transaction #
Puritan Life Insurance Company of America	\$50.00	10/07/2012	63529109
Puritan Life Insurance Company of America	\$100.00	10/10/2012	63624135

SERFF Tracking #:

PLCA-128706630

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State: Arkansas

Filing Company:

Puritan Life Insurance Company of America

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/11/2012	10/11/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	10/10/2012	10/10/2012
Pending Industry Response	Linda Bird	10/08/2012	10/08/2012

Response Letters

Responded By	Created On	Date Submitted
Eric Johansson	10/10/2012	10/10/2012
Eric Johansson	10/10/2012	10/10/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Added Policy Form and Rider	Note To Reviewer	Eric Johansson	10/10/2012	10/10/2012

State: Arkansas **Filing Company:** Puritan Life Insurance Company of America
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Disposition

Disposition Date: 10/11/2012

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 Demonstrating the Effect of an Accelerated Death Benefit Payment		Yes
Supporting Document	Accelerated Death Benefit Payment Rider Disclosure		Yes
Supporting Document	Certification		Yes
Form (revised)	Policy		Yes
Form	Policy		Yes
Form (revised)	ADB Rider		Yes
Form	ADB Rider		Yes
Form	Application for Individual Life Insurance		Yes
Form	Replacement Form Page 1		Yes
Form	Replacement Form Page 2		Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/10/2012
Submitted Date	10/10/2012
Respond By Date	11/12/2012

Dear Eric Johansson,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that a new or revised filing submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

SERFF Tracking #:

PLCA-128706630

State Tracking #:

Company Tracking #:

State: Arkansas **Filing Company:** Puritan Life Insurance Company of America
TOI/Sub-TOI: L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life
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Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/10/2012
Submitted Date 10/10/2012

Dear Linda Bird,

Introduction:

We are in receipt of your objection.

Response 1

Comments:

Attached, please find a certification of compliance with the above mentioned statutes.

Related Objection 1

Comments:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that a new or revised filing submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Certification

Comment: Attached, please find a certification that we will comply with Rule 19, Regulation 49, and ACA 23-79-138.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you.

Sincerely,

Eric Johansson

State: Arkansas **Filing Company:** Puritan Life Insurance Company of America
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Product Name: Puritan Beacon SPWL
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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/08/2012
Submitted Date	10/08/2012
Respond By Date	11/08/2012

Dear Eric Johansson,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$100.00 is received.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

SERFF Tracking #:

PLCA-128706630

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Puritan Life Insurance Company of America

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life

Product Name:

Puritan Beacon SPWL

Project Name/Number:

Puritan Beacon SPWL/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/10/2012
Submitted Date	10/10/2012

Dear Linda Bird,

Introduction:

I have created an additional EFT payment of \$100 per your instruction.

Thank you.

Response 1

Comments:

Below, I added the policy form and ADB rider, which were not attached to the original filing.

Related Objection 1

Comments:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$100.00 is received.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

PLCA-128706630

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Puritan Life Insurance Company of America

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Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	AR-PLICA-SPWL100	POL	Policy	Initial	53.100	AR-PLICA-SPWL100 Policy.pdf	Date Submitted: 10/10/2012 By: Eric Johansson
<i>Previous Version</i>							
1	AR-PLICA-SPWL 100	POL	Policy	Initial	53.100		Date Submitted: 10/10/2012 By: Eric Johansson
2	AR-PLICA-SPWL100-ADB	POLA	ADB Rider	Initial	50.500	AR-PLICA-SPWL100-ADB Rider.pdf	Date Submitted: 10/10/2012 By: Eric Johansson
<i>Previous Version</i>							
2	AR-PLICA-SPWL 100-ADB	POLA	ADB Rider	Initial	50.500		Date Submitted: 10/10/2012 By: Eric Johansson

No Rate/Rule Schedule items changed.

Conclusion:

Thank you.

Sincerely,

Eric Johansson

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Product Name: Puritan Beacon SPWL
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Note To Reviewer

Created By:

Eric Johansson on 10/10/2012 09:21 AM

Last Edited By:

Linda Bird

Submitted On:

10/10/2012 10:11 AM

Subject:

Added Policy Form and Rider

Comments:

When originally submitted, the Policy Form and ADB Rider were not attached to the Form Schedule tab. I have now added them.

Thank you.

PURITAN

Life Insurance Company of America

HOME OFFICE
16801 ADDISON ROAD, ADDISON, TEXAS 75001
PHONE: 1.800.513.3243
ADMINISTRATIVE OFFICE
PO BOX 717, FRANKFORT, KENTUCKY 40602-0717
PHONE: 877.249.1966

We will pay the proceeds of this policy to the beneficiary upon receipt of due proof of death of the insured while this policy is in force.

We will pay the cash surrender value of this policy to you upon its surrender.

This policy is a legal contract between you and us. It is issued in consideration of the application and the payment of the single premium on or before the date of policy delivery.

PLEASE READ YOUR POLICY CAREFULLY!

Signed at our home office at 16801 Addison Road, Addison, Texas 75001.



Paul Crooks
Secretary



Kenneth W Phillips
President

30 DAY EXAMINATION PERIOD

You may return this policy within 30 days after receiving it by mailing it to us, taking it to the agent through whom it was purchased, or by taking it to any other agent of Puritan Life Insurance Company of America. It will then be void as of the date of issue. Any premium paid will be returned.

Surrender of this Policy may result in a substantial penalty because the cash value may be less than the premiums paid.

SINGLE PREMIUM WHOLE LIFE INSURANCE POLICY

Proceeds payable at death of insured and prior to the maturity date;
Cash surrender value payable on the maturity date;
Non-participating - no dividends.

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**POLICY SCHEDULE
SINGLE PREMIUM WHOLE LIFE INSURANCE**

POLICY NUMBER: 999888

INSURED: John Doe

OWNER: John Doe

FACE AMOUNT: \$ 106,000

ISSUE DATE: May 1, 2010

ISSUE AGE: 55

SEX: Male

RISK CLASSIFICATION: Non-Tobacco

SINGLE PREMIUM: \$ 50,000.20

MATURITY DATE: May 1, 2075

BENEFICIARY: As stated in the application unless changed by you.

The owner and beneficiary are subject to change as described in this policy.

Guaranteed cash values are based on the 2001 CSO Mortality Table, Male or Female, Non-Tobacco or Tobacco, Age Last Birthday, and 5.00% interest per year, compounded annually.

The maximum policy loan interest rate is 7.4% per year, payable in arrears, compounded annually.

**TABLE OF GUARANTEED POLICY VALUES
DEATH BENEFITS SHOWN AS OF BEGINNING OF POLICY YEAR
CASH VALUES SHOWN AS OF END OF POLICY YEAR
VALUES ASSUME NO POLICY LOANS OR PARTIAL SURRENDERS**

ISSUE AGE 55

Policy Year	Attained Age	Guar. Death Benefit	Basic Cash Value	Policy Year	Attained Age	Guar. Death Benefit	Basic Cash Value	Policy Year	Attained Age	Guar. Death Benefit	Basic Cash Value
1	56	\$ 106,000	\$ 33,711.18	23	78	\$ 106,000	\$ 70,950.04	45	100	\$ 106,000	\$ 94,018.82
2	57	106,000	35,199.42	24	79	106,000	72,602.58	46	101	106,000	94,467.20
3	58	106,000	36,719.46	25	80	106,000	74,213.78	47	102	106,000	94,907.10
4	59	106,000	38,279.78	26	81	106,000	75,755.02	48	103	106,000	95,336.40
5	60	106,000	39,884.62	27	82	106,000	77,247.50	49	104	106,000	95,755.10
6	61	106,000	41,521.26	28	83	106,000	78,695.46	50	105	106,000	96,162.14
7	62	106,000	43,178.04	29	84	106,000	80,096.78	51	106	106,000	96,558.58
8	63	106,000	44,846.48	30	85	106,000	81,444.04	52	107	106,000	96,945.48
9	64	106,000	46,530.82	31	86	106,000	82,727.70	53	108	106,000	97,321.78
10	65	106,000	48,227.88	32	87	106,000	83,939.28	54	109	106,000	97,687.48
11	66	106,000	49,941.90	33	88	106,000	85,072.42	55	110	106,000	98,041.52
12	67	106,000	51,662.28	34	89	106,000	86,126.06	56	111	106,000	98,384.96
13	68	106,000	53,394.32	35	90	106,000	87,097.02	57	112	106,000	98,716.74
14	69	106,000	55,146.50	36	91	106,000	88,001.20	58	113	106,000	99,036.86
15	70	106,000	56,912.46	37	92	106,000	88,854.50	59	114	106,000	99,346.38
16	71	106,000	58,680.54	38	93	106,000	89,660.10	60	115	106,000	99,644.24
17	72	106,000	60,451.80	39	94	106,000	90,413.76	61	116	106,000	99,930.44
18	73	106,000	62,228.36	40	95	106,000	91,110.18	62	117	106,000	100,208.16
19	74	106,000	64,004.92	41	96	106,000	91,761.02	63	118	106,000	100,490.12
20	75	106,000	65,765.58	42	97	106,000	92,384.30	64	119	106,000	100,952.28
21	76	106,000	67,516.70	43	98	106,000	92,974.72	65	120	106,000	106,000.00
22	77	106,000	69,249.80	44	99	106,000	93,525.92				

DEFINITIONS

ATTAINED AGE

The issue age of the insured plus the number of completed policy years.

EVIDENCE OF INSURABILITY

Proof of the good health of the insured that is satisfactory to us.

INDEBTEDNESS

Unpaid policy loans and unpaid policy loan interest, if any.

INSURED

The individual named as the insured in the policy schedule.

ISSUE AGE

Age on the insured's last birthday on or preceding the issue date.

ISSUE DATE

The date from which policy anniversaries, policy years and policy months are determined.

MATURITY DATE

The final date on which any proceeds are payable under this policy if the insured is still alive.

POLICY ANNIVERSARY

The same day and month as the issue date for each succeeding year this policy remains in force.

POLICY SCHEDULE

On the issue date, page 3 of this policy. An updated policy schedule will be provided after the exercise of a partial withdrawal option.

PROCEEDS

The amount we are obligated to pay under the terms of this policy.

RIDER

A rider is an attachment to this policy which provides additional benefits.

TABLE OF GUARANTEED POLICY VALUES

On the issue date, page 4 of this policy. An updated table of guaranteed policy values will be provided after the exercise of a partial withdrawal option.

WE, OUR, US

Puritan Life Insurance Company of America.

WRITTEN REQUEST

A notification or request received from the owner in a form satisfactory to us. Written requests are recorded at our home office. We will not be responsible for the validity of any written request.

YOU, YOURS

The owner of this policy. The owner is designated in the application unless later changed by written notice to us.

GENERAL PROVISIONS

CONTRACT

The entire contract between you and us consists of this policy, any riders or endorsements, and the written application, a copy of which is attached at issue or delivery. All statements between you and us in the application, in the absence of fraud, are representations and not warranties. No statement shall be used in defense of a claim under this policy unless it is contained in a written application that is attached to the policy when issued or delivered.

SINGLE PREMIUM

The single premium as shown in the policy schedule is due on the issue date. It is payable to us on or before the delivery of this policy. There is no insurance coverage in effect until the single premium is paid. The single premium may be paid to our authorized agent who will provide a receipt. The receipt must be signed by the agent who received payment on our behalf.

AUTHORITY TO CHANGE

Only our officers may change the terms of this policy. Any change must be made in writing.

INCONTESTABILITY

We will not contest the validity of this policy after it has been in force during the lifetime of the insured for a period of two (2) years from the issue date as shown in the policy schedule, except for non-payment of premium.

A reinstatement of this policy will be incontestable after it has been in force during the lifetime of the insured for two (2) years from the effective date of reinstatement. Contest of a reinstatement may be made only with respect to material misrepresentations made in the application for reinstatement.

No statement made by the owner or by the insured related to the insured's insurability may be used in a contest or to reduce benefits unless (a) it is contained in a written instrument signed by the owner or the insured, and (b) the statement on which the contest is based is material to the risk accepted by us, and (c) a copy of such instrument has been given to the owner, the insured, or the beneficiary.

SUICIDE

If the insured commits suicide, while sane or insane, within two (2) years from the issue date, the proceeds under the policy will be an amount equal to the premiums paid.

MISSTATEMENT OF AGE OR SEX

If the age or sex of the insured is misstated, any amount of proceeds payable will be adjusted to that amount which the premiums paid would have purchased at the true age and sex of the insured.

NON-PARTICIPATING

This policy will not share in our surplus earnings. No dividends will be paid.

TERMINATION

This policy will terminate and all coverage will cease on the earliest of the following dates:

1. The date we receive your written request to surrender this policy;
2. The date of death of the insured;
3. If indebtedness equals or exceeds the cash value, the date that falls thirty (30) days after notice of termination has been mailed to your last known address and to any assignee of record; or
4. The maturity date shown on the policy schedule.

OWNERSHIP AND BENEFICIARY PROVISIONS

OWNER

The owner of this policy is the person or party designated to exercise the rights and receive the benefits of ownership. The insured is the owner unless otherwise stated in the application or later changed.

Subject to the terms of any beneficiary designation or assignment, the owner may, during the lifetime of the insured:

1. Assign or surrender this policy;
2. Obtain a policy loan;
3. Obtain a partial surrender;
4. With our consent, make a change in this policy;
5. Transfer the ownership of this policy; and
6. Exercise other rights and receive other benefits as defined in this policy.

If the owner has not named a successor owner, at the death of the owner, the insured becomes the owner of this policy unless the insured is a minor or otherwise legally incompetent, in which case the owner will be the legally appointed guardian of the insured.

BENEFICIARY

The beneficiary is as shown in the application. The beneficiary will receive the amount of proceeds payable at the death of the insured subject to any assignment made by you. The interest of a beneficiary terminates if the beneficiary dies before the insured. If no beneficiary survives at the death of the insured, payment may be made to you or to your estate or successors.

If more than one beneficiary survives at the death of the insured, proceeds will be allocated according to written instructions from the owner of this policy received by us prior to the death of the insured. If no allocation of proceeds between beneficiaries is specified, proceeds will be divided equally among all surviving beneficiaries.

CHANGE OF OWNER OR BENEFICIARY

You may change the designations of owner and beneficiary while the insured is alive. Any change is subject to the consent of an irrevocable beneficiary. Written request of change must be filed at our home office. Unless otherwise specified by you, the new designation will then take effect as of the date you signed the notice. Such a change does not affect any payment made or other action taken by us before we received the notice.

ASSIGNMENT

You may assign this policy by written request. We are not responsible for the validity or effect of any assignment of this policy. No assignment will bind us until it is received at our home office. Unless otherwise specified, any assignment will take effect on the date the notice of assignment is signed by you, subject to any payments made or actions taken by us prior to receipt of the assignment.

INSURANCE PROVISIONS

DEATH BENEFIT

The death benefit payable under this policy is equal to:

1. The face amount as shown in the policy schedule; plus
2. The amount of insurance on the life of the insured provided by riders; less
3. Any policy loan balance.

PROCEEDS AT DEATH

The amount of proceeds payable at death of the insured while this policy is in force will be the death benefit described above adjusted for any misstatement of age or sex.

INTEREST ON PROCEEDS

Interest on proceeds will be paid from the date of death of the insured to the date of payment. Interest will accrue at a rate which is the greater of (a) the rate declared by us for proceeds left on deposit, or (b) the rate required by law.

Additional interest will accrue at an annual rate of ten (10) percent from date of death to thirty-one (31) days after the latest of the following:

1. The date we receive due proof of death;
2. The date we receive sufficient information to determine the amount of payment and the appropriate payee legally entitled to the proceeds; and
3. The date that any legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of the same is provided to us. Legal impediments include, but are not limited to (a) the establishment of guardianships and conservatorships, or (b) the appointment and qualification of trustees, executors and administrators, or (c) the submission of information required to satisfy a state and federal reporting requirement.

PAYMENT OF PROCEEDS

To claim the proceeds, due proof of death must be furnished. Due proof of death will consist of a certified copy of the death certificate of the insured, or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

POLICY VALUE PROVISIONS

CASH SURRENDER VALUE

The cash surrender value at the end of any policy year is equal to the cash value as shown in the policy schedule, less any indebtedness. The cash surrender value at any other point in time will be calculated with allowance for lapse of time from the last preceding policy anniversary.

EXERCISING THE CASH SURRENDER POLICY OPTION

You may surrender this policy by returning it to our home office and filing a written request in a form acceptable to us. The date of surrender will be the date you signed the request provided the insured was then living. The amount that will be paid is the cash surrender value. With written permission from the Commissioner of the state in which this policy was delivered, the payment of the cash surrender value may be deferred for a period up to six (6) months after the request is received at our home office.

If surrender is requested within thirty (30) days after a policy anniversary, the cash surrender value will not be less than the cash surrender value on the policy anniversary. This policy will terminate as of the date of surrender.

BASIS OF POLICY VALUES

Cash value calculations are based on the Commissioners 2001 Standard Ordinary Mortality Table, Male or Female, Non-Tobacco or Tobacco, Age Last Birthday, with interest as shown in the policy schedule. Policy benefits are not less than the minimum values required on the issue date by the NAIC Standard Nonforfeiture Law for Life Insurance as adopted by the state in which this policy was issued. A detailed statement of the method of computing policy values and benefits has been filed with the insurance department of the state in which this policy was delivered.

PARTIAL SURRENDERS

A partial surrender may be made at any time after the first policy year and prior to the termination of this policy. The minimum partial surrender is \$500. The maximum partial surrender varies by policy year, and is equal to the smaller of:

1. The available partial surrender amount on the date the partial surrender is requested, minus \$1,000; and
2. The available partial surrender amount on the date the partial surrender is requested, multiplied by the percentage as set forth in the table below.

Policy Year	Maximum Partial Surrender Percentage
1	0%
2	10%
3	20%
4	30%
5	40%
6+	100%

The available partial surrender amount is:

1. The cash surrender value; less
2. Indebtedness; less
3. The policy loan interest from the calculation date of the partial surrender amount to the next policy anniversary.

Only one partial surrender is allowed in any policy year.

A surrender fee of \$25 will be deducted from each partial surrender amount. With written permission from the Commissioner of the state in which this policy was delivered, the payment of the partial surrender may be deferred for a period up to six (6) months after the request is received at our home office.

When a partial surrender is made, the face amount of this policy will be reduced by (a) the face amount just prior to the partial surrender, multiplied by (b) the partial surrender amount (including the partial surrender fee); divided by (c) the cash value just prior to the partial surrender.

We will amend this policy to show the face amount after the partial surrender. We will send you a new policy schedule and a new table of guaranteed policy values to attach to your policy.

LOAN PROVISIONS

POLICY LOAN

We will make a loan to you upon the sole security and assignment of this policy. You may obtain a loan at any time while this policy is in force. The amount of the loan may not exceed the loan value, as defined below. We may defer making a policy loan up to six months after written request is received at our home office unless the loan is used to pay a premium to us.

You may repay the loan in full or in part while your policy is in force prior to the death of the insured. Any payments received will be credited as loan repayments only if so designated.

LOAN VALUE

The loan value is equal to the cash surrender value on the date of the loan. The amount advanced as a policy loan may not exceed (a) the loan value, less (b) the amount of any existing loan, less (c) loan interest to the end of the current policy year. Unless it is paid in cash at the date of the loan, any existing policy loan, along with interest to the date of the loan, will be added to and become a part of the new policy loan.

LOAN INTEREST

Policy loan interest accrues from the date of the loan. It is payable in arrears on each policy anniversary and on the date the loan is settled. If interest is not paid when due, it will be added to the loan and will bear interest at the policy loan interest rate.

The maximum annual interest rate for loans is stated in the policy schedule. Interest is compounded annually.

INDEBTEDNESS

Indebtedness means all outstanding policy loans on this policy including interest accrued and accruing from day to day. Indebtedness may be repaid in full or in part while the insured is alive. If not repaid, it will be deducted in one sum from the proceeds of this policy.

If indebtedness exceeds the cash surrender value, this policy will terminate thirty (30) days after notice of termination has been mailed to your last known address and to any assignee of record.

REINSTATEMENT PROVISIONS

REINSTATEMENT

If this policy terminated because indebtedness exceeded the cash surrender value, it may be reinstated within five (5) years after termination if:

1. This policy was not surrendered for its cash surrender value; and
2. You submit a written request and application during the lifetime of the insured; and
3. You provide evidence of insurability satisfactory to us; and
4. You pay or reinstate any indebtedness which existed at the date of termination at the policy loan interest rate stated in the policy schedule.

The date of reinstatement will be the latest of (a) the date we approve your application for reinstatement, or (b) the date we receive all past amounts due.

SETTLEMENT PROVISIONS

POLICY PROCEEDS

Proceeds payable under this policy may be paid in a single sum or left with us for payment under any settlement option we then provide. The amount applied under an option must be at least \$5,000.

ELECTION OF OPTIONS

With the consent of any irrevocable beneficiary, you may elect or revoke a settlement option at any time before the proceeds are payable. If no settlement option election is in effect at the time the proceeds become payable, the payee may make an election. Written notice of election or revocation must be filed at our home office in a form acceptable to us. The notice will then take effect as of the date you or the payee signed the notice. An election does not affect any payment made or other action taken by us before the notice is received. A payee who is not a natural person may elect a settlement option only with our consent. An assignee cannot elect a settlement option. Change of owner or beneficiary automatically revokes any election in effect.

EFFECTIVE DATE

The first payment under options 1, 2, and 4 is payable on the effective date of the option. The effective date is (a) the date of the death of the insured, or (2) any later date agreeable with us.

DEATH OF PAYEE

Unless otherwise specified, at the death of the last payee a final payment will be made to the estate of the payee. For options 1 and 2 the final payment will be the commuted value of the remaining unpaid installments certain. Such value will be computed based on the rate of interest used in the calculation of payments. For options 3 and 4 the final payment will be the unpaid proceeds with any unpaid interest to the date of death of the payee.

SETTLEMENT OPTION INTEREST RATE

The guaranteed interest rate for options 1, 2, 3, and 4 is 3% per year, compounded annually. Additional interest may be declared by us from time to time.

OPTION 1

Proceeds will be paid for a fixed period. The amount of each payment is determined from the option 1 table on the following page.

OPTION 2

Proceeds will be paid in equal installments throughout the certain period. After the certain period, payments will continue to be made throughout the lifetime of the payee. The amount and certain period of the payments are determined from the option 2 table on the following page. Satisfactory proof of the age and sex of the payee is required. We may require evidence that the payee is living on the due date of any payment.

OPTION 3

Interest on the proceeds will be paid in the manner agreed upon when the option is elected.

OPTION 4

Proceeds will be paid in fixed installments at regular intervals until the proceeds, together with interest on the unpaid balance, are exhausted.

OPTION 5

Proceeds will be used to purchase any single premium annuity we offer at the time proceeds are applied.

OPTION 1 TABLE							
Monthly payments for a fixed number of years for each \$1,000 of proceeds							
Number of years	Monthly payment	Number of years	Monthly payment	Number of years	Monthly payment	Number of years	Monthly payment
1	84.48	6	15.16	11	8.88	16	6.55
2	42.87	7	13.18	12	8.26	17	6.25
3	29.01	8	11.70	13	7.73	18	5.98
4	22.08	9	10.55	14	7.28	19	5.75
5	17.92	10	9.63	15	6.89	20	5.53
The amount of monthly payment for other periods will be furnished on request.							

OPTION 2 TABLE											
Monthly payments are shown for each \$1,000 of proceeds. Age is the age last birthday of the payee when the first installment is payable.											
Number of Years Certain											
None						10 years					
Age	Male	Female	Age	Male	Female	Age	Male	Female	Age	Male	Female
46	3.83	3.61	66	5.85	5.31	46	3.81	3.61	66	5.64	5.20
47	3.88	3.66	67	6.03	5.47	47	3.86	3.65	67	5.79	5.34
48	3.94	3.71	68	6.23	5.63	48	3.92	3.70	68	5.94	5.48
49	4.01	3.76	69	6.44	5.81	49	3.98	3.75	69	6.10	5.63
50	4.07	3.82	70	6.66	6.00	50	4.04	3.81	70	6.26	5.79
51	4.14	3.88	71	6.90	6.20	51	4.11	3.86	71	6.43	5.96
52	4.21	3.94	72	7.15	6.43	52	4.18	3.92	72	6.60	6.13
53	4.29	4.01	73	7.42	6.67	53	4.25	3.99	73	6.78	6.32
54	4.37	4.08	74	7.70	6.93	54	4.33	4.05	74	6.96	6.51
55	4.46	4.15	75	8.01	7.21	55	4.41	4.12	75	7.15	6.71
56	4.55	4.22	76	8.34	7.51	56	4.49	4.20	76	7.33	6.91
57	4.64	4.31	77	8.69	7.84	57	4.58	4.27	77	7.52	7.12
58	4.75	4.39	78	9.07	8.20	58	4.68	4.36	78	7.71	7.33
59	4.85	4.48	79	9.47	8.58	59	4.78	4.44	79	7.89	7.54
60	4.97	4.58	80	9.90	9.00	60	4.88	4.53	80	8.07	7.76
61	5.09	4.68	81	10.36	9.45	61	4.99	4.63	81	8.25	7.97
62	5.23	4.79	82	10.85	9.94	62	5.11	4.73	82	8.42	8.17
63	5.37	4.91	83	11.37	10.47	63	5.23	4.84	83	8.59	8.37
64	5.52	5.04	84	11.92	11.04	64	5.36	4.96	84	8.74	8.56
65	5.68	5.17	85	12.52	11.66	65	5.50	5.08	85	8.89	8.73

Values were calculated using the Annuity 2000 Mortality Table, male or female, and 3.0% interest per year. Satisfactory proof of the age and sex of the payee is required. The amount of monthly payments for other ages and certain periods will be furnished on request.

PURITAN LIFE INSURANCE COMPANY OF AMERICA ACCELERATED DEATH BENEFIT RIDER

NOTICE: Death benefits and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.

GENERAL PROVISIONS

This rider is made part of this policy. It is subject to all applicable terms of the policy as well as the terms of this rider. Rider provisions apply in lieu of any policy provisions to the contrary. The consideration is the application.

RIDER EFFECTIVE DATE

The effective date of this rider is the effective date of the policy to which it is attached, unless otherwise stated.

OWNER

The owner of this rider is the owner of the policy to which this rider is attached, unless otherwise provided. The owner of this rider may exercise all the rights under this rider during the lifetime of the insured by making written request to us. All the rights of the owner are subject to the rights of any assignee or any irrevocable beneficiary we have on record.

NON-PARTICIPATING

This rider will not share in our surplus earnings. No dividends will be paid.

CASH VALUES

This rider does not provide cash or loan values.

TERMINATION

Benefits under this rider will terminate on the earliest of the following dates:

1. The date we receive your request to surrender the policy;
2. The date you request cancellation of this rider, in writing;
3. The date of termination of the policy to which this rider is attached.

DEFINITIONS

ACCELERATED BENEFIT

A benefit that may be requested by the owner if the insured is terminally ill or if the insured is chronically ill and is either confined to a nursing home or requires home health care. Terminal illness and chronic illness are defined below.

ACCELERATED PERCENTAGE

The accelerated percentage is equal to the requested accelerated benefit divided by the face amount immediately prior to the request.

ACCELERATION DATE

The date the accelerated benefits are paid.

ADJUSTED CASH VALUE

The cash value, adjusted for any accelerated benefits paid.

ADJUSTED FACE AMOUNT

The face amount, adjusted for any accelerated benefits paid.

CHRONIC ILLNESS

A disease or illness, certified by a physician, such that the insured:

1. Is unable to perform at least two activities of daily living and has been unable to do so for the previous ninety (90) days due to a loss of functional capacity. The activities of daily living are eating, toileting, transferring, bathing, dressing, and continence; or
2. Requires substantial supervision to protect the person from threats to health and safety because of severe cognitive impairment. Severity of cognitive impairment is measured by impairment in short or long term memory, orientation to people, places, or time, and deductive or abstract reasoning.

HOME HEALTH CARE

Skilled services, including custodial care, that are performed by an RN or an LPN in the home of the insured. These services must be medically necessary to maintain or improve the health of the insured.

LICENSED PRACTICAL NURSE OR LPN

A licensed practical nurse, performing within the scope of his/her current license. The person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

NURSING HOME

A facility that is a Medicare certified skilled nursing facility whose primary function is to provide continuous, 24-hours-per-day nursing care, and room and board. The facility must charge for these services. The care must be performed under the direction of a physician, RN, or an LPN. It may not be, other than incidentally, a home for the aged, a hospital, a retirement home, a rest home, a community living center, or a place mainly for the treatment of drug abuse, alcoholism or mental illness.

PHYSICIAN

A licensed medical doctor performing within the scope of his/her current license. This person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

REGISTERED NURSE OR RN

A licensed professional nurse, performing with the scope of his/her current license. This person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

TERMINAL ILLNESS

A disease or illness that is expected to result in the death of the insured within twelve (12) months. We will require satisfactory proof that the insured is terminally ill. This proof will include, but is not limited to, a physician's statement.

ACCELERATED BENEFIT PROVISIONS

MAXIMUM ACCELERATED DEATH BENEFIT

The sum of all accelerated benefits payments may not exceed the lesser of \$250,000 or 80% of the face amount, subject to the additional requirement that the remaining death benefit be no less than \$10,000.

TERMINAL ILLNESS BENEFIT

If the insured is diagnosed as being terminally ill, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

NURSING HOME BENEFIT

If the insured is diagnosed as being chronically ill, is confined to a nursing home, and has been for the previous ninety (90) days, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

HOME HEALTH CARE BENEFIT

If the insured is diagnosed as being chronically ill and has required home health care for the previous ninety (90) days, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

ACCELERATED BENEFIT PAYMENT AMOUNT

The accelerated benefit payment amount will be equal to the sum of:

1. The accelerated amount requested subject to the maximum amount allowed;
2. Any premium paid on the accelerated amount beyond the end of the policy month in which payment is made;
3. Any loan interest paid for the time beyond the acceleration date on loan amounts reduced on payment.

Less the sum of:

1. An interest charge for twelve (12) months at an interest rate declared by the Board of Directors;
2. The applicable percentage times the outstanding loan balance;
3. Any premium due and unpaid during the grace period of the policy that applies to the period before the date of acceleration;
4. An administrative expense charge, not to exceed \$100.

If the insured dies after an accelerated benefit has been elected but before any such benefits are received, the election shall be cancelled and the death benefit will be paid as stated in the policy.

INTEREST CHARGE

The interest rate used to calculate the interest charge will not exceed the greater of:

1. The current yield on 90-day treasury bills on the acceleration date; and
2. The maximum statutory adjustable policy loan interest rate effective on the acceleration date.

POLICY ADJUSTMENTS AFTER PAYMENT OF AN ACCELERATED BENEFIT

Policy Values will be adjusted as follows:

1. The adjusted face amount will be equal to the face amount immediately prior to the accelerated benefit date reduced by the accelerated percentage.
2. The adjusted cash value will be equal to the cash value immediately prior to the accelerated benefit payment reduced by the accelerated percentage.
3. Any premium payable in the future on the adjusted face amount will be equal to the premium immediately prior to the accelerated benefit date reduced by the accelerated percentage.
4. Indebtedness will be reduced by the accelerated percentage.

A statement of the accelerated benefit payable and the resulting adjusted policy values will be sent to you prior to the payment of any accelerated benefit. Updated policy pages will be sent to you after the payment of any accelerated benefit.

CONDITIONS FOR PAYMENT OF AN ACCELERATED BENEFIT

Before an accelerated benefit is paid we must receive, in writing on a form acceptable to us:

1. A properly completed proof of eligibility claim form. If we do not provide the proof of eligibility claim form to you within 15 days after you request it, it is considered that you complied with the claim requirements if you submit written proof covering the occurrence, and the character and extent of the occurrence for which the claim is made.
2. A physician's certification that the insured:
 - a. Has a terminal illness; or
 - b. Is chronically ill and is confined to a nursing home, and has been so confined for the previous ninety (90) days; or
 - c. Is chronically ill and is currently receiving home health care, and has been receiving such care for the previous ninety (90) days.
3. The consent of any irrevocable beneficiary or assignee of record.

We reserve the right to a second or third medical opinion to confirm benefit eligibility, at our expense. The second medical opinion may include a physical examination by a physician designated by us. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion that is provided by a physician that is mutually acceptable to the insured and the company.

Payment of an accelerated benefit is due immediately upon receipt of due written proof of eligibility. Accelerated benefit payments will be paid as a lump sum, or upon request, in equal monthly installments for a fixed period. The annual guaranteed interest rate for computing any monthly payment is 3.0%. If the insured dies prior to the termination of the monthly payments, the present value of the remaining payments will be paid in a lump sum to the beneficiary.

Interest will accrue prior to payment of any accelerated benefit amount as described in the policy. Payment will be made to the owner or the owners's estate, unless the accelerated benefit has been otherwise assigned or designated by the owner.

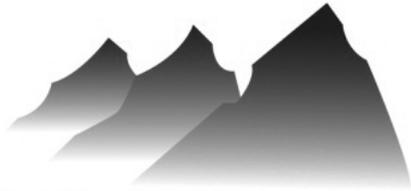
Signed at our home office at 16801 Addison Road, Addison, Texas 75001.



Paul Crooks
Secretary



Kenneth W Phillips
President



PURITAN®

Life Insurance Company of America

TO OBTAIN INFORMATION, MAKE A CLAIM, OR MAKE A COMPLAINT

Call us toll-free:

1.877.249.1966

Or write to us:

**PURITAN LIFE INSURANCE COMPANY OF AMERICA
ADMINISTRATIVE OFFICE
PO BOX 717
FRANKFORT KY 40602-0717**

Or email us:

info@puritanlife.com

SINGLE PREMIUM WHOLE LIFE INSURANCE POLICY

Proceeds payable at death of insured and prior to the maturity date;
Cash surrender value payable on the maturity date;
Non-participating - no dividends.

PURITAN LIFE INSURANCE COMPANY OF AMERICA ACCELERATED DEATH BENEFIT RIDER

NOTICE: Death benefits and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.

GENERAL PROVISIONS

This rider is made part of this policy. It is subject to all applicable terms of the policy as well as the terms of this rider. Rider provisions apply in lieu of any policy provisions to the contrary. The consideration is the application.

RIDER EFFECTIVE DATE

The effective date of this rider is the effective date of the policy to which it is attached, unless otherwise stated.

OWNER

The owner of this rider is the owner of the policy to which this rider is attached, unless otherwise provided. The owner of this rider may exercise all the rights under this rider during the lifetime of the insured by making written request to us. All the rights of the owner are subject to the rights of any assignee or any irrevocable beneficiary we have on record.

NON-PARTICIPATING

This rider will not share in our surplus earnings. No dividends will be paid.

CASH VALUES

This rider does not provide cash or loan values.

TERMINATION

Benefits under this rider will terminate on the earliest of the following dates:

1. The date we receive your request to surrender the policy;
2. The date you request cancellation of this rider, in writing;
3. The date of termination of the policy to which this rider is attached.

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ACCELERATION DATE

The date the accelerated benefits are paid.

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A disease or illness, certified by a physician, such that the insured:

1. Is unable to perform at least two activities of daily living and has been unable to do so for the previous ninety (90) days due to a loss of functional capacity. The activities of daily living are eating, toileting, transferring, bathing, dressing, and continence; or
2. Requires substantial supervision to protect the person from threats to health and safety because of severe cognitive impairment. Severity of cognitive impairment is measured by impairment in short or long term memory, orientation to people, places, or time, and deductive or abstract reasoning.

HOME HEALTH CARE

Skilled services, including custodial care, that are performed by an RN or an LPN in the home of the insured. These services must be medically necessary to maintain or improve the health of the insured.

LICENSED PRACTICAL NURSE OR LPN

A licensed practical nurse, performing within the scope of his/her current license. The person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

NURSING HOME

A facility that is a Medicare certified skilled nursing facility whose primary function is to provide continuous, 24-hours-per-day nursing care, and room and board. The facility must charge for these services. The care must be performed under the direction of a physician, RN, or an LPN. It may not be, other than incidentally, a home for the aged, a hospital, a retirement home, a rest home, a community living center, or a place mainly for the treatment of drug abuse, alcoholism or mental illness.

PHYSICIAN

A licensed medical doctor performing within the scope of his/her current license. This person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

REGISTERED NURSE OR RN

A licensed professional nurse, performing with the scope of his/her current license. This person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

TERMINAL ILLNESS

A disease or illness that is expected to result in the death of the insured within twelve (12) months. We will require satisfactory proof that the insured is terminally ill. This proof will include, but is not limited to, a physician's statement.

ACCELERATED BENEFIT PROVISIONS

MAXIMUM ACCELERATED DEATH BENEFIT

The sum of all accelerated benefits payments may not exceed the lesser of \$250,000 or 80% of the face amount, subject to the additional requirement that the remaining death benefit be no less than \$10,000.

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If the insured is diagnosed as being terminally ill, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

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If the insured is diagnosed as being chronically ill, is confined to a nursing home, and has been for the previous ninety (90) days, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

HOME HEALTH CARE BENEFIT

If the insured is diagnosed as being chronically ill and has required home health care for the previous ninety (90) days, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

ACCELERATED BENEFIT PAYMENT AMOUNT

The accelerated benefit payment amount will be equal to the sum of:

1. The accelerated amount requested subject to the maximum amount allowed;
2. Any premium paid on the accelerated amount beyond the end of the policy month in which payment is made;
3. Any loan interest paid for the time beyond the acceleration date on loan amounts reduced on payment.

Less the sum of:

1. An interest charge for twelve (12) months at an interest rate declared by the Board of Directors;
2. The applicable percentage times the outstanding loan balance;
3. Any premium due and unpaid during the grace period of the policy that applies to the period before the date of acceleration;
4. An administrative expense charge, not to exceed \$100.

If the insured dies after an accelerated benefit has been elected but before any such benefits are received, the election shall be cancelled and the death benefit will be paid as stated in the policy.

INTEREST CHARGE

The interest rate used to calculate the interest charge will not exceed the greater of:

1. The current yield on 90-day treasury bills on the acceleration date; and
2. The maximum statutory adjustable policy loan interest rate effective on the acceleration date.

POLICY ADJUSTMENTS AFTER PAYMENT OF AN ACCELERATED BENEFIT

Policy Values will be adjusted as follows:

1. The adjusted face amount will be equal to the face amount immediately prior to the accelerated benefit date reduced by the accelerated percentage.
2. The adjusted cash value will be equal to the cash value immediately prior to the accelerated benefit payment reduced by the accelerated percentage.
3. Any premium payable in the future on the adjusted face amount will be equal to the premium immediately prior to the accelerated benefit date reduced by the accelerated percentage.
4. Indebtedness will be reduced by the accelerated percentage.

A statement of the accelerated benefit payable and the resulting adjusted policy values will be sent to you prior to the payment of any accelerated benefit. Updated policy pages will be sent to you after the payment of any accelerated benefit.

CONDITIONS FOR PAYMENT OF AN ACCELERATED BENEFIT

Before an accelerated benefit is paid we must receive, in writing on a form acceptable to us:

1. A properly completed proof of eligibility claim form. If we do not provide the proof of eligibility claim form to you within 15 days after you request it, it is considered that you complied with the claim requirements if you submit written proof covering the occurrence, and the character and extent of the occurrence for which the claim is made.
2. A physician's certification that the insured:
 - a. Has a terminal illness; or
 - b. Is chronically ill and is confined to a nursing home, and has been so confined for the previous ninety (90) days; or
 - c. Is chronically ill and is currently receiving home health care, and has been receiving such care for the previous ninety (90) days.
3. The consent of any irrevocable beneficiary or assignee of record.

We reserve the right to a second or third medical opinion to confirm benefit eligibility, at our expense. The second medical opinion may include a physical examination by a physician designated by us. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion that is provided by a physician that is mutually acceptable to the insured and the company.

Payment of an accelerated benefit is due immediately upon receipt of due written proof of eligibility. Accelerated benefit payments will be paid as a lump sum, or upon request, in equal monthly installments for a fixed period. The annual guaranteed interest rate for computing any monthly payment is 3.0%. If the insured dies prior to the termination of the monthly payments, the present value of the remaining payments will be paid in a lump sum to the beneficiary.

Interest will accrue prior to payment of any accelerated benefit amount as described in the policy. Payment will be made to the owner or the owners's estate, unless the accelerated benefit has been otherwise assigned or designated by the owner.

Signed at our home office at 16801 Addison Road, Addison, Texas 75001.



Paul Crooks
Secretary



Kenneth W Phillips
President

State: Arkansas

Filing Company:

Puritan Life Insurance Company of America

TOI/Sub-TOI: L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life

Product Name: Puritan Beacon SPWL

Project Name/Number: Puritan Beacon SPWL/

Form Schedule

Lead Form Number: AR-PLICA-SPWL100

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		AR-PLICA-SPWL100	POL	Policy	Initial:	53.100	AR-PLICA-SPWL100 Policy.pdf
2		AR-PLICA-SPWL100-ADB	POLA	ADB Rider	Initial:	50.500	AR-PLICA-SPWL100-ADB Rider.pdf
3		AR-PLICA-SPWL100-APP	AEF	Application for Individual Life Insurance	Initial:	52.500	AR-PLICA-SPWL100-APP.pdf
4		PLICA-REP-AR	OTH	Replacement Form Page 1	Initial:		PLICA-REP-AR.pdf
5		PLICA-REP2-AR	OTH	Replacement Form Page 2	Initial:		PLICA-REP2-AR.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

PURITAN

Life Insurance Company of America

HOME OFFICE
16801 ADDISON ROAD, ADDISON, TEXAS 75001
PHONE: 1.800.513.3243
ADMINISTRATIVE OFFICE
PO BOX 717, FRANKFORT, KENTUCKY 40602-0717
PHONE: 877.249.1966

We will pay the proceeds of this policy to the beneficiary upon receipt of due proof of death of the insured while this policy is in force.

We will pay the cash surrender value of this policy to you upon its surrender.

This policy is a legal contract between you and us. It is issued in consideration of the application and the payment of the single premium on or before the date of policy delivery.

PLEASE READ YOUR POLICY CAREFULLY!

Signed at our home office at 16801 Addison Road, Addison, Texas 75001.



Paul Crooks
Secretary



Kenneth W Phillips
President

30 DAY EXAMINATION PERIOD

You may return this policy within 30 days after receiving it by mailing it to us, taking it to the agent through whom it was purchased, or by taking it to any other agent of Puritan Life Insurance Company of America. It will then be void as of the date of issue. Any premium paid will be returned.

Surrender of this Policy may result in a substantial penalty because the cash value may be less than the premiums paid.

SINGLE PREMIUM WHOLE LIFE INSURANCE POLICY

Proceeds payable at death of insured and prior to the maturity date;
Cash surrender value payable on the maturity date;
Non-participating - no dividends.

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**POLICY SCHEDULE
SINGLE PREMIUM WHOLE LIFE INSURANCE**

POLICY NUMBER: 999888

INSURED: John Doe

OWNER: John Doe

FACE AMOUNT: \$ 106,000

ISSUE DATE: May 1, 2010

ISSUE AGE: 55

SEX: Male

RISK CLASSIFICATION: Non-Tobacco

SINGLE PREMIUM: \$ 50,000.20

MATURITY DATE: May 1, 2075

BENEFICIARY: As stated in the application unless changed by you.

The owner and beneficiary are subject to change as described in this policy.

Guaranteed cash values are based on the 2001 CSO Mortality Table, Male or Female, Non-Tobacco or Tobacco, Age Last Birthday, and 5.00% interest per year, compounded annually.

The maximum policy loan interest rate is 7.4% per year, payable in arrears, compounded annually.

**TABLE OF GUARANTEED POLICY VALUES
DEATH BENEFITS SHOWN AS OF BEGINNING OF POLICY YEAR
CASH VALUES SHOWN AS OF END OF POLICY YEAR
VALUES ASSUME NO POLICY LOANS OR PARTIAL SURRENDERS**

ISSUE AGE 55

Policy Year	Attained Age	Guar. Death Benefit	Basic Cash Value	Policy Year	Attained Age	Guar. Death Benefit	Basic Cash Value	Policy Year	Attained Age	Guar. Death Benefit	Basic Cash Value
1	56	\$ 106,000	\$ 33,711.18	23	78	\$ 106,000	\$ 70,950.04	45	100	\$ 106,000	\$ 94,018.82
2	57	106,000	35,199.42	24	79	106,000	72,602.58	46	101	106,000	94,467.20
3	58	106,000	36,719.46	25	80	106,000	74,213.78	47	102	106,000	94,907.10
4	59	106,000	38,279.78	26	81	106,000	75,755.02	48	103	106,000	95,336.40
5	60	106,000	39,884.62	27	82	106,000	77,247.50	49	104	106,000	95,755.10
6	61	106,000	41,521.26	28	83	106,000	78,695.46	50	105	106,000	96,162.14
7	62	106,000	43,178.04	29	84	106,000	80,096.78	51	106	106,000	96,558.58
8	63	106,000	44,846.48	30	85	106,000	81,444.04	52	107	106,000	96,945.48
9	64	106,000	46,530.82	31	86	106,000	82,727.70	53	108	106,000	97,321.78
10	65	106,000	48,227.88	32	87	106,000	83,939.28	54	109	106,000	97,687.48
11	66	106,000	49,941.90	33	88	106,000	85,072.42	55	110	106,000	98,041.52
12	67	106,000	51,662.28	34	89	106,000	86,126.06	56	111	106,000	98,384.96
13	68	106,000	53,394.32	35	90	106,000	87,097.02	57	112	106,000	98,716.74
14	69	106,000	55,146.50	36	91	106,000	88,001.20	58	113	106,000	99,036.86
15	70	106,000	56,912.46	37	92	106,000	88,854.50	59	114	106,000	99,346.38
16	71	106,000	58,680.54	38	93	106,000	89,660.10	60	115	106,000	99,644.24
17	72	106,000	60,451.80	39	94	106,000	90,413.76	61	116	106,000	99,930.44
18	73	106,000	62,228.36	40	95	106,000	91,110.18	62	117	106,000	100,208.16
19	74	106,000	64,004.92	41	96	106,000	91,761.02	63	118	106,000	100,490.12
20	75	106,000	65,765.58	42	97	106,000	92,384.30	64	119	106,000	100,952.28
21	76	106,000	67,516.70	43	98	106,000	92,974.72	65	120	106,000	106,000.00
22	77	106,000	69,249.80	44	99	106,000	93,525.92				

DEFINITIONS

ATTAINED AGE

The issue age of the insured plus the number of completed policy years.

EVIDENCE OF INSURABILITY

Proof of the good health of the insured that is satisfactory to us.

INDEBTEDNESS

Unpaid policy loans and unpaid policy loan interest, if any.

INSURED

The individual named as the insured in the policy schedule.

ISSUE AGE

Age on the insured's last birthday on or preceding the issue date.

ISSUE DATE

The date from which policy anniversaries, policy years and policy months are determined.

MATURITY DATE

The final date on which any proceeds are payable under this policy if the insured is still alive.

POLICY ANNIVERSARY

The same day and month as the issue date for each succeeding year this policy remains in force.

POLICY SCHEDULE

On the issue date, page 3 of this policy. An updated policy schedule will be provided after the exercise of a partial withdrawal option.

PROCEEDS

The amount we are obligated to pay under the terms of this policy.

RIDER

A rider is an attachment to this policy which provides additional benefits.

TABLE OF GUARANTEED POLICY VALUES

On the issue date, page 4 of this policy. An updated table of guaranteed policy values will be provided after the exercise of a partial withdrawal option.

WE, OUR, US

Puritan Life Insurance Company of America.

WRITTEN REQUEST

A notification or request received from the owner in a form satisfactory to us. Written requests are recorded at our home office. We will not be responsible for the validity of any written request.

YOU, YOURS

The owner of this policy. The owner is designated in the application unless later changed by written notice to us.

GENERAL PROVISIONS

CONTRACT

The entire contract between you and us consists of this policy, any riders or endorsements, and the written application, a copy of which is attached at issue or delivery. All statements between you and us in the application, in the absence of fraud, are representations and not warranties. No statement shall be used in defense of a claim under this policy unless it is contained in a written application that is attached to the policy when issued or delivered.

SINGLE PREMIUM

The single premium as shown in the policy schedule is due on the issue date. It is payable to us on or before the delivery of this policy. There is no insurance coverage in effect until the single premium is paid. The single premium may be paid to our authorized agent who will provide a receipt. The receipt must be signed by the agent who received payment on our behalf.

AUTHORITY TO CHANGE

Only our officers may change the terms of this policy. Any change must be made in writing.

INCONTESTABILITY

We will not contest the validity of this policy after it has been in force during the lifetime of the insured for a period of two (2) years from the issue date as shown in the policy schedule, except for non-payment of premium.

A reinstatement of this policy will be incontestable after it has been in force during the lifetime of the insured for two (2) years from the effective date of reinstatement. Contest of a reinstatement may be made only with respect to material misrepresentations made in the application for reinstatement.

No statement made by the owner or by the insured related to the insured's insurability may be used in a contest or to reduce benefits unless (a) it is contained in a written instrument signed by the owner or the insured, and (b) the statement on which the contest is based is material to the risk accepted by us, and (c) a copy of such instrument has been given to the owner, the insured, or the beneficiary.

SUICIDE

If the insured commits suicide, while sane or insane, within two (2) years from the issue date, the proceeds under the policy will be an amount equal to the premiums paid.

MISSTATEMENT OF AGE OR SEX

If the age or sex of the insured is misstated, any amount of proceeds payable will be adjusted to that amount which the premiums paid would have purchased at the true age and sex of the insured.

NON-PARTICIPATING

This policy will not share in our surplus earnings. No dividends will be paid.

TERMINATION

This policy will terminate and all coverage will cease on the earliest of the following dates:

1. The date we receive your written request to surrender this policy;
2. The date of death of the insured;
3. If indebtedness equals or exceeds the cash value, the date that falls thirty (30) days after notice of termination has been mailed to your last known address and to any assignee of record; or
4. The maturity date shown on the policy schedule.

OWNERSHIP AND BENEFICIARY PROVISIONS

OWNER

The owner of this policy is the person or party designated to exercise the rights and receive the benefits of ownership. The insured is the owner unless otherwise stated in the application or later changed.

Subject to the terms of any beneficiary designation or assignment, the owner may, during the lifetime of the insured:

1. Assign or surrender this policy;
2. Obtain a policy loan;
3. Obtain a partial surrender;
4. With our consent, make a change in this policy;
5. Transfer the ownership of this policy; and
6. Exercise other rights and receive other benefits as defined in this policy.

If the owner has not named a successor owner, at the death of the owner, the insured becomes the owner of this policy unless the insured is a minor or otherwise legally incompetent, in which case the owner will be the legally appointed guardian of the insured.

BENEFICIARY

The beneficiary is as shown in the application. The beneficiary will receive the amount of proceeds payable at the death of the insured subject to any assignment made by you. The interest of a beneficiary terminates if the beneficiary dies before the insured. If no beneficiary survives at the death of the insured, payment may be made to you or to your estate or successors.

If more than one beneficiary survives at the death of the insured, proceeds will be allocated according to written instructions from the owner of this policy received by us prior to the death of the insured. If no allocation of proceeds between beneficiaries is specified, proceeds will be divided equally among all surviving beneficiaries.

CHANGE OF OWNER OR BENEFICIARY

You may change the designations of owner and beneficiary while the insured is alive. Any change is subject to the consent of an irrevocable beneficiary. Written request of change must be filed at our home office. Unless otherwise specified by you, the new designation will then take effect as of the date you signed the notice. Such a change does not affect any payment made or other action taken by us before we received the notice.

ASSIGNMENT

You may assign this policy by written request. We are not responsible for the validity or effect of any assignment of this policy. No assignment will bind us until it is received at our home office. Unless otherwise specified, any assignment will take effect on the date the notice of assignment is signed by you, subject to any payments made or actions taken by us prior to receipt of the assignment.

INSURANCE PROVISIONS

DEATH BENEFIT

The death benefit payable under this policy is equal to:

1. The face amount as shown in the policy schedule; plus
2. The amount of insurance on the life of the insured provided by riders; less
3. Any policy loan balance.

PROCEEDS AT DEATH

The amount of proceeds payable at death of the insured while this policy is in force will be the death benefit described above adjusted for any misstatement of age or sex.

INTEREST ON PROCEEDS

Interest on proceeds will be paid from the date of death of the insured to the date of payment. Interest will accrue at a rate which is the greater of (a) the rate declared by us for proceeds left on deposit, or (b) the rate required by law.

Additional interest will accrue at an annual rate of ten (10) percent from date of death to thirty-one (31) days after the latest of the following:

1. The date we receive due proof of death;
2. The date we receive sufficient information to determine the amount of payment and the appropriate payee legally entitled to the proceeds; and
3. The date that any legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of the same is provided to us. Legal impediments include, but are not limited to (a) the establishment of guardianships and conservatorships, or (b) the appointment and qualification of trustees, executors and administrators, or (c) the submission of information required to satisfy a state and federal reporting requirement.

PAYMENT OF PROCEEDS

To claim the proceeds, due proof of death must be furnished. Due proof of death will consist of a certified copy of the death certificate of the insured, or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

POLICY VALUE PROVISIONS

CASH SURRENDER VALUE

The cash surrender value at the end of any policy year is equal to the cash value as shown in the policy schedule, less any indebtedness. The cash surrender value at any other point in time will be calculated with allowance for lapse of time from the last preceding policy anniversary.

EXERCISING THE CASH SURRENDER POLICY OPTION

You may surrender this policy by returning it to our home office and filing a written request in a form acceptable to us. The date of surrender will be the date you signed the request provided the insured was then living. The amount that will be paid is the cash surrender value. With written permission from the Commissioner of the state in which this policy was delivered, the payment of the cash surrender value may be deferred for a period up to six (6) months after the request is received at our home office.

If surrender is requested within thirty (30) days after a policy anniversary, the cash surrender value will not be less than the cash surrender value on the policy anniversary. This policy will terminate as of the date of surrender.

BASIS OF POLICY VALUES

Cash value calculations are based on the Commissioners 2001 Standard Ordinary Mortality Table, Male or Female, Non-Tobacco or Tobacco, Age Last Birthday, with interest as shown in the policy schedule. Policy benefits are not less than the minimum values required on the issue date by the NAIC Standard Nonforfeiture Law for Life Insurance as adopted by the state in which this policy was issued. A detailed statement of the method of computing policy values and benefits has been filed with the insurance department of the state in which this policy was delivered.

PARTIAL SURRENDERS

A partial surrender may be made at any time after the first policy year and prior to the termination of this policy. The minimum partial surrender is \$500. The maximum partial surrender varies by policy year, and is equal to the smaller of:

1. The available partial surrender amount on the date the partial surrender is requested, minus \$1,000; and
2. The available partial surrender amount on the date the partial surrender is requested, multiplied by the percentage as set forth in the table below.

Policy Year	Maximum Partial Surrender Percentage
1	0%
2	10%
3	20%
4	30%
5	40%
6+	100%

The available partial surrender amount is:

1. The cash surrender value; less
2. Indebtedness; less
3. The policy loan interest from the calculation date of the partial surrender amount to the next policy anniversary.

Only one partial surrender is allowed in any policy year.

A surrender fee of \$25 will be deducted from each partial surrender amount. With written permission from the Commissioner of the state in which this policy was delivered, the payment of the partial surrender may be deferred for a period up to six (6) months after the request is received at our home office.

When a partial surrender is made, the face amount of this policy will be reduced by (a) the face amount just prior to the partial surrender, multiplied by (b) the partial surrender amount (including the partial surrender fee); divided by (c) the cash value just prior to the partial surrender.

We will amend this policy to show the face amount after the partial surrender. We will send you a new policy schedule and a new table of guaranteed policy values to attach to your policy.

LOAN PROVISIONS

POLICY LOAN

We will make a loan to you upon the sole security and assignment of this policy. You may obtain a loan at any time while this policy is in force. The amount of the loan may not exceed the loan value, as defined below. We may defer making a policy loan up to six months after written request is received at our home office unless the loan is used to pay a premium to us.

You may repay the loan in full or in part while your policy is in force prior to the death of the insured. Any payments received will be credited as loan repayments only if so designated.

LOAN VALUE

The loan value is equal to the cash surrender value on the date of the loan. The amount advanced as a policy loan may not exceed (a) the loan value, less (b) the amount of any existing loan, less (c) loan interest to the end of the current policy year. Unless it is paid in cash at the date of the loan, any existing policy loan, along with interest to the date of the loan, will be added to and become a part of the new policy loan.

LOAN INTEREST

Policy loan interest accrues from the date of the loan. It is payable in arrears on each policy anniversary and on the date the loan is settled. If interest is not paid when due, it will be added to the loan and will bear interest at the policy loan interest rate.

The maximum annual interest rate for loans is stated in the policy schedule. Interest is compounded annually.

INDEBTEDNESS

Indebtedness means all outstanding policy loans on this policy including interest accrued and accruing from day to day. Indebtedness may be repaid in full or in part while the insured is alive. If not repaid, it will be deducted in one sum from the proceeds of this policy.

If indebtedness exceeds the cash surrender value, this policy will terminate thirty (30) days after notice of termination has been mailed to your last known address and to any assignee of record.

REINSTATEMENT PROVISIONS

REINSTATEMENT

If this policy terminated because indebtedness exceeded the cash surrender value, it may be reinstated within five (5) years after termination if:

1. This policy was not surrendered for its cash surrender value; and
2. You submit a written request and application during the lifetime of the insured; and
3. You provide evidence of insurability satisfactory to us; and
4. You pay or reinstate any indebtedness which existed at the date of termination at the policy loan interest rate stated in the policy schedule.

The date of reinstatement will be the latest of (a) the date we approve your application for reinstatement, or (b) the date we receive all past amounts due.

SETTLEMENT PROVISIONS

POLICY PROCEEDS

Proceeds payable under this policy may be paid in a single sum or left with us for payment under any settlement option we then provide. The amount applied under an option must be at least \$5,000.

ELECTION OF OPTIONS

With the consent of any irrevocable beneficiary, you may elect or revoke a settlement option at any time before the proceeds are payable. If no settlement option election is in effect at the time the proceeds become payable, the payee may make an election. Written notice of election or revocation must be filed at our home office in a form acceptable to us. The notice will then take effect as of the date you or the payee signed the notice. An election does not affect any payment made or other action taken by us before the notice is received. A payee who is not a natural person may elect a settlement option only with our consent. An assignee cannot elect a settlement option. Change of owner or beneficiary automatically revokes any election in effect.

EFFECTIVE DATE

The first payment under options 1, 2, and 4 is payable on the effective date of the option. The effective date is (a) the date of the death of the insured, or (2) any later date agreeable with us.

DEATH OF PAYEE

Unless otherwise specified, at the death of the last payee a final payment will be made to the estate of the payee. For options 1 and 2 the final payment will be the commuted value of the remaining unpaid installments certain. Such value will be computed based on the rate of interest used in the calculation of payments. For options 3 and 4 the final payment will be the unpaid proceeds with any unpaid interest to the date of death of the payee.

SETTLEMENT OPTION INTEREST RATE

The guaranteed interest rate for options 1, 2, 3, and 4 is 3% per year, compounded annually. Additional interest may be declared by us from time to time.

OPTION 1

Proceeds will be paid for a fixed period. The amount of each payment is determined from the option 1 table on the following page.

OPTION 2

Proceeds will be paid in equal installments throughout the certain period. After the certain period, payments will continue to be made throughout the lifetime of the payee. The amount and certain period of the payments are determined from the option 2 table on the following page. Satisfactory proof of the age and sex of the payee is required. We may require evidence that the payee is living on the due date of any payment.

OPTION 3

Interest on the proceeds will be paid in the manner agreed upon when the option is elected.

OPTION 4

Proceeds will be paid in fixed installments at regular intervals until the proceeds, together with interest on the unpaid balance, are exhausted.

OPTION 5

Proceeds will be used to purchase any single premium annuity we offer at the time proceeds are applied.

OPTION 1 TABLE							
Monthly payments for a fixed number of years for each \$1,000 of proceeds							
Number of years	Monthly payment	Number of years	Monthly payment	Number of years	Monthly payment	Number of years	Monthly payment
1	84.48	6	15.16	11	8.88	16	6.55
2	42.87	7	13.18	12	8.26	17	6.25
3	29.01	8	11.70	13	7.73	18	5.98
4	22.08	9	10.55	14	7.28	19	5.75
5	17.92	10	9.63	15	6.89	20	5.53
The amount of monthly payment for other periods will be furnished on request.							

OPTION 2 TABLE											
Monthly payments are shown for each \$1,000 of proceeds. Age is the age last birthday of the payee when the first installment is payable.											
Number of Years Certain											
None						10 years					
Age	Male	Female	Age	Male	Female	Age	Male	Female	Age	Male	Female
46	3.83	3.61	66	5.85	5.31	46	3.81	3.61	66	5.64	5.20
47	3.88	3.66	67	6.03	5.47	47	3.86	3.65	67	5.79	5.34
48	3.94	3.71	68	6.23	5.63	48	3.92	3.70	68	5.94	5.48
49	4.01	3.76	69	6.44	5.81	49	3.98	3.75	69	6.10	5.63
50	4.07	3.82	70	6.66	6.00	50	4.04	3.81	70	6.26	5.79
51	4.14	3.88	71	6.90	6.20	51	4.11	3.86	71	6.43	5.96
52	4.21	3.94	72	7.15	6.43	52	4.18	3.92	72	6.60	6.13
53	4.29	4.01	73	7.42	6.67	53	4.25	3.99	73	6.78	6.32
54	4.37	4.08	74	7.70	6.93	54	4.33	4.05	74	6.96	6.51
55	4.46	4.15	75	8.01	7.21	55	4.41	4.12	75	7.15	6.71
56	4.55	4.22	76	8.34	7.51	56	4.49	4.20	76	7.33	6.91
57	4.64	4.31	77	8.69	7.84	57	4.58	4.27	77	7.52	7.12
58	4.75	4.39	78	9.07	8.20	58	4.68	4.36	78	7.71	7.33
59	4.85	4.48	79	9.47	8.58	59	4.78	4.44	79	7.89	7.54
60	4.97	4.58	80	9.90	9.00	60	4.88	4.53	80	8.07	7.76
61	5.09	4.68	81	10.36	9.45	61	4.99	4.63	81	8.25	7.97
62	5.23	4.79	82	10.85	9.94	62	5.11	4.73	82	8.42	8.17
63	5.37	4.91	83	11.37	10.47	63	5.23	4.84	83	8.59	8.37
64	5.52	5.04	84	11.92	11.04	64	5.36	4.96	84	8.74	8.56
65	5.68	5.17	85	12.52	11.66	65	5.50	5.08	85	8.89	8.73

Values were calculated using the Annuity 2000 Mortality Table, male or female, and 3.0% interest per year. Satisfactory proof of the age and sex of the payee is required. The amount of monthly payments for other ages and certain periods will be furnished on request.

PURITAN LIFE INSURANCE COMPANY OF AMERICA ACCELERATED DEATH BENEFIT RIDER

NOTICE: Death benefits and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.

GENERAL PROVISIONS

This rider is made part of this policy. It is subject to all applicable terms of the policy as well as the terms of this rider. Rider provisions apply in lieu of any policy provisions to the contrary. The consideration is the application.

RIDER EFFECTIVE DATE

The effective date of this rider is the effective date of the policy to which it is attached, unless otherwise stated.

OWNER

The owner of this rider is the owner of the policy to which this rider is attached, unless otherwise provided. The owner of this rider may exercise all the rights under this rider during the lifetime of the insured by making written request to us. All the rights of the owner are subject to the rights of any assignee or any irrevocable beneficiary we have on record.

NON-PARTICIPATING

This rider will not share in our surplus earnings. No dividends will be paid.

CASH VALUES

This rider does not provide cash or loan values.

TERMINATION

Benefits under this rider will terminate on the earliest of the following dates:

1. The date we receive your request to surrender the policy;
2. The date you request cancellation of this rider, in writing;
3. The date of termination of the policy to which this rider is attached.

DEFINITIONS

ACCELERATED BENEFIT

A benefit that may be requested by the owner if the insured is terminally ill or if the insured is chronically ill and is either confined to a nursing home or requires home health care. Terminal illness and chronic illness are defined below.

ACCELERATED PERCENTAGE

The accelerated percentage is equal to the requested accelerated benefit divided by the face amount immediately prior to the request.

ACCELERATION DATE

The date the accelerated benefits are paid.

ADJUSTED CASH VALUE

The cash value, adjusted for any accelerated benefits paid.

ADJUSTED FACE AMOUNT

The face amount, adjusted for any accelerated benefits paid.

CHRONIC ILLNESS

A disease or illness, certified by a physician, such that the insured:

1. Is unable to perform at least two activities of daily living and has been unable to do so for the previous ninety (90) days due to a loss of functional capacity. The activities of daily living are eating, toileting, transferring, bathing, dressing, and continence; or
2. Requires substantial supervision to protect the person from threats to health and safety because of severe cognitive impairment. Severity of cognitive impairment is measured by impairment in short or long term memory, orientation to people, places, or time, and deductive or abstract reasoning.

HOME HEALTH CARE

Skilled services, including custodial care, that are performed by an RN or an LPN in the home of the insured. These services must be medically necessary to maintain or improve the health of the insured.

LICENSED PRACTICAL NURSE OR LPN

A licensed practical nurse, performing within the scope of his/her current license. The person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

NURSING HOME

A facility that is a Medicare certified skilled nursing facility whose primary function is to provide continuous, 24-hours-per-day nursing care, and room and board. The facility must charge for these services. The care must be performed under the direction of a physician, RN, or an LPN. It may not be, other than incidentally, a home for the aged, a hospital, a retirement home, a rest home, a community living center, or a place mainly for the treatment of drug abuse, alcoholism or mental illness.

PHYSICIAN

A licensed medical doctor performing within the scope of his/her current license. This person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

REGISTERED NURSE OR RN

A licensed professional nurse, performing with the scope of his/her current license. This person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

TERMINAL ILLNESS

A disease or illness that is expected to result in the death of the insured within twelve (12) months. We will require satisfactory proof that the insured is terminally ill. This proof will include, but is not limited to, a physician's statement.

ACCELERATED BENEFIT PROVISIONS

MAXIMUM ACCELERATED DEATH BENEFIT

The sum of all accelerated benefits payments may not exceed the lesser of \$250,000 or 80% of the face amount, subject to the additional requirement that the remaining death benefit be no less than \$10,000.

TERMINAL ILLNESS BENEFIT

If the insured is diagnosed as being terminally ill, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

NURSING HOME BENEFIT

If the insured is diagnosed as being chronically ill, is confined to a nursing home, and has been for the previous ninety (90) days, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

HOME HEALTH CARE BENEFIT

If the insured is diagnosed as being chronically ill and has required home health care for the previous ninety (90) days, you may request the acceleration of an amount not to exceed that described by the maximum accelerated death benefit.

ACCELERATED BENEFIT PAYMENT AMOUNT

The accelerated benefit payment amount will be equal to the sum of:

1. The accelerated amount requested subject to the maximum amount allowed;
2. Any premium paid on the accelerated amount beyond the end of the policy month in which payment is made;
3. Any loan interest paid for the time beyond the acceleration date on loan amounts reduced on payment.

Less the sum of:

1. An interest charge for twelve (12) months at an interest rate declared by the Board of Directors;
2. The applicable percentage times the outstanding loan balance;
3. Any premium due and unpaid during the grace period of the policy that applies to the period before the date of acceleration;
4. An administrative expense charge, not to exceed \$100.

If the insured dies after an accelerated benefit has been elected but before any such benefits are received, the election shall be cancelled and the death benefit will be paid as stated in the policy.

INTEREST CHARGE

The interest rate used to calculate the interest charge will not exceed the greater of:

1. The current yield on 90-day treasury bills on the acceleration date; and
2. The maximum statutory adjustable policy loan interest rate effective on the acceleration date.

POLICY ADJUSTMENTS AFTER PAYMENT OF AN ACCELERATED BENEFIT

Policy Values will be adjusted as follows:

1. The adjusted face amount will be equal to the face amount immediately prior to the accelerated benefit date reduced by the accelerated percentage.
2. The adjusted cash value will be equal to the cash value immediately prior to the accelerated benefit payment reduced by the accelerated percentage.
3. Any premium payable in the future on the adjusted face amount will be equal to the premium immediately prior to the accelerated benefit date reduced by the accelerated percentage.
4. Indebtedness will be reduced by the accelerated percentage.

A statement of the accelerated benefit payable and the resulting adjusted policy values will be sent to you prior to the payment of any accelerated benefit. Updated policy pages will be sent to you after the payment of any accelerated benefit.

CONDITIONS FOR PAYMENT OF AN ACCELERATED BENEFIT

Before an accelerated benefit is paid we must receive, in writing on a form acceptable to us:

1. A properly completed proof of eligibility claim form. If we do not provide the proof of eligibility claim form to you within 15 days after you request it, it is considered that you complied with the claim requirements if you submit written proof covering the occurrence, and the character and extent of the occurrence for which the claim is made.
2. A physician's certification that the insured:
 - a. Has a terminal illness; or
 - b. Is chronically ill and is confined to a nursing home, and has been so confined for the previous ninety (90) days; or
 - c. Is chronically ill and is currently receiving home health care, and has been receiving such care for the previous ninety (90) days.
3. The consent of any irrevocable beneficiary or assignee of record.

We reserve the right to a second or third medical opinion to confirm benefit eligibility, at our expense. The second medical opinion may include a physical examination by a physician designated by us. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion that is provided by a physician that is mutually acceptable to the insured and the company.

Payment of an accelerated benefit is due immediately upon receipt of due written proof of eligibility. Accelerated benefit payments will be paid as a lump sum, or upon request, in equal monthly installments for a fixed period. The annual guaranteed interest rate for computing any monthly payment is 3.0%. If the insured dies prior to the termination of the monthly payments, the present value of the remaining payments will be paid in a lump sum to the beneficiary.

Interest will accrue prior to payment of any accelerated benefit amount as described in the policy. Payment will be made to the owner or the owners's estate, unless the accelerated benefit has been otherwise assigned or designated by the owner.

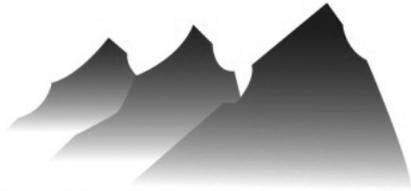
Signed at our home office at 16801 Addison Road, Addison, Texas 75001.



Paul Crooks
Secretary



Kenneth W Phillips
President



PURITAN®

Life Insurance Company of America

TO OBTAIN INFORMATION, MAKE A CLAIM, OR MAKE A COMPLAINT

Call us toll-free:

1.877.249.1966

Or write to us:

**PURITAN LIFE INSURANCE COMPANY OF AMERICA
ADMINISTRATIVE OFFICE
PO BOX 717
FRANKFORT KY 40602-0717**

Or email us:

info@puritanlife.com

SINGLE PREMIUM WHOLE LIFE INSURANCE POLICY

Proceeds payable at death of insured and prior to the maturity date;
Cash surrender value payable on the maturity date;
Non-participating - no dividends.

PURITAN LIFE INSURANCE COMPANY OF AMERICA ACCELERATED DEATH BENEFIT RIDER

NOTICE: Death benefits and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.

GENERAL PROVISIONS

This rider is made part of this policy. It is subject to all applicable terms of the policy as well as the terms of this rider. Rider provisions apply in lieu of any policy provisions to the contrary. The consideration is the application.

RIDER EFFECTIVE DATE

The effective date of this rider is the effective date of the policy to which it is attached, unless otherwise stated.

OWNER

The owner of this rider is the owner of the policy to which this rider is attached, unless otherwise provided. The owner of this rider may exercise all the rights under this rider during the lifetime of the insured by making written request to us. All the rights of the owner are subject to the rights of any assignee or any irrevocable beneficiary we have on record.

NON-PARTICIPATING

This rider will not share in our surplus earnings. No dividends will be paid.

CASH VALUES

This rider does not provide cash or loan values.

TERMINATION

Benefits under this rider will terminate on the earliest of the following dates:

1. The date we receive your request to surrender the policy;
2. The date you request cancellation of this rider, in writing;
3. The date of termination of the policy to which this rider is attached.

DEFINITIONS

ACCELERATED BENEFIT

A benefit that may be requested by the owner if the insured is terminally ill or if the insured is chronically ill and is either confined to a nursing home or requires home health care. Terminal illness and chronic illness are defined below.

ACCELERATED PERCENTAGE

The accelerated percentage is equal to the requested accelerated benefit divided by the face amount immediately prior to the request.

ACCELERATION DATE

The date the accelerated benefits are paid.

ADJUSTED CASH VALUE

The cash value, adjusted for any accelerated benefits paid.

ADJUSTED FACE AMOUNT

The face amount, adjusted for any accelerated benefits paid.

CHRONIC ILLNESS

A disease or illness, certified by a physician, such that the insured:

1. Is unable to perform at least two activities of daily living and has been unable to do so for the previous ninety (90) days due to a loss of functional capacity. The activities of daily living are eating, toileting, transferring, bathing, dressing, and continence; or
2. Requires substantial supervision to protect the person from threats to health and safety because of severe cognitive impairment. Severity of cognitive impairment is measured by impairment in short or long term memory, orientation to people, places, or time, and deductive or abstract reasoning.

HOME HEALTH CARE

Skilled services, including custodial care, that are performed by an RN or an LPN in the home of the insured. These services must be medically necessary to maintain or improve the health of the insured.

LICENSED PRACTICAL NURSE OR LPN

A licensed practical nurse, performing within the scope of his/her current license. The person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

NURSING HOME

A facility that is a Medicare certified skilled nursing facility whose primary function is to provide continuous, 24-hours-per-day nursing care, and room and board. The facility must charge for these services. The care must be performed under the direction of a physician, RN, or an LPN. It may not be, other than incidentally, a home for the aged, a hospital, a retirement home, a rest home, a community living center, or a place mainly for the treatment of drug abuse, alcoholism or mental illness.

PHYSICIAN

A licensed medical doctor performing within the scope of his/her current license. This person cannot be you, the insured, a beneficiary, or a family member of any of these individuals.

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 - b. Is chronically ill and is confined to a nursing home, and has been so confined for the previous ninety (90) days; or
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Interest will accrue prior to payment of any accelerated benefit amount as described in the policy. Payment will be made to the owner or the owners's estate, unless the accelerated benefit has been otherwise assigned or designated by the owner.

Signed at our home office at 16801 Addison Road, Addison, Texas 75001.



Paul Crooks
Secretary



Kenneth W Phillips
President



Administrative Address
 PO Box 717
 Frankfort, KY 40602-0717



APPLICATION FOR LIFE INSURANCE

PART ONE

Section A. Proposed Insured

FIRST	MI	LAST		
STREET ADDRESS				SSN, TAX ID#, OR GREEN CARD #
CITY	STATE	ZIP	EMAIL ADDRESS	
PHONE NUMBER ()	GENDER	BIRTH DATE	BIRTH STATE	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, are you a permanent U.S. resident? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section B. Owner Information (complete only if other than Proposed Insured)

FIRST	MI	LAST		
STREET ADDRESS				SSN, TAX ID#, OR GREEN CARD #
CITY	STATE	ZIP	PHONE NUMBER ()	
RELATIONSHIP TO PROPOSED INSURED				

Section C. Other Coverage & Arrangements

Does the Proposed Insured and/or Owner, have any existing life insurance or annuity coverage? Yes No

Has the Owner, Proposed Insured, or Beneficiary entered into or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in this policy? Yes No (If yes, no coverage will be issued.)

Is this policy being purchased to replace any existing life insurance or annuity coverage? Yes No

If Yes, please complete the following:

COMPANY NAME	POLICY #		
STREET ADDRESS			
CITY	STATE	ZIP	

Section D. Beneficiary

PRIMARY	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	SSN	%
PRIMARY	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	SSN	%
CONTINGENT	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	SSN	%
CONTINGENT	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	SSN	%

Section E. Coverage Information

PREMIUM AMOUNT \$ _____	FACE AMOUNT \$ _____
-------------------------	----------------------

MARK IF APPLYING FOR RIDER:
 Accelerated Death Benefit Rider (ADB) Yes No (Automatically included unless "No" is marked.)

PART TWO

Section A. Health Questions If any question in Part Two, Section A is answered "Yes", or if height and weight exceeds the maximum range, no coverage will be issued.

ANSWER FOR
PROPOSED INSURED

- | | |
|---|--|
| 1. What is your height and weight? | H_____ W_____ |
| 2. Have you had, or been medically advised to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or have you been diagnosed, treated (including dialysis) or taken medication for chronic kidney disease or kidney (renal) insufficiency or kidney or liver failure or do you have paralysis of two or more extremities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Are you currently: hospitalized, confined to a bed or nursing facility, or using oxygen equipment to assist in breathing, or receiving Hospice Care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you been treated for insulin shock, diabetic coma, or ever taken insulin shots prior to the age of 50 or were you diagnosed with Diabetes prior to age 30? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you ever been medically diagnosed, treated, or taken medication for: congestive heart failure (CHF), cardiomyopathy, Alzheimer's, dementia, organic brain syndrome, schizophrenia, bipolar disorder, mental incapacity, Lou Gehrig's disease (ALS), or Huntington's disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Within the past 24 months have you been diagnosed with internal cancer or melanoma, leukemia, lymphoma, stroke, transient ischemic attack (TIA) or have you had an amputation caused by any disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have you had more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Within the past 24 months have you: | |
| a. been medically diagnosed, treated or taken medication for: angina, chronic hepatitis or Hepatitis C, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure or required oxygen equipment to assist in breathing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been diagnosed as having, been treated for or hospitalized for: heart attack, heart disease, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty or stent implant), uncontrolled high blood pressure or any procedure to improve circulation to the heart or brain? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. had Hodgkin's Disease, cirrhosis, liver disease, or systemic lupus (SLE)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. had any neuromuscular disease (including cerebral palsy, multiple sclerosis, grand mal seizures, or Parkinson's disease)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Within the past 10 years, have you been convicted of a felony or are you currently on parole or on probation? ... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Within the last 5 years have you been treated for, been advised to have treatment for, or excessively used, alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while impaired or under the influence of alcohol or any drugs, or had your driver's license suspended or revoked, or currently is your driver's license suspended or revoked, or attempted suicide? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Have you been declined or postponed for life or health insurance in the past two years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as dressing, eating, bathing, incontinence, toileting, taking medications, or moving without any type of physical assistance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Section B. Other Questions If any question in Part Two, Section B is answered "Yes", coverage may still be issued.

- | | |
|---|--|
| 15. Are you taking medication for any impairment in Part Two, Section A? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Have you used any nicotine based products in the past 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Have you applied for life insurance with any other insurance companies in the last two years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Proposed Insured's driver's license number _____ State _____ <input type="checkbox"/> None | |

PART THREE

Section A. Statements and Authorizations

PROPOSED INSURED'S STATEMENT (or Owner if legal representative)

I have read and understood this Application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. The representations in Part One, Sections A, B, C, D and E and Part Two, Sections A and B are true. I agree the policy shall not be in effect until it has been issued by Puritan Life Insurance Company of America ("the Company") and the premium is paid during my lifetime. I understand that the Producer has no authority to approve this Application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date signed in the policy and all eligibility requirements are met. The purpose of this Application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company.

Proposed Insured's Initials

MEDICAL AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc. (formerly known as the Medical Information Bureau), pharmacy, pharmacy benefit manager, insurance laboratories, my employer or consumer reporting agency, to give Puritan Life Insurance Company of America or its reinsurers any information they have about my health, including confidential HIV-related information. I authorize Puritan Life Insurance Company of America, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.. I acknowledge receipt of the MIB, Inc. Pre-Notice on page 7. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for use in underwriting risk selection purposes only and is valid for 36 months, except for HIV-related information, which is only valid for 180 days from the date below.

----- WARNING -----

FRAUD NOTICE

Any person who knowingly submits a false statement in an Application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.

I have read, understand, and acknowledge the Fraud Notice.

Proposed Insured's Initials

Owner's Initials

MISREPRESENTATION NOTICE

If your answers to the questions in this application are incorrect or untrue, Puritan Life Insurance Company of America may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary(ies).

I have read, understand, and acknowledge the Misrepresentation Notice. I agree that the information on this application will be relied upon to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy.

Proposed Insured's Initials

Owner's Initials

Proposed Insured's Signature

Owner's Signature

Date

Section B. Producer Statement

PRODUCER'S STATEMENT

To the best of my knowledge and belief the Proposed Insured and/or Owner does does not have any existing life insurance or annuity coverage and the life insurance applied for will will not replace any existing life insurance or annuity coverage. I certify that I have verified the personal information of the Applicant. I further certify that any information recorded by me on this Application is true and accurate to the best of my knowledge and that the Proposed Insured and Owner seemed to me to be lucid and to fully understand all of the questions on this Application. I certify to the best of my knowledge that the Owner or Proposed Insured is not being paid cash or promised services as an inducement to enter into this insurance transaction and to my knowledge, this insurance transaction will not be sold or assigned for any type of senior settlement, life settlement or any other secondary market.

Writing Producer's Signature

Producer's Printed Name / Producer's Number

Date

COMPLETE ONLY IF REQUESTING COMMISSION SPLIT:

Producer's Name

Producer's Number

Split %

Producer's Name

Producer's Number

Split %



Administrative Address
 PO Box 717
 Frankfort, KY 40602-0717

ELECTRONIC FUNDS TRANSFER PLAN

I, the undersigned, agree that I want all premiums withdrawn from the account listed below in an amount sufficient to pay the premium due for the insurance policy. Additionally, I hereby authorize and request Puritan Life Insurance Company of America to initiate electronic debit entries or effect a change by any other commercially accepted practice to my account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I agree that this Authorization in no way affects the terms of the policy. This Authorization may be terminated by either party by giving written notice to the other.

Premium Amount to Withdraw \$ _____

Bank Account Information:

Bank Name and Phone Number: _____

Bank Address: _____

Payor Name: _____

Bank Routing Number: _____ Account Number: _____

Type of Account: Savings (write routing and account numbers below and circle the corresponding numbers)
 Checking (attach void check)

Bank Routing Number

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

Bank Account Number

0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
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6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9	9	9

**FOR
CHECKING
ACCOUNTS:**

**TAPE OR
STAPLE
VOIDED
CHECK
HERE**

PAYOR SIGNATURE: (Must match your financial institution's records). A copy of this document sent via electronic transmission is as valid as the original.)

X _____ Date _____



Administrative Address
PO Box 717
Frankfort, KY 40602-0717

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION

Name(s) of Primary Proposed Insured/Patient

Date of Birth

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy; pharmacy benefit manager; medical facility; insurance company; insurance support organization (such as MIB, Inc. or any of its members or affiliates); or other health care provider that has provided payment, treatment, or services to me or on my behalf (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their Producers; employees; and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol; drugs; and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction for use in underwriting risk selection purposes.

This protected health information can be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). This authorization will remain in force for 36 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company (Attention: Policyholder Service Department, 16801 Addison Road - Suite 400, Addison, TX 75001). I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record the Company may not be able to process my Application; or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Primary Proposed Insured/Personal Representative

Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

Power of Attorney Other (please describe): _____



Administrative Address
 PO Box 717
 Frankfort, KY 40602-0717

IMPORTANT NOTICES

PRIVACY NOTICE

At Puritan Life Insurance Company of America (We, Us, Our), We are committed to protecting your privacy and the confidentiality of your personal and financial information. We, like other insurance companies, sometimes evaluate the medical history and other personal information about Applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and career.) We also use this information to administer Your insurance coverage after it is in force.

We rely heavily on information provided by You. We may also supplement this information from other sources, such as medical professionals or institutions that have treated You or family members covered under Your policy; insurance support organizations; other insurance companies to which You have applied; and employers.

Any information You give Us regarding Your insurability and any information received from other sources will be treated as confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless You request otherwise, Your name, address, date of birth, and phone number may also be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

If you wish, You have the right to request a copy of, items of personal information that appear in Our files. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO OUR PRIVACY OFFICER AT PURITAN LIFE INSURANCE COMPANY OF AMERICA, 16801 ADDISON ROAD - SUITE 400, ADDISON, TX 75001, OR VISIT WWW.PURITANLIFE.COM.

FAIR CREDIT REPORTING ACT NOTICE

With regard to Your Application, We may have requested an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health except as may be related directly or indirectly to Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, We will give You the name and address of the consumer reporting firm so that You may request a copy of the report.

MIB, Inc. PRE-NOTICE - Proposed Insured

Information regarding Your insurability will be treated as confidential. Puritan Life Insurance Company of America, or its reinsurers, may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, that operates an information exchange on behalf of its members. If You apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply Puritan Life Insurance Company of America with the information in its file.

Upon receipt of a request from You, the MIB, Inc. will arrange disclosure of any information it may have in Your file. Please contact MIB, Inc. at 866-692-6901 (TTY: 866-346-3642). If You question the accuracy of information in the MIB, Inc.'s file, you may contact the MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc. is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. Puritan Life Insurance Company of America, or its reinsurers, may also release information in its file to MIB, Inc. and to other life or health insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

LEAVE THIS PAGE WITH OWNER

IMPORTANT NOTICE
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES
(Continued)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older—are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?



Administrative Office:

PO Box 717 • Frankfort KY • 40602-0717

Phone: 877.249.1966 • Fax: 502.875.7084

LIFE INSURANCE AND ANNUITIES

REPLACEMENT MEMORANDUM

EXISTING CONTRACT/POLICY	PROPOSED CONTRACT /POLICY
Owner/Annuitant(s) _____	Owner/Annuitant(s) _____
Insurer _____	Insurer _____
Contract # _____	Application # _____
Product Type * _____	Product Type * _____
Product Name _____	Product Name _____

FOR BOTH LIFE INSURANCE AND ANNUITIES

Complete all that is applicable)

CONTRACT OR POLICY PROVISION	EXISTING CONTRACT/POLICY	REPLACEMENT CONTRACT/POLICY
Current Proposed Premium / Annual Consideration		
Current Contract Value		
Current Surrender Value		
Death Benefit Amount		
Current Interest Rate & Guarantee Period		
Guaranteed Minimum Accumulation/Interest Rate		

* Deferred Fixed Annuity, Deferred Variable Annuity, Deferred Indexed Fixed Annuity, Immediate Annuity, Indexed Life Insurance, Variable Life Insurance, Whole Life Insurance, Universal Life Insurance, Term Life Insurance and Endowment

SERFF Tracking #:

PLCA-128706630

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Puritan Life Insurance Company of America

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life

Product Name:

Puritan Beacon SPWL

Project Name/Number:

Puritan Beacon SPWL/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Attached is the Flesch certification for this filing submission.		
Attachment(s):			
FLESCH Certification - SPWL - 09.26 AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Attached, please find the Application for Insurance that corresponds to this policy.		
Attachment(s):			
AR-PLICA-SPWL100-APP.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement Demonstrating the Effect of an Accelerated Death Benefit Payment		
Comments:	For information purposes, attached is a demonstration form that will be given to policyholders when they file an ADB claim demonstrating the impact on their face amount and other policy benefits.		
Attachment(s):			
AR-PLICA-SPWL100-ADBCLDISC.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Accelerated Death Benefit Payment Rider Disclosure		
Comments:	For information purposes, attached is a disclosure form that will be given to policyholders at the time of the sale that explains the ADB rider.		
Attachment(s):			
AR-PLICA-SPWL100-ADBDISC.pdf			

Item Status:**Status Date:**

SERFF Tracking #:

PLCA-128706630

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Puritan Life Insurance Company of America

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life

Product Name:

Puritan Beacon SPWL

Project Name/Number:

Puritan Beacon SPWL/

Satisfied - Item:	Certification		
Comments:	Attached, please find a certification that we will comply with Rule 19, Regulation 49, and ACA 23-79-138.		
Attachment(s):			
Certification for AR.pdf			

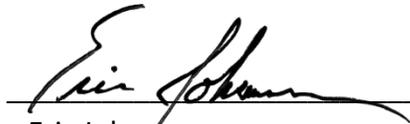


16801 Addison Road, Suite 400
Addison, Texas 75001
800-513-3243

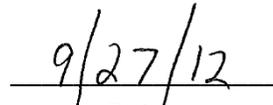
I have reviewed or supervised the preparation of the forms listed below and certify that the forms comply with the applicable readability requirements of Arkansas.

<u>Form Number</u>	<u>Description</u>	<u>Flesch Score</u>
AR-PLICA-SPWL100	Single Premium Whole Life Insurance Policy	53.1
AR-PLICA-SPWL100-ADB	Accelerated Death Benefit Rider	50.5
AR-PLICA-SPWL100-APP	Application for Individual Life Insurance and Annuity	52.5

Puritan Life Insurance Company of America


Eric Johansson

Vice President of Administration


Date



Administrative Address
 PO Box 717
 Frankfort, KY 40602-0717



APPLICATION FOR LIFE INSURANCE

PART ONE

Section A. Proposed Insured

FIRST	MI	LAST		
STREET ADDRESS				SSN, TAX ID#, OR GREEN CARD #
CITY	STATE	ZIP	EMAIL ADDRESS	
PHONE NUMBER ()	GENDER	BIRTH DATE	BIRTH STATE	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, are you a permanent U.S. resident? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section B. Owner Information (complete only if other than Proposed Insured)

FIRST	MI	LAST		
STREET ADDRESS				SSN, TAX ID#, OR GREEN CARD #
CITY	STATE	ZIP	PHONE NUMBER ()	
RELATIONSHIP TO PROPOSED INSURED				

Section C. Other Coverage & Arrangements

Does the Proposed Insured and/or Owner, have any existing life insurance or annuity coverage? Yes No

Has the Owner, Proposed Insured, or Beneficiary entered into or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in this policy? Yes No (If yes, no coverage will be issued.)

Is this policy being purchased to replace any existing life insurance or annuity coverage? Yes No

If Yes, please complete the following:

COMPANY NAME	POLICY #		
STREET ADDRESS			
CITY	STATE	ZIP	

Section D. Beneficiary

PRIMARY	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	SSN	%
PRIMARY	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	SSN	%
CONTINGENT	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	SSN	%
CONTINGENT	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	SSN	%

Section E. Coverage Information

PREMIUM AMOUNT \$ _____	FACE AMOUNT \$ _____
-------------------------	----------------------

MARK IF APPLYING FOR RIDER:
 Accelerated Death Benefit Rider (ADB) Yes No (Automatically included unless "No" is marked.)

PART TWO

Section A. Health Questions If any question in Part Two, Section A is answered "Yes", or if height and weight exceeds the maximum range, no coverage will be issued.

ANSWER FOR
PROPOSED INSURED

- | | |
|---|--|
| 1. What is your height and weight? | H_____ W_____ |
| 2. Have you had, or been medically advised to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or have you been diagnosed, treated (including dialysis) or taken medication for chronic kidney disease or kidney (renal) insufficiency or kidney or liver failure or do you have paralysis of two or more extremities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Are you currently: hospitalized, confined to a bed or nursing facility, or using oxygen equipment to assist in breathing, or receiving Hospice Care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you been treated for insulin shock, diabetic coma, or ever taken insulin shots prior to the age of 50 or were you diagnosed with Diabetes prior to age 30? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you ever been medically diagnosed, treated, or taken medication for: congestive heart failure (CHF), cardiomyopathy, Alzheimer's, dementia, organic brain syndrome, schizophrenia, bipolar disorder, mental incapacity, Lou Gehrig's disease (ALS), or Huntington's disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Within the past 24 months have you been diagnosed with internal cancer or melanoma, leukemia, lymphoma, stroke, transient ischemic attack (TIA) or have you had an amputation caused by any disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have you had more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Within the past 24 months have you: | |
| a. been medically diagnosed, treated or taken medication for: angina, chronic hepatitis or Hepatitis C, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure or required oxygen equipment to assist in breathing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been diagnosed as having, been treated for or hospitalized for: heart attack, heart disease, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty or stent implant), uncontrolled high blood pressure or any procedure to improve circulation to the heart or brain? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. had Hodgkin's Disease, cirrhosis, liver disease, or systemic lupus (SLE)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. had any neuromuscular disease (including cerebral palsy, multiple sclerosis, grand mal seizures, or Parkinson's disease)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Within the past 10 years, have you been convicted of a felony or are you currently on parole or on probation? ... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Within the last 5 years have you been treated for, been advised to have treatment for, or excessively used, alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while impaired or under the influence of alcohol or any drugs, or had your driver's license suspended or revoked, or currently is your driver's license suspended or revoked, or attempted suicide? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Have you been declined or postponed for life or health insurance in the past two years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as dressing, eating, bathing, incontinence, toileting, taking medications, or moving without any type of physical assistance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Section B. Other Questions If any question in Part Two, Section B is answered "Yes", coverage may still be issued.

- | | |
|---|--|
| 15. Are you taking medication for any impairment in Part Two, Section A? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Have you used any nicotine based products in the past 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Have you applied for life insurance with any other insurance companies in the last two years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Proposed Insured's driver's license number _____ State _____ <input type="checkbox"/> None | |

PART THREE

Section A. Statements and Authorizations

PROPOSED INSURED'S STATEMENT (or Owner if legal representative)

I have read and understood this Application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. The representations in Part One, Sections A, B, C, D and E and Part Two, Sections A and B are true. I agree the policy shall not be in effect until it has been issued by Puritan Life Insurance Company of America ("the Company") and the premium is paid during my lifetime. I understand that the Producer has no authority to approve this Application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date signed in the policy and all eligibility requirements are met. The purpose of this Application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company.

Proposed Insured's Initials

MEDICAL AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc. (formerly known as the Medical Information Bureau), pharmacy, pharmacy benefit manager, insurance laboratories, my employer or consumer reporting agency, to give Puritan Life Insurance Company of America or its reinsurers any information they have about my health, including confidential HIV-related information. I authorize Puritan Life Insurance Company of America, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.. I acknowledge receipt of the MIB, Inc. Pre-Notice on page 7. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for use in underwriting risk selection purposes only and is valid for 36 months, except for HIV-related information, which is only valid for 180 days from the date below.

----- WARNING -----

FRAUD NOTICE

Any person who knowingly submits a false statement in an Application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.

I have read, understand, and acknowledge the Fraud Notice.

Proposed Insured's Initials

Owner's Initials

MISREPRESENTATION NOTICE

If your answers to the questions in this application are incorrect or untrue, Puritan Life Insurance Company of America may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary(ies).

I have read, understand, and acknowledge the Misrepresentation Notice. I agree that the information on this application will be relied upon to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy.

Proposed Insured's Initials

Owner's Initials

Proposed Insured's Signature

Owner's Signature

Date

Section B. Producer Statement

PRODUCER'S STATEMENT

To the best of my knowledge and belief the Proposed Insured and/or Owner does does not have any existing life insurance or annuity coverage and the life insurance applied for will will not replace any existing life insurance or annuity coverage. I certify that I have verified the personal information of the Applicant. I further certify that any information recorded by me on this Application is true and accurate to the best of my knowledge and that the Proposed Insured and Owner seemed to me to be lucid and to fully understand all of the questions on this Application. I certify to the best of my knowledge that the Owner or Proposed Insured is not being paid cash or promised services as an inducement to enter into this insurance transaction and to my knowledge, this insurance transaction will not be sold or assigned for any type of senior settlement, life settlement or any other secondary market.

Writing Producer's Signature

Producer's Printed Name / Producer's Number

Date

COMPLETE ONLY IF REQUESTING COMMISSION SPLIT:

Producer's Name

Producer's Number

Split %

Producer's Name

Producer's Number

Split %



Administrative Address
 PO Box 717
 Frankfort, KY 40602-0717

ELECTRONIC FUNDS TRANSFER PLAN

I, the undersigned, agree that I want all premiums withdrawn from the account listed below in an amount sufficient to pay the premium due for the insurance policy. Additionally, I hereby authorize and request Puritan Life Insurance Company of America to initiate electronic debit entries or effect a change by any other commercially accepted practice to my account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I agree that this Authorization in no way affects the terms of the policy. This Authorization may be terminated by either party by giving written notice to the other.

Premium Amount to Withdraw \$ _____

Bank Account Information:

Bank Name and Phone Number: _____

Bank Address: _____

Payor Name: _____

Bank Routing Number: _____ Account Number: _____

Type of Account: Savings (write routing and account numbers below and circle the corresponding numbers)
 Checking (attach void check)

Bank Routing Number

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

Bank Account Number

0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9	9

FOR
CHECKING
ACCOUNTS:

TAPE OR
STAPLE
VOIDED
CHECK
HERE

PAYOR SIGNATURE: (Must match your financial institution's records). A copy of this document sent via electronic transmission is as valid as the original.)

X _____ Date _____



Administrative Address
PO Box 717
Frankfort, KY 40602-0717

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION

Name(s) of Primary Proposed Insured/Patient

Date of Birth

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy; pharmacy benefit manager; medical facility; insurance company; insurance support organization (such as MIB, Inc. or any of its members or affiliates); or other health care provider that has provided payment, treatment, or services to me or on my behalf (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their Producers; employees; and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol; drugs; and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction for use in underwriting risk selection purposes.

This protected health information can be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). This authorization will remain in force for 36 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company (Attention: Policyholder Service Department, 16801 Addison Road - Suite 400, Addison, TX 75001). I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record the Company may not be able to process my Application; or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Primary Proposed Insured/Personal Representative

Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

Power of Attorney Other (please describe): _____



Administrative Address
 PO Box 717
 Frankfort, KY 40602-0717

IMPORTANT NOTICES

PRIVACY NOTICE

At Puritan Life Insurance Company of America (We, Us, Our), We are committed to protecting your privacy and the confidentiality of your personal and financial information. We, like other insurance companies, sometimes evaluate the medical history and other personal information about Applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and career.) We also use this information to administer Your insurance coverage after it is in force.

We rely heavily on information provided by You. We may also supplement this information from other sources, such as medical professionals or institutions that have treated You or family members covered under Your policy; insurance support organizations; other insurance companies to which You have applied; and employers.

Any information You give Us regarding Your insurability and any information received from other sources will be treated as confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless You request otherwise, Your name, address, date of birth, and phone number may also be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

If you wish, You have the right to request a copy of, items of personal information that appear in Our files. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO OUR PRIVACY OFFICER AT PURITAN LIFE INSURANCE COMPANY OF AMERICA, 16801 ADDISON ROAD - SUITE 400, ADDISON, TX 75001, OR VISIT WWW.PURITANLIFE.COM.

FAIR CREDIT REPORTING ACT NOTICE

With regard to Your Application, We may have requested an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health except as may be related directly or indirectly to Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, We will give You the name and address of the consumer reporting firm so that You may request a copy of the report.

MIB, Inc. PRE-NOTICE - Proposed Insured

Information regarding Your insurability will be treated as confidential. Puritan Life Insurance Company of America, or its reinsurers, may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, that operates an information exchange on behalf of its members. If You apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply Puritan Life Insurance Company of America with the information in its file.

Upon receipt of a request from You, the MIB, Inc. will arrange disclosure of any information it may have in Your file. Please contact MIB, Inc. at 866-692-6901 (TTY: 866-346-3642). If You question the accuracy of information in the MIB, Inc.'s file, you may contact the MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc. is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. Puritan Life Insurance Company of America, or its reinsurers, may also release information in its file to MIB, Inc. and to other life or health insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

LEAVE THIS PAGE WITH OWNER

Puritan Life Insurance Company of America
STATEMENT DEMONSTRATING THE EFFECT OF AN ACCELERATED DEATH
BENEFIT PAYMENT

Policy Number: **999888** Insured: **John Doe**

You have requested payment under the Accelerated Death Benefit Rider attached to the above policy. This disclosure is to help you decide whether or not payment of this benefit is right for you.

NOTICE: Death benefits and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.

The accelerated percentage you requested is **25%**.
 The face amount of your policy just prior to the accelerated benefit date is **\$106,000**.
 You requested an acceleration date of **May 1, 2020**.

After payment of an accelerated benefit, policy values will be adjusted as follows:

	<u>Immediately prior to accelerated benefit date</u>	<u>After payment of accelerated benefit</u>
Face amount	\$106,000.00	\$79,500.00
Cash Value	\$48,227.88	\$36,170.91
Annual Premium	\$0.00	\$0.00
Indebtedness	\$0.00	\$0.00

The accelerated benefit payment will be equal to:

The Accelerated amount		\$26,500.00
Plus premium paid for periods beyond the acceleration date	+	\$0.00
Plus loan interest paid for periods beyond the acceleration date	+	\$0.00
Less An interest charge for twelve (12) months	-	\$795.00
Less the applicable percentage of the outstanding loan balance	-	\$0.00
Less an administrative expense charge	-	\$100.00
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Total accelerated benefit payment		\$25,605.00

The interest charge is computed using an annual interest rate of **3.00%**.

Signature of Policy Owner

Date

Puritan Life Insurance Company of America
ACCELERATED DEATH BENEFIT PAYMENT RIDER DISCLOSURE

NOTICE: Death benefits and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.

PREMIUMS

There is no premium charge for the accelerated death benefit rider.

EFFECT ON POLICY VALUES

After payment of the accelerated death benefit, the death benefit of the policy will be reduced by the amount of accelerated death benefit. Any premium payments, cash values, and other obligations and benefits under this policy, excluding that for riders, will be reduced proportionately.

AMENDED POLICY SCHEDULE

An amended policy schedule will be sent to you upon payment of this benefit. The schedule will show the reduced death benefit, cash value and premium amounts.

MAXIMUM ACCELERATED DEATH BENEFIT

The sum of all accelerated benefit payments may not exceed the smaller of \$250,000 or 80% of the face amount. This is subject to the additional requirement that the remaining death benefit be no less than \$10,000.

CONDITION OF PAYMENT

We will pay an amount up to the maximum accelerated death benefit if we receive proof that the insured has been (a) diagnosed with a terminal illness; or (b) is chronically ill and for the past ninety (90) days has either been confined to a nursing home or has required home health care.

DEFINITION OF TERMINAL ILLNESS

Terminal illness is considered a disease or illness that is expected to result in the death of the insured within twenty-four (24) months.

DEFINITION OF CHRONIC ILLNESS

Chronic illness is considered a disease or illness such that the insured is unable to perform at least two activities of daily living or requires substantial supervision as protections from threats to health or safety.

CERTIFICATION OF PHYSICIAN

The certification by a physician must include documentation supported by clinical, radiological, histological, or laboratory evidence of the condition.

PHYSICIAN OF OUR CHOICE

We may require an additional examination by a physician of our choice, and at our expense. If there is a conflict of medical opinion as to the life expectancy of the insured, a third medical opinion that is provided by a physician that is mutually acceptable to the insured and the company will govern.

I have received a copy of this disclosure.

Applicant

Date

Agent

Date



16801 Addison Road, Suite 400
Addison, Texas 75001
800-513-3243

Certificate of Compliance

Re: Forms: AR-PLICA-SPWL100, AR-PLICA-SPWL100-ADB, AR-PLICA-SPWL100-APP, ICC10-PLICA-ADBDISC and ICC10-PLICA-ADBCLDISC.

I hereby certify that the submitted forms listed above meet all applicable Arkansas requirements including the requirements of Rule and Regulation 19 and the requirements of Rule and Regulation 49.

I also hereby certify that the submitted forms listed above meet with the applicable readability requirements of the Arkansas Code.

I also certify that the Consumer Information Notice as required by ACA 23-79-138 is attached to every policy at policy issue.

Puritan Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Eric Johansson", is written over a horizontal line.

Eric Johansson
Vice President of Administration

10/10/2012

Date

SERFF Tracking #:

PLCA-128706630

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Puritan Life Insurance Company of America

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life

Product Name:

Puritan Beacon SPWL

Project Name/Number:

Puritan Beacon SPWL/

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/04/2012	Form	Policy	10/10/2012	
10/04/2012	Form	ADB Rider	10/10/2012	