

**State:** Arkansas **Filing Company:** Washington National Insurance Company  
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.500 Other  
**Product Name:** WNIC-3002-PS3  
**Project Name/Number:** Modal Factor Change/

## Filing at a Glance

Company: Washington National Insurance Company  
Product Name: WNIC-3002-PS3  
State: Arkansas  
TOI: L04I Individual Life - Term  
Sub-TOI: L04I.500 Other  
Filing Type: Form  
Date Submitted: 11/26/2012  
SERFF Tr Num: CNSC-128770966  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: WNIC-3002-PS2  
  
Implementation: 06/01/2013  
Date Requested:  
Author(s): Janet Jones, Tammy O'Connor  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 11/30/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** Washington National Insurance Company  
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.500 Other  
**Product Name:** WNIC-3002-PS3  
**Project Name/Number:** Modal Factor Change/

## General Information

Project Name: Modal Factor Change Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 11/30/2012  
State Status Changed: 11/30/2012  
Deemer Date: Created By: Janet Jones  
Submitted By: Janet Jones Corresponding Filing Tracking Number:

### Filing Description:

RE: Washington National Insurance Company / NAIC No. 233-70319 / FEIN # 36-1933760  
WNIC-3002-PS3 - Policy Specifications Page

Dear Sir or Madam:

On 2/24/11, we received approval of Policy Form WNIC-3002-AR under SERFF Tracking # CNSC-126997100. A copy of the original disposition report is attached to the Supporting Documentation tab.

Form WNIC-3002-AR is a renewable term life insurance policy to age 98. The death benefit is level for the life of the contract. The premiums are guaranteed and will increase annually after the Level Premium Period. The Level Premium Periods are 15 years or To Age 65 (selected at time of application by the applicant). The premiums are unisex and vary by issue age, level premium period length, and non-tobacco/tobacco underwriting classes. The policy fee is \$48 per year. The available issue ages, on an age last birthday basis, are 18 to 65 for the 15-year level premium period and 18-55 for the level premium period To Age 65.

We now wish to make the following changes to the policy.

- We have revised our modal factors to remove modal loads. The modal factors are shown on the Policy Specifications Page. A revised Page 3, Form WNIC-3002-PS3, is being filed for approval. A revised Actuarial Memorandum is attached to the Supporting Documentation tab.
- The premium rates have been increased for new issues.

Previously approved Applications WNIC-8001-GI and WNIC-8001-EOI will be used with this policy. A copy of the approved policy is also being attached to the Supporting Documentation tab in SERFF.

Upon your approval, the rate change and modal factor change will be effective June 1, 2013. This filing does not contain any controversial or unusual items from normal company or industry standards.

Thank you for your time and consideration on this filing. If you have any further questions regarding this filing, please feel free to contact me.

Sincerely,

**State:** Arkansas **Filing Company:** Washington National Insurance Company  
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.500 Other  
**Product Name:** WNIC-3002-PS3  
**Project Name/Number:** Modal Factor Change/

Janet Jones, HIA, AIRC  
 Product Filing Analyst  
 Policy Approval & Compliance  
 1-800-888-4918 extension 73177  
 Janet.Jones@cnoinc.com

## Company and Contact

### Filing Contact Information

Janet Jones, Janet\_Jones@conseco.com  
 11815 N. Pennsylvania Street 800-888-4918 [Phone] 3177 [Ext]  
 Carmel, IN 46032 317-817-2333 [FAX]

### Filing Company Information

Washington National Insurance Company  
 11815 N. Pennsylvania St.  
 Carmel, IN 46032  
 (800) 888-4918 ext. [Phone]

CoCode: 70319  
 Group Code: 233  
 Group Name:  
 FEIN Number: 36-1933760

State of Domicile: Indiana  
 Company Type: Insurance  
 State ID Number:

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: Indiana domiciliary state, \$35 per form  
 Arkansas \$50 per form  
 one form = \$50.00  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Washington National Insurance Company	\$50.00	11/26/2012	65167246

State: Arkansas Filing Company: Washington National Insurance Company  
TOI/Sub-TOI: L041 Individual Life - Term/L041.500 Other  
Product Name: WNIC-3002-PS3  
Project Name/Number: Modal Factor Change/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/30/2012	11/30/2012

SERFF Tracking #:

CNSC-128770966

State Tracking #:

Company Tracking #:

WNIC-3002-PS2

State:

Arkansas

Filing Company:

Washington National Insurance Company

TOI/Sub-TOI:

L04I Individual Life - Term/L04I.500 Other

Product Name:

WNIC-3002-PS3

Project Name/Number:

Modal Factor Change/

## Disposition

Disposition Date: 11/30/2012

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	Copy of approved policy and original Disposition Report		Yes
Supporting Document	Statement of Variability		Yes
Form	Policy Specifications		Yes

SERFF Tracking #:

CNSC-128770966

State Tracking #:

Company Tracking #:

WNIC-3002-PS2

State: Arkansas  
 TOI/Sub-TOI: L041 Individual Life - Term/L041.500 Other  
 Product Name: WNIC-3002-PS3  
 Project Name/Number: Modal Factor Change/

Filing Company: Washington National Insurance Company

## Form Schedule

Lead Form Number: WNIC-3002-PS3								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Policy Specifications	WNIC-3002-PS3	POLA	Initial		50.000	WNIC-3002-PS3.pdf

### Form Type Legend:

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

**POLICY SPECIFICATIONS**

POLICY NUMBER: [0000000]	INSURED: [JOHN DOE]
POLICY EFFECTIVE DATE: [OCTOBER 15, 2010]	AGE: [35]
EXPIRY DATE: [OCTOBER 15, 2073]	RATING
INITIAL ANNUAL PREMIUM: \$[278.00]	CLASS: [STANDARD NON-TOBACCO]
PREMIUM MODE: [ANNUAL]	LEVEL PREMIUM
	PERIOD: [15 YEARS]
	DEATH BENEFIT: \$[100,000]

THE PREMIUMS ARE GUARANTEED AND ARE SHOWN ON THE TABLE OF GUARANTEED ANNUAL PREMIUMS, SEE PAGE 4. THE PREMIUMS WILL INCREASE ANNUALLY AFTER THE LEVEL PREMIUM PERIOD, WHICH IS SHOWN ABOVE.

<u>Modal Factors:</u>		<u>* Premiums:</u>
{*Payroll Deduction Mode: [26 Pay]}	[0.03846]	[\$10.69]
Annual }	[1.00]	[\$278.00]
Semiannual	[0.50]	[\$139.00]
Quarterly	[0.25]	[\$69.50]
Monthly (EFT)	[0.08333]	[\$23.17]

[mined by multiplying the total annual premium by the factors shown above.

\*THE PREMIUMS LISTED ABOVE INCLUDE A \$48 ANNUAL POLICY FEE.

{\*\*IF PREMIUM CEASES TO BE REMITTED THROUGH A VALID PAYROLL GROUP, YOU MAY CONTINUE YOUR INSURANCE BY REMITTING PREMIUM THROUGH ONE OF OUR OTHER PAYMENT METHODS SHOWN ABOVE. }

**POLICY/RIDER BENEFIT SCHEDULE**

<b>Form Number</b>	<b>Description of Benefit</b>	<b>Insurance Amount</b>	<b>Annual Premium</b>	<b>Years Payable</b>
WNIC-3002	Renewable Term Insurance To Age 98	[\$100,000]	[\$278.00]	[63]

**SERFF Tracking #:**

CNSC-128770966

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

WNIC-3002-PS2

**State:**

Arkansas

**Filing Company:**

Washington National Insurance Company

**TOI/Sub-TOI:**

L04I Individual Life - Term/L04I.500 Other

**Product Name:**

WNIC-3002-PS3

**Project Name/Number:**

Modal Factor Change/

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):	Readability Certification.pdf Certification Rule 19.pdf AR Guaranty Notice.pdf WNIC-CN-AR.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:			
Attachment(s):	WNIC-8001-GI.pdf WNIC-8001-EOI.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Copy of approved policy and original Disposition Report		
Comments:			
Attachment(s):	WNIC-3002-AR.pdf Disposition Report.pdf		

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

## READABILITY CERTIFICATION

**Company Name:** WASHINGTON NATIONAL INSURANCE COMPANY

**NAIC Number:** 233-70319

As an officer of Washington National Insurance Company, I hereby certify that the below captioned forms achieve the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements in your state.

<b>Flesch Score</b>	<b>Form Number</b>	<b>Description</b>
50	WNIC-3002-PS3	Policy Specifications Page



Mathias E. Brown  
Sr. Director and Assistant Secretary, Product Approval and Compliance  
Date 11/19/2012

# WASHINGTON NATIONAL INSURANCE COMPANY

## Arkansas Certification for Compliance

### With Rule and Regulation 19

WNIC-3002-PS3	Policy Specifications Page for Renewable Term Life Insurance To Age 98
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I, Mathias E. Brown, an authorized officer for the company, do hereby certify that the form(s) identified above are in compliance with Arkansas Rule and Regulation 19 in regards to Unfair Sex Discrimination in the Sale of Insurance.



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**Mathias E. Brown**  
**Senior Director and Assistant Secretary**

**11/26/2012**

**DATE**

**LIMITATIONS AND EXCLUSIONS UNDER THE  
ARKANSAS LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

(Please turn to back of page)

## **COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## **EXCLUSIONS FROM COVERAGE**

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insurers who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees.)

## **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**IMPORTANT NOTICE**

Should you have any questions concerning this policy, you may direct your question to:

1. If to the Company,

Washington National Insurance Company  
11815 N. Pennsylvania St.  
Carmel, Indiana 46032-4555  
Telephone: 1-800-940-1843

2. If to your licensed representative:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

3. If to the Arkansas Insurance Department

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201  
Telephone: 1-501-371-2640  
1-800-852-5494



**APPLICATION FOR LIFE INSURANCE**  
**Underwritten by: Washington National Insurance Company**  
 Home Office: [11825 N. Pennsylvania Street, Carmel, IN 46032]  
 Telephone: [1-800-888-4918]

**SECTION 1 – EMPLOYEE**

<b>A. Personal Information</b>					
First Name:		MI:	Last Name: (indicate if hyphenated name)		
Home Address: (Street/Box No.)				City, State, Zip Code:	
Social Security No.:	Home Phone:	Work Phone:	E-Mail Address:		
Place of Birth:	Date of Birth:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Occupation:			Employer's Name:		

**B. Beneficiary Designation**

Primary Beneficiary:		Contingent Beneficiary:	
Relationship:	Date of Birth:	Relationship:	Date of Birth:
Home Address: (Street/Box No.)		Home Address: (Street/Box No.)	
City, State, Zip Code:		City, State, Zip Code:	

**SECTION 2 – SPOUSE (as defined by State law)**  
 Complete ONLY if applying for a term life insurance policy for your Spouse (as defined by state law).

<b>A. Personal Information</b>					
First Name:		MI:	Last Name: (indicate if hyphenated name)		
Home Address: (Street/Box No.)				City State, Zip Code	
Social Security No.:	Home Phone:	Work Phone:	E-Mail Address:		
Place of Birth:	Date of Birth:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Occupation:			Employer's Name:		

<b>SECTION 2 – SPOUSE (as defined by State law) (continued)</b> Complete ONLY if applying for a term life insurance policy for your Spouse (as defined by state law).	
<b>B. Beneficiary Designation</b>	
Primary Beneficiary:	Contingent Beneficiary:
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Home Address: (Street/Box No.)	Home Address: (Street/Box No.)
City, State, Zip Code:	City, State, Zip Code:

**SECTION 3 – PLAN OF INSURANCE, RIDERS and BENEFIT (Riders and Benefits may vary by plan and may not be available in all states).**

	Employee / Proposed Insured	Modal Premium	Spouse (as defined by State law)	Modal Premium
<b>Plan of Insurance:</b>				
Term Life Insurance	<input type="checkbox"/>		<input type="checkbox"/>	
Term Life Insurance with Return of Premium	<input type="checkbox"/>		<input type="checkbox"/>	
<b>Level Premium Period:</b>				
15 Years (Issue Ages 18-65)	<input type="checkbox"/>		<input type="checkbox"/>	
To Age 65 (Issue Ages 18-55)	<input type="checkbox"/>		<input type="checkbox"/>	
<b>Insurance Amount:</b>				
Death Benefit	\$	\$	\$	\$
<b>Riders:</b>				
Critical Illness Rider	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$
Total and Permanent Disability Waiver of Premium Rider	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$
* Accidental Death Benefit Rider	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$
** Child Term Insurance Rider	<input type="checkbox"/> [\$10,000]	\$	<input type="checkbox"/> [\$10,000]	\$
<b>Total Modal Premium:</b>		\$		\$

\* Accidental Death Benefit Amount equal to the initial Death Benefit of the Policy up to \$150,000.

\*\* For the Children's Term Rider -List all unmarried dependent children who are under age 19 and proposed for coverage. (Attach a separate sheet for additional persons not listed.) (Children's Term Rider can only be attached to one policy).

Name (First, Middle Initial, Last Name)	Gender	Relationship	Date of Birth

**SECTION 4 – METHOD OF PAYMENT**

Worksite:

Payroll Group No.:

Current Payroll Deduction Options: [Frequency:  9 pay;  10 pay;  12 pay;  13 pay;  24 pay;  26 pay;  52 pay]

Employee Non-payroll:  Monthly Electronic Funds Transfer

**SECTION 5 – REPLACEMENT & IN FORCE INSURANCE – REGARDING ALL INDIVIDUALS TO BE INSURED**

- Will any existing life insurance or annuity with this or any other company be replaced, changed, or used as a source of premium payment for the insurance applied for? (If "Yes", list below).  Yes  No
- Does any individual applying for life insurance have any in force life insurance policies or annuity contracts? (If "Yes", list below).  Yes  No

Name of Person	Name of Company

Type of Coverage	Insurance Amount	Accidental Death Amount	Year Issued	To Be Replaced
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Person	Name of Company

Type of Coverage	Insurance Amount	Accidental Death Amount	Year Issued	To Be Replaced
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 6– ADDITIONAL INFORMATION**

ANSWER QUESTIONS BELOW ON ALL INDIVIDUALS TO BE INSURED.	Employee	Spouse <i>(as defined by State Law)</i>
1. Have you used tobacco or nicotine in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you actively at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, do you regularly work [20] hours per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you been employed [90] days with your current employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 7 – DECLARATIONS**

I represent that all statements and answers made in all parts of this application are full, complete and true. It is understood and agreed that:

- All such statements and answers shall be the basis for and become a part of any life insurance issued as a result of this application.
- Washington National Insurance Company (hereinafter, the "Company") and its reinsurers will use the information in order to determine whether I am insurable pursuant to the Company's underwriting standards.
- No agent, producer, broker nor examiner has the authority to accept risks, to make or change contracts or to waive any of the Company's rights or requirements.
- As a condition precedent to coverage taking effect on the Policy Effective Date, all persons to be covered under the policy must be alive and not in a hospital, nursing home or other medical facility, which provides skilled medical care on the Policy Effective Date and the full first premium must be paid. Deferred Effective Date of Coverage will apply, if any person to be covered under the policy is in a hospital, nursing home or other medical facility on the Policy Effective Date. The insurance coverage will not become effective until the date the covered person is discharged from the hospital, nursing home or other medical facility and is able to perform his/her normal activities.
- If applicable, I authorize my employer to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which my employer cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my employer in writing to cancel the premium deductions.

**Soliciting Agent Statements:**

Will there be any replacement, as defined by any regulation of the state in which this application is taken? (If "YES", fulfill all state requirements.)

Yes  No

**Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

Signed at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month, Day, Year

**Sign Full Legal Name**

X \_\_\_\_\_  
Signature of Applicant/Owner

X \_\_\_\_\_  
Signature of Witness  
(Licensed Agent must witness where required by law)

X \_\_\_\_\_  
Agent Signature

X \_\_\_\_\_  
Print Agent Name

\_\_\_\_\_  
Agent Number (Company Number)

## LIFE APPLICATION SUPPLEMENT

**Underwritten by: Washington National Insurance Company**

Home Office: [11825 N. Pennsylvania Street, Carmel, IN 46032]

Telephone: [1-800-888-4918]

- Employee – Evidence of Insurability  
 Spouse – Evidence of Insurability

- Reinstatement – Policy # \_\_\_\_\_  
 Child/Children – Evidence of Insurability

**THIS APPLICATION WILL BE USED WITH APPLICATION WNIC-8001-GI**

SECTION 1 – MEDICAL INFORMATION – EVIDENCE OF INSURABILITY					
ANSWER QUESTIONS BELOW ON ALL INDIVIDUALS TO BE INSURED.		Employee / Proposed Insured	Spouse <i>(as defined by State Law)</i>	Child / Children	
1. Provide height and weight for each proposed insured.		Height ____ft. ____in.  Weight ____lbs.	Height ____ft. ____in.  Weight ____lbs.	<i>Enter requested information in Question 12</i>	
2. Has any proposed insured used tobacco or nicotine in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	
3. Is any proposed insured actively at work? a. If yes, does the proposed insured on average work [20] hours per week? b. Has the proposed insured been employed [90] days with their current employer?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	
4. In the past 5 years has any proposed insured, received medical treatment or counseling, or been advised to seek treatment for alcohol or illegal drug use or for Marijuana?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. In the past 5 years, has any proposed insured been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. In the past 5 years has any proposed insured, or does any proposed insured intend to engage in piloting an aircraft, motor vehicle racing, scuba diving, sky diving, hang gliding, parachuting, mountain climbing, horse racing or any other hazardous sports?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Has any proposed insured in the past 6 months prior to application been: a. seen by a physician for anything other than a cold, flu, or routine examination? b. hospitalized? c. disabled due to accident or illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Has any proposed insured missed more than 5 consecutive days of active work due to an illness or injury in the past 6 months prior to application?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	
9. Has any proposed insured ever been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. In the past 5 years, has any proposed insured had: a. chest pain, heart attack, heart disease, high blood pressure, congestive heart failure; palpitations or other disorder of the heart or cardiovascular system? b. stroke, including transient ischemic attack (TIA), diabetes? c. lung disease, chronic obstructive pulmonary disease (COPD); asthma; emphysema? d. liver disease, hepatitis; cirrhosis? e. cancer, tumor, leukemia? f. kidney disease, blood disorder (excluding HIV)? g. memory loss, dementia, mental disorder, nervous system disorder? h. other known health impairments not included on this list?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Has any proposed insured taken any prescription medicine in the past 12 months? If "yes", state name of medication, reason for taking, frequency and dosage.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. For the Children's Term Rider -List all unmarried dependent children who are under age 19 and proposed for coverage. (Attach a separate sheet for additional persons not listed.) <b>(Children's Term Rider can only be attached to one policy).</b>					
Name (First, Middle Initial, Last Name)	Gender	Relationship	Date of Birth	Height	Weight

12. For the Children's Term Rider -List all unmarried dependent children who are under age 19 and proposed for coverage. (Attach a separate sheet for additional persons not listed.) **(Children's Term Rider can only be attached to one policy)**. (continued)

Name (First, Middle Initial, Last Name)	Gender	Relationship	Date of Birth	Height	Weight

**REMARKS –** Provide details to “yes” answers in Section 1 Questions 4-11 in space provided below. (Attach extra sheet of paper, if necessary.)

Question Number:	Name of Person:
------------------	-----------------

*Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

Question Number:	Name of Person:
------------------	-----------------

*Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

Question Number:	Name of Person:
------------------	-----------------

*Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

Question Number:	Name of Person:
------------------	-----------------

*Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

**SECTION 2 – CONDITIONAL AMENDMENTS TO APPLICATION**

If coverage cannot be issued as initially applied for, I hereby authorize Washington National Insurance Company to amend the application under the following circumstances:

- Issue a lesser benefit amount.  Yes     No
- Issue coverage on the remaining individuals applying for coverage if any one person's coverage is declined.  Yes     No
- Increase or decrease the premium amount to cover the benefit actually issued.  Yes     No

**NOTE: NONE OF THE ABOVE CONDITIONAL AMENDMENTS CREATE ANY ADDITIONAL OBLIGATION BY WASHINGTON NATIONAL INSURANCE COMPANY TO ISSUE COVERAGE TO ANY INDIVIDUAL PROPOSED FOR COVERAGE.**

**SECTION 3 – ACKNOWLEDGMENTS**

The Applicant/Owner's has received and acknowledges receipt of the following forms:

- Notice of Information Practices, which includes pre-notification information relating to investigative consumer reports and the Medical Information Bureau, Inc.
- Conditional Receipt (if applicable)
- Notice Regarding Replacement Form (if applicable)

**SECTION 4 – DECLARATIONS**

I represent that all statements and answers made in all parts of this application are full, complete and true. It is understood and agreed that:

1. All such statements and answers shall be the basis for and become a part of any life insurance issued as a result of this application.
2. No agent, producer, broker nor examiner has the authority to accept risks, to make or change contracts or to waive any of Washington National Insurance Company (hereinafter, collectively "Company") rights or requirements.
3. **As a condition precedent to coverage taking effect on the Policy Effective Date, all persons to be covered under the policy must be alive and not in a hospital, nursing home or other medical facility, which provides skilled medical care on the Policy Effective Date and the full first premium must be paid. Deferred Effective Date of Coverage will apply, if any person to be covered under the policy is in a hospital, nursing home or other medical facility on the Policy Effective Date. The insurance coverage will not become effective until the date the covered person is discharged from the hospital, nursing home or other medical facility and is able to perform his/her normal activities.**
4. Acceptance of a policy by the Owner constitutes ratification of any changes made by the Company.
5. If authorizing payroll deduction, I authorize my employer to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which my employer cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my employer in writing to cancel the premium deductions.

**Fraud Warning: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.**

Signed at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month, Day, Year

Sign Full Legal Name

X \_\_\_\_\_  
Signature of Applicant/Owner

X \_\_\_\_\_  
Signature of Witness  
(Licensed Agent Must Witness Where Required by Law)

X \_\_\_\_\_  
Agent Signature

X \_\_\_\_\_  
Print Agent Name

\_\_\_\_\_  
Agent Number (Company Number)

**SECTION 5**

**AUTHORIZATION TO OBTAIN AND USE INFORMATION – PROPOSED INSURED**

**Compliant with HIPAA Privacy Standards**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

1. I authorize Washington National Insurance Company or its representatives (Company) to obtain the following information:
  - a. **Health Information.** Any information related to my: (i) past, present or future health condition(s), (ii) medical care or treatment, including information pertaining to mental health, communicable disease(s), HIV/AIDS and substance abuse, but excluding Psychotherapy Notes. (Psychotherapy Notes means notes recorded by a mental health professional documenting or analyzing the contents of a counseling session that are maintained separate from the individual's medical record. Psychotherapy Notes do not include information relating to prescriptions, diagnosis or functional status.)
  - b. **Non-Health Information.** Any information related to my: (i) finances, (ii) credit reports, (iii) consumer reports, (iv) driving record or motor vehicle reports, (v) criminal record, (vi) occupation and (vii) avocations, including aviation activity.
2. I authorize the following persons or entities to release Health and Non-Health Information to the Company: (i) physicians and other health care practitioners, (ii) hospitals, clinics and all other medically-related facilities, (iii) clinical laboratories, (iv) pharmacies and pharmacy-related organizations, (v) insurance companies and health plans, (vi) past and present employers, (vii) government agencies including the Veteran's Administration and Social Security Administration, and (viii) MIB, Inc. (formerly known as Medical Information Bureau) and commercial consumer reporting agencies (CRA).
3. I understand that the Company will use Health and Non-Health Information to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of this application or in connection with a claim(s) for insurance benefits.
4. I understand that: (i) if I refuse to sign this Authorization the insurance for which I am applying will not be issued, (ii) I have the right to revoke this Authorization (except to the extent it has already been relied upon) by writing to the Company (Attention New Business, 11825 N. Pennsylvania Street, Carmel IN 46032), (iii) refusing to sign or revoking this Authorization will not effect my ability to obtain medical treatment or my eligibility for health insurance benefits, (iv) authorizing a disclosure of Health Information to persons/entities not regulated by federal privacy laws may result in the information no longer being protected, and (v) a copy of this Authorization is as valid as the original.
5. I have been offered a copy of this Authorization.
6. This Authorization is valid for twenty-four (24) months.

**Sign Full Legal Name**

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**SECTION 6**

**AUTHORIZATION TO OBTAIN AND USE INFORMATION – SPOUSE (as defined by state law)  
Compliant with HIPAA Privacy Standards**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

1. I authorize Washington National Insurance Company or its representatives (Company) to obtain the following information:
  - a. **Health Information.** Any information related to my: (i) past, present or future health condition(s), (ii) medical care or treatment, including information pertaining to mental health, communicable disease(s), HIV/AIDS and substance abuse, but excluding Psychotherapy Notes. (Psychotherapy Notes means notes recorded by a mental health professional documenting or analyzing the contents of a counseling session that are maintained separate from the individual's medical record. Psychotherapy Notes do not include information relating to prescriptions, diagnosis or functional status.)
  - b. **Non-Health Information.** Any information related to my: (i) finances, (ii) credit reports, (iii) consumer reports, (iv) driving record or motor vehicle reports, (v) criminal record, (vi) occupation and (vii) avocations, including aviation activity.
2. I authorize the following persons or entities to release Health and Non-Health Information to the Company: (i) physicians and other health care practitioners, (ii) hospitals, clinics and all other medically-related facilities, (iii) clinical laboratories, (iv) pharmacies and pharmacy-related organizations, (v) insurance companies and health plans, (vi) past and present employers, (vii) government agencies including the Veteran's Administration and Social Security Administration, and (viii) MIB, Inc. (formerly known as Medical Information Bureau) and commercial consumer reporting agencies (CRA).
3. I understand that the Company will use Health and Non-Health Information to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of this application or in connection with a claim(s) for insurance benefits.
4. I understand that: (i) if I refuse to sign this Authorization the insurance for which I am applying will not be issued, (ii) I have the right to revoke this Authorization (except to the extent it has already been relied upon) by writing to the Company (Attention New Business, 11825 N. Pennsylvania Street, Carmel IN 46032), (iii) refusing to sign or revoking this Authorization will not effect my ability to obtain medical treatment or my eligibility for health insurance benefits, (iv) authorizing a disclosure of Health Information to persons/entities not regulated by federal privacy laws may result in the information no longer being protected, and (v) a copy of this Authorization is as valid as the original.
5. I have been offered a copy of this Authorization.
6. This Authorization is valid for twenty-four (24) months.

**Sign Full Legal Name**

X \_\_\_\_\_  
Signature

\_\_\_\_\_   
Print Name

\_\_\_\_\_  
Date

**WASHINGTON NATIONAL INSURANCE COMPANY**  
Home Office: [11825 N. Pennsylvania St., Carmel, Indiana 46032-4555]  
Telephone: [1-800-888-4918]

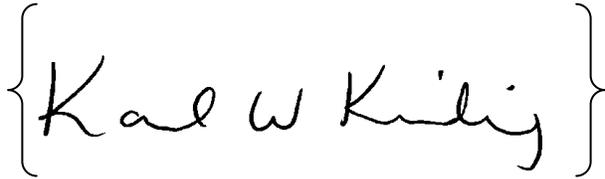
**READ YOUR POLICY CAREFULLY**

This policy is a legal contract between the Owner and Washington National Insurance Company ("The Company"). The Company agrees to pay the Proceeds of this policy to the Beneficiary upon surrender of this policy and receipt of due proof of death of the Insured, while this policy is in force, and to provide the other benefits, rights and privileges in accordance with the terms of this policy.

**NOTICE OF 20 DAY RIGHT TO EXAMINE THE POLICY**

Please carefully review this policy and the attached application. If You are dissatisfied for any reason, this policy can be cancelled by You by delivering or mailing the policy to Our Home Office or to the insurance agent through whom it was effected before midnight of the twentieth day after receipt of such policy by the applicant. Upon such delivery or mailing, the policy shall be void from the beginning. Return of the policy by mail is effective if postmarked, properly addressed and postage is prepaid. Any premiums paid, including any policy fee or other charges, will be refunded within twenty days after We receive this policy.

Signed for Washington National Insurance Company by



Secretary



President

**RENEWABLE TERM LIFE INSURANCE TO AGE 98  
CONVERSION OPTION  
PREMIUMS PAYABLE DURING LIFETIME OF THE INSURED  
PREMIUMS WILL INCREASE ANNUALLY AFTER THE LEVEL PREMIUM PERIOD  
PROCEEDS PAYABLE AT DEATH PRIOR TO EXPIRY DATE  
NONPARTICIPATING**

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**POLICY SPECIFICATIONS**

POLICY NUMBER: [0000000]	INSURED: [JOHN DOE]
POLICY EFFECTIVE DATE: [OCTOBER 15, 2010]	AGE: [35]
EXPIRY DATE: [OCTOBER 15, 2073]	RATING
INITIAL ANNUAL PREMIUM: \$[244.00]	CLASS: [STANDARD NON-TOBACCO]
PREMIUM MODE: [ANNUAL]	LEVEL PREMIUM
	PERIOD: [15 YEARS]
	DEATH BENEFIT: \$[100,000]

THE PREMIUMS ARE GUARANTEED AND ARE SHOWN ON THE TABLE OF GUARANTEED ANNUAL PREMIUMS, SEE PAGE 4. THE PREMIUMS WILL INCREASE ANNUALLY AFTER THE LEVEL PREMIUM PERIOD, WHICH IS SHOWN ABOVE.

<u>Modal Factors:</u>		<u>* Premiums:</u>	
{**Payroll Deduction Mode: [26 Pay]}	[0.04002]	{ \$9.76 }	
Annual	1.00	{ \$244.00 }	
Semiannual	0.51	{ \$124.44 }	
Quarterly	0.26	{ \$63.44 }	
Monthly (EFT)	0.0867	{ \$21.15 }	

Premiums paid other than annually are determined by multiplying the total annual premium by the factors shown above.

\*THE PREMIUMS LISTED ABOVE INCLUDE A \$48 ANNUAL POLICY FEE.

{ \*\*IF PREMIUM CEASES TO BE REMITTED THROUGH A VALID PAYROLL GROUP, YOU MAY CONTINUE YOUR INSURANCE BY REMITTING PREMIUM THROUGH ONE OF OUR OTHER PAYMENT METHODS SHOWN ABOVE. }

**POLICY/RIDER BENEFIT SCHEDULE**

<b>Form Number</b>	<b>Description of Benefit</b>	<b>Insurance Amount</b>	<b>Annual Premium</b>	<b>Years Payable</b>
WNIC-3002	Renewable Term Insurance To Age 98	{ \$100,000 }	{ \$244.00 }	{ 63 }

**POLICY SPECIFICATIONS (Cont'd)**

**TABLE OF GUARANTEED ANNUAL PREMIUMS**

LEVEL PREMIUM PERIOD: [15 YEARS]

**PREMIUMS ARE BASED ON YOUR ATTAINED AGE. PREMIUMS ARE LEVEL DURING THE LEVEL PREMIUM PERIOD. AFTER THE LEVEL PREMIUM PERIOD, THE PREMIUM WILL INCREASE ANNUALLY.**

AGE	POLICY YEAR	PREMIUM	AGE	POLICY YEAR	PREMIUM
35	1	\$244.00	67	33	4,980.00
36	2	244.00	68	34	5,415.00
37	3	244.00	69	35	5,898.00
38	4	244.00	70	36	6,447.00
39	5	244.00	71	37	7,101.00
40	6	244.00	72	38	7,845.00
41	7	244.00	73	39	8,637.00
42	8	244.00	74	40	9,492.00
43	9	244.00	75	41	10,428.00
44	10	244.00	76	42	11,466.00
45	11	244.00	77	43	12,645.00
46	12	244.00	78	44	13,974.00
47	13	244.00	79	45	15,444.00
48	14	244.00	80	46	17,139.00
49	15	244.00	81	47	19,077.00
50	16	1,008.00	82	48	21,111.00
51	17	1,107.00	83	49	23,277.00
52	18	1,218.00	84	50	25,671.00
53	19	1,347.00	85	51	28,188.00
54	20	1,494.00	86	52	31,020.00
55	21	1,659.00	87	53	34,272.00
56	22	1,836.00	88	54	37,680.00
57	23	2,013.00	89	55	41,103.00
58	24	2,193.00	90	56	43,896.00
59	25	2,391.00	91	57	46,482.00
60	26	2,616.00	92	58	50,037.00
61	27	2,880.00	93	59	54,558.00
62	28	3,180.00	94	60	60,066.00
63	29	3,501.00	95	61	66,045.00
64	30	3,840.00	96	62	72,006.00
65	31	4,200.00	97	63	76,263.00
66	32	4,578.00			

**PREMIUMS LISTED ABOVE INCLUDE A \$48 ANNUAL POLICY FEE.**

**DEFINITIONS**  
**(Defined terms are capitalized throughout this policy)**

**AGE AND ATTAINED AGE.** Age means the Insured's Age last birthday on the Policy Effective Date. Attained Age means the Age on the Policy Effective Date plus the number of Policy Years elapsed since the Policy Effective Date.

**BENEFICIARY.** The person or persons shown on the application, or later changed by You, to whom We will pay the Proceeds.

**CLAIM FORMS.** The forms and authorizations, including but not limited to HIPAA authorization and affidavit of relationship, that We provide to the Beneficiary for the submission of a claim for the Death Benefit.

**DEATH BENEFIT.** The amount of insurance shown on the Policy Specifications Page or any supplemental Policy Specifications Page.

**DEFERRED EFFECTIVE DATE OF COVERAGE.** A Deferred Effective Date of Coverage may apply if any person covered under the policy is in a hospital, nursing home or other medical facility, which provides skilled medical care, on the Policy Effective Date. The insurance coverage will not become effective until the date the covered person is discharged from the hospital, nursing home, or other medical facility and is able to perform his/her normal activities. We will refund any premium accepted before the Policy Effective Date.

**EXPIRY DATE.** The Expiration Date is shown on the Policy Specifications Page. The Expiry Date will be the Policy Anniversary date coinciding with or next following the Insured's 98<sup>th</sup> birthday.

**HOME OFFICE.** Washington National Insurance Company 11825 N. Pennsylvania Street, Carmel, IN 46032-4555.

**INSURED.** The Insured is the person whose life is insured under this policy. The Insured is named on the Policy Specifications Page.

**LEVEL PREMIUM PERIOD.** The number of years or the Attained Age to which premiums are level. See Policy Specifications Page 4 for the table of guaranteed annual premiums.

**NONPARTICIPATING.** This is a nonparticipating policy. This policy will not share in the Company's profits or surplus earnings. We will not pay dividends on this policy.

**NOTICE, NOTIFY, NOTIFYING.** Written requests and information We receive at Our Home Office, which You sign, and We accept.

**OWNER(S).** The Owner(s) named in the application, unless changed.

**POLICY ANNIVERSARY.** The same date each year as of the Policy Effective Date.

**POLICY EFFECTIVE DATE.** This is the effective date of Your policy. This date will be used to determine Policy Years and Policy Anniversaries.

**POLICY MONTH.** A period beginning each month on the day of your Policy Effective Date and ending the next month on the day preceding the day of the Policy Effective Date.

**POLICY SPECIFICATIONS PAGE.** The Policy Specifications Page or any supplemental Policy Specifications Page that We have most recently sent You.

**DEFINITIONS (cont'd)**  
**(Defined terms are capitalized throughout this policy)**

**POLICY YEAR.** One year from the Policy Effective Date and from each Policy Anniversary.

**PREMIUM MODE.** The frequency You have chosen to pay premiums on this policy.

**PROCEEDS.** The Proceeds are the Death Benefit then in force, plus any death benefit insurance amount on the Insured provided by benefit rider; plus that portion of any premium paid which applies to a period beyond the Policy Month in which the Insured dies; less any unpaid premium if death occurs during the grace period.

**WE, OUR, US, COMPANY.** "We", "Us" or "Our" means Washington National Insurance Company (the Company).

**YOU, YOUR .** "You" or "Your" means the Owner(s) of this policy.

**OWNER, BENEFICIARY & ASSIGNMENT PROVISIONS**

**OWNERSHIP.** This contract belongs to You. During the lifetime of the Insured, You have all rights, subject to the right of:

- (1) any assignee of record with Us;
- (2) any irrevocable Beneficiary; and
- (3) any restricted ownership.

You may make changes, including change of Owner, by Notifying Us, during the lifetime of the Insured. You must do this in writing on a form acceptable by Us. Any changes will take effect on the date We receive Notice and the change is recorded by Us. Any change is subject to any action We take before receiving Notice. A change of Owner does not change the Beneficiary. The rights of the Owner end on the death of the Insured.

**BENEFICIARY.** If the Insured dies while this policy is in force, the Beneficiary will receive the Proceeds provided by the policy and any rider. The Beneficiary is the person(s) or entity You name in the application(s), unless changed by later designation.

You may make the Beneficiary irrevocable. If there is an irrevocable Beneficiary, You must obtain the written consent of that Beneficiary to any policy transactions, except for payment of premiums.

Unless otherwise provided, if more than one person is named as Beneficiary, the Proceeds will be paid in equal shares to the surviving Beneficiaries as follows: (1) to the primary Beneficiaries surviving at the time of the Insured's death, otherwise; (2) to the contingent Beneficiaries surviving at the time of the Insured's death, otherwise; (3) to the Owner, or the Owner's estate.

If the Beneficiary is "children," this means children born to or legally adopted by the Insured. Payments to minors will only be made to a court-appointed guardian of the assets of the minor or to the minor at age majority.

**OWNER AND BENEFICIARY CHANGE.** You may change the Owner and the Beneficiary at any time during the lifetime of the Insured unless otherwise provided in a previous designation. Any change must be in written form satisfactory to Us. Any change will take effect on the date We receive Notice at Our Home Office and the change is recorded by Us. The change will not apply to any payments made or actions taken by Us before We receive and record the Notice.

## **OWNER, BENEFICIARY & ASSIGNMENT PROVISIONS (cont'd)**

**SIMULTANEOUS DEATH.** If any Beneficiary dies within 15 days after the death of the Insured, the Proceeds will be paid as if the Beneficiary died before such Insured. However, this provision will not apply to any payment We make before receiving and recording Notice of the Beneficiary's death.

**ASSIGNMENT.** You can assign this policy. No assignment will be binding on Us unless it is in writing and received by Us at Our Home Office. We will not be responsible for the validity of any assignment. We will not be liable for any payments We make or action We take before We receive and record notice of an assignment. Payments to an assignee will be made only in a lump sum. Any debt owed to Us, will be deducted prior to payment made to the assignee. The rights of the Beneficiary and Owner are subject to the rights of any assignee.

## **PREMIUM PAYMENT PROVISIONS**

**PAYMENT OF PREMIUM.** Premiums must be paid in a form acceptable to the Company. The first premium is due on the Policy Effective Date. After the first premium, all premiums are to be paid to Us at Our Home Office. Receipts will be given upon request.

**Exception:** During the time, if any, that it is agreed between You and Us that premiums will be billed and remitted through payroll deduction or credit union share account deduction, premium is due in Our Home Office on the due date indicated in the billing provided to the administrator coordinating premium payments on Your behalf.

If after at least one premium payment, premiums cease to be remitted through a valid payroll group, You may continue Your insurance by remitting premium through one of Our other payment methods that is shown on the Policy Specifications Page.

**GUARANTEED PREMIUMS.** The premiums are guaranteed and are shown on the table of guaranteed annual premiums. The premium will increase annually after the Level Premium Period.

**POLICY FEE.** This policy has an annual policy fee. The amount of this policy fee is shown on the Policy Specifications Page and included in Your premium payment.

**GRACE PERIOD.** A grace period of 31 days will be allowed for payment of each premium after the first. This policy will continue in force during the grace period. If the premium remains unpaid at the end of the grace period, this policy will lapse. It then provides no further value or benefits unless kept in force under the options on premium default provision, see page 9. If the insured dies during the grace period, the unpaid premium through the Policy Month of death will be deducted in the Proceeds.

**REINSTATEMENT.** If the premium is not paid by the end of the grace period, We will allow the policy to be put back in force, subject to the following:

- (1) Your request in writing;
- (2) evidence of insurability satisfactory to Us;
- (3) payment to Us of all overdue premiums with 6% interest compounded annually to the date this policy is reinstated;
- (4) reinstatement of the policy within 5 years of the due date of the first unpaid premium; and

The date of reinstatement will be the first day of the Policy Month on or next following the date We approve Your application for reinstatement.

## DEATH OF INSURED PROVISIONS

**DEATH BENEFIT.** We will pay the Death Benefit of this policy to the Beneficiary after We receive a completed Claim Form and due proof that the Insured died while this policy was in force. Failure of the Beneficiary to cooperate in the claims process may delay payment of the Death Benefit.

This policy is intended to comply with the cash value accumulation test under Section 7702 of the Internal Revenue Code of 1986, as amended.

**AMOUNT AND PAYMENT OF PROCEEDS.** If the Insured dies while this policy is in force, We will pay the Proceeds to the Beneficiary. The Proceeds are the sum of:

- (1) the Death Benefit then in force; plus
- (2) any death benefit insurance amount on the Insured provided by benefit riders; plus
- (3) that portion of any premium paid which applies to a period beyond the Policy Month in which the Insured dies; less
- (4) any unpaid premium if death occurs during the grace period.

Proceeds will be paid in one sum to the Beneficiary unless a payment option is elected as provided by this policy. We will pay the Proceeds to the Beneficiary upon receipt of proof that the Insured died while this policy was in force. If Proceeds are not paid within thirty (30) days after We receive due proof of death and proper written claim, We will pay interest on the Proceeds at the rate of eight percent (8%) per year from the date of death until the date the claim is paid.

## CONVERSION PROVISION

**CONVERSION.** Until the earlier of the Insured's Attained Age 70 or the end of the Level Premium Period, You may convert this policy to a new policy without evidence of insurability. The new policy may be any plan of insurance, except term, then in effect and approved by Us as available for conversion. There will always be at least one policy available for conversion.

At time of conversion, the premium rate for the new policy must be greater than the premium rate for this policy. The Death Benefit on the new policy may not be more than the Death Benefit provided by this policy. The new policy will be in an equivalent rating class as this policy. The conversion date will be the Policy Effective Date of the new policy.

A conversion policy will be issued in exchange for this policy. We must receive this policy and Your Notice of conversion at Our Home Office signed by You, any assignee and any irrevocable Beneficiary of record. The first premium for the conversion policy must be paid.

If the original application is made a part of the new policy, evidence included in such original application will not be contestable after two years from the original Policy Effective Date. The period for death by suicide under the new policy will begin as of the Policy Effective Date of the original policy.

## RENEWAL PROVISION

**RENEWAL.** If You do not convert and continue to pay required premiums Your policy will continue to the Policy Anniversary coinciding with or next following the Insured's 98<sup>th</sup> birthday.

## GENERAL PROVISIONS

**ENTIRE CONTRACT.** The entire contract consists of this policy, any riders or endorsements, the attached copy of the initial application and all supplemental applications to change this policy. All statements in the application and any supplemental applications will be deemed representations and not warranties. No statement will be used to contest this policy, or to contest a claim under it, unless it appears on the application or a supplemental application. Any application for modifications in the policy, which are to be based upon additional evidence of insurability, shall be attached to the policy in order to become part of the contract between the parties.

**MODIFICATION OF POLICY.** Only the President, a Vice President, the Secretary, or an Assistant Secretary of the Company has power on behalf of the Company to change, modify, or waive the provisions of this policy and then only in writing. No agent, broker, or person other than the above named officers has the authority to change or modify this policy or waive any of its provisions.

**INCONTESTABILITY.** Except in the case of fraud, We will not contest this policy after it has been in force during the lifetime of the Insured for two years from the Policy Effective Date or the effective date of reinstatement. If the policy has been reinstated, and was in force two years from the Policy Effective Date prior to reinstatement, only statements made in the application for reinstatement may be contested. The reinstatement application will be subject to underwriting.

**CHOICE OF LAW.** The insurance policy and claims arising under it are governed by the laws of the state where this policy's application has been signed by the Owner, exclusive of such state's choice of laws provisions.

**MISSTATEMENT OF AGE.** If the Insured's Age is misstated in the application, the Death Benefit will be adjusted. The adjusted amount will be the Death Benefit the premium paid would have provided based on the Insured's correct Age. The Age shown on the Policy Specifications Page is the Insured's Age as of the Policy Effective Date.

**SUICIDE.** If the Insured commits suicide, while sane or insane, within two years from the Policy Effective Date, We will not pay a Death Benefit. We will terminate this policy and refund the premiums paid.

**TERMINATION.** This policy and its attached riders, if any, will terminate:

- (1) upon the death of the Insured; or
- (2) the Policy Anniversary date coinciding with or next following the Insured's 98<sup>th</sup> birthday; or
- (3) at the expiration of the grace period; or
- (4) on the premium due date following receipt of a written request from You.

## SETTLEMENT OPTIONS/PAYOUT PROVISIONS

**ELECTION OF OPTIONS.** Any amount payable at the death of the Insured will be paid in one sum unless otherwise provided. All or part of this sum may be applied to any settlement option.

Payment under a combination of options, or payment to joint or successive payees, or payment to a Beneficiary that is not a natural person may be elected only with Our consent. We have the right to change the frequency of payment in order to make a payment of at least \$25.

Any election must be made in writing to Us.

**ELECTION BY OWNER.** During the lifetime of the Insured, the Owner may elect to have the Proceeds paid under one of the payment options in this policy.

**ELECTION BY BENEFICIARY.** If no settlement option is in effect when the Insured dies, a Beneficiary may elect payment according to the provisions of this section by filing a request after the death of the Insured and before any settlement is made. The beneficiary's election is subject to any existing assignment of this policy, and will take effect when We record it. Once recorded, the effective date is the date the request was signed. The election is subject to any Proceeds paid or other action taken by Us before the election was recorded.

**SUPPLEMENTARY CONTRACT.** When We receive a request for a settlement option, We will issue a supplementary contract in exchange for the policy stating the terms under which We will make payments. The supplementary contract will state to whom We will pay any remaining Proceeds if the Beneficiary dies.

If the Beneficiary dies before payments under the supplementary contract are complete, We will pay any remaining balance at least as rapidly as under the method of payment in effect on the date of death.

**INTEREST ON SETTLEMENT OPTIONS.** We will pay the greater of:

- (1) the current rate of interest on settlement options We declare; or
- (2) the minimum rate required.

**EXCESS INTEREST.** Excess interest is the difference between the current rate We declare, and the minimum rate required. We will determine excess interest, if any, on settlement option amounts. We will pay this excess under Options 1, 2, and 4, and will add it to the period of payment under Option 3.

**OPTION 1. EQUAL PAYMENTS FOR A GUARANTEED PERIOD** – Equal monthly payments for the number of years elected, not to exceed 25 years. Payment will begin on the option date.

**Guaranteed Minimum Payment for each \$1,000 of net proceeds**

**Guaranteed interest rate: 1.00%**

<b>ANNUAL YEARS</b>	<b>ANNUAL</b>	<b>SEMI-ANNUAL</b>	<b>QUARTERLY</b>	<b>MONTHLY</b>
1	\$1,000.00	\$501.24	\$250.93	\$83.71
2	502.49	251.87	126.09	42.07
3	336.66	168.75	84.48	28.18
4	253.74	127.19	63.67	21.24
5	204.00	102.25	51.19	17.08
6	170.84	85.63	42.87	14.30
7	147.16	73.76	36.93	12.32
8	129.40	64.86	32.47	10.83
9	115.58	57.94	29.00	9.68
10	104.54	52.40	26.23	8.75
11	95.50	47.87	23.96	7.99
12	87.97	44.09	22.07	7.36
13	81.60	40.90	20.48	6.83
14	76.14	38.16	19.11	6.37
15	71.41	35.79	17.92	5.98
16	67.27	33.72	16.88	5.63
17	63.62	31.89	15.96	5.33
18	60.38	30.26	15.15	5.05
19	57.48	28.81	14.42	4.81
20	54.87	27.50	13.77	4.59
21	52.51	26.32	13.18	4.40
22	50.36	25.24	12.64	4.22
23	48.40	24.26	12.15	4.05
24	46.61	23.36	11.70	3.90
25	44.96	22.53	11.28	3.76

**OPTION 2. EQUAL PAYMENTS FOR LIFE** – Equal monthly payments for a guaranteed period of 10, 15, or 20 years as elected and for life thereafter as shown in the table below. Amount of each monthly installment per \$1,000 net proceeds. Amounts based on 2000 IAM Table age last birthday and an annual interest rate of 1.00%.

**OPTION 2/MALE**

Monthly Income for Life with Guaranteed Period of:				Monthly Income for Life with Guaranteed Period of:			
Age of Payee	10 Years	15 Years	20 Years	Age of Payee	10 Years	15 Years	20 Years
18	\$1.78	\$1.78	\$1.78	52	\$3.11	\$3.08	\$3.02
19	1.80	1.80	1.80	53	3.19	3.15	3.08
20	1.82	1.82	1.82	54	3.27	3.22	3.15
21	1.84	1.84	1.84	55	3.35	3.30	3.21
22	1.87	1.86	1.86	56	3.44	3.38	3.28
23	1.89	1.89	1.88	57	3.53	3.46	3.35
24	1.91	1.91	1.91	58	3.62	3.55	3.42
25	1.94	1.93	1.93	59	3.73	3.63	3.49
26	1.96	1.96	1.96	60	3.83	3.73	3.56
27	1.99	1.98	1.98	61	3.94	3.82	3.63
28	2.01	2.01	2.01	62	4.06	3.92	3.70
29	2.04	2.04	2.04	63	4.19	4.02	3.77
30	2.07	2.07	2.06	64	4.31	4.12	3.84
31	2.10	2.10	2.09	65	4.45	4.23	3.91
32	2.13	2.13	2.12	66	4.59	4.34	3.98
33	2.16	2.16	2.15	67	4.74	4.45	4.05
34	2.20	2.19	2.19	68	4.89	4.55	4.11
35	2.23	2.23	2.22	69	5.05	4.66	4.17
36	2.27	2.26	2.26	70	5.22	4.77	4.22
37	2.31	2.30	2.29	71	5.39	4.88	4.27
38	2.35	2.34	2.33	72	5.56	4.98	4.32
39	2.39	2.38	2.37	73	5.74	5.08	4.36
40	2.43	2.42	2.41	74	5.92	5.18	4.40
41	2.48	2.47	2.45	75	6.10	5.27	4.43
42	2.52	2.51	2.49	76	6.29	5.36	4.46
43	2.57	2.56	2.54	77	6.47	5.44	4.49
44	2.62	2.61	2.59	78	6.66	5.51	4.51
45	2.67	2.66	2.63	79	6.84	5.58	4.53
46	2.73	2.71	2.68	80	7.01	5.64	4.55
47	2.79	2.77	2.74	81	7.19	5.70	4.56
48	2.85	2.82	2.79	82	7.35	5.75	4.57
49	2.91	2.88	2.84	83	7.51	5.79	4.58
50	2.97	2.95	2.90	84	7.66	5.83	4.58
51	3.04	3.01	2.96	85	7.80	5.86	4.59

**OPTION 2/FEMALE**

Monthly Income for Life with Guaranteed Period of:				Monthly Income for Life with Guaranteed Period of:			
Age of Payee	10 Years	15 Years	20 Years	Age of Payee	10 Years	15 Years	20 Years
18	\$1.71	\$1.70	\$1.70	52	\$2.87	\$2.85	\$2.82
19	1.72	1.72	1.72	53	2.93	2.91	2.88
20	1.74	1.74	1.74	54	3.00	2.98	2.94
21	1.76	1.76	1.76	55	3.07	3.05	3.00
22	1.78	1.78	1.78	56	3.15	3.12	3.07
23	1.80	1.80	1.80	57	3.23	3.19	3.13
24	1.82	1.82	1.82	58	3.31	3.27	3.20
25	1.84	1.84	1.84	59	3.40	3.36	3.27
26	1.86	1.86	1.86	60	3.50	3.44	3.35
27	1.89	1.89	1.88	61	3.60	3.53	3.42
28	1.91	1.91	1.91	62	3.70	3.62	3.50
29	1.94	1.93	1.93	63	3.81	3.72	3.58
30	1.96	1.96	1.96	64	3.93	3.82	3.65
31	1.99	1.99	1.98	65	4.05	3.93	3.73
32	2.01	2.01	2.01	66	4.18	4.04	3.81
33	2.04	2.04	2.04	67	4.31	4.15	3.89
34	2.07	2.07	2.07	68	4.46	4.26	3.96
35	2.10	2.10	2.10	69	4.61	4.38	4.03
36	2.13	2.13	2.13	70	4.77	4.50	4.10
37	2.17	2.16	2.16	71	4.94	4.62	4.17
38	2.20	2.20	2.19	72	5.11	4.74	4.23
39	2.24	2.23	2.23	73	5.30	4.86	4.28
40	2.27	2.27	2.26	74	5.49	4.98	4.34
41	2.31	2.31	2.30	75	5.69	5.09	4.38
42	2.35	2.35	2.34	76	5.89	5.20	4.42
43	2.39	2.39	2.38	77	6.10	5.30	4.45
44	2.44	2.43	2.42	78	6.30	5.39	4.48
45	2.48	2.48	2.46	79	6.51	5.48	4.51
46	2.53	2.52	2.51	80	6.72	5.56	4.53
47	2.58	2.57	2.56	81	6.93	5.63	4.54
48	2.63	2.62	2.60	82	7.12	5.69	4.56
49	2.69	2.68	2.66	83	7.31	5.75	4.57
50	2.74	2.73	2.71	84	7.49	5.79	4.58
51	2.80	2.79	2.76	85	7.66	5.83	4.58

**OPTION 3. Income of Specified Amount**

We will pay an income of a specified amount until the principal and interest are exhausted.

**OPTION 4. Interest Payments**

We will hold the Proceeds as principal and pay interest at the current rate We declare annually. By Notifying Us, the Beneficiary may withdraw the Proceeds at any time, in amounts of at least \$1,000.

**WASHINGTON NATIONAL INSURANCE COMPANY**  
Home Office: [11825 N. Pennsylvania St., Carmel, Indiana 46032-4555]  
[Telephone: 1-800-888-4918]

**RENEWABLE TERM LIFE INSURANCE TO AGE 98  
CONVERSION OPTION  
PREMIUMS PAYABLE DURING LIFETIME OF THE INSURED  
PREMIUMS WILL INCREASE ANNUALLY AFTER THE LEVEL PREMIUM PERIOD  
PROCEEDS PAYABLE AT DEATH PRIOR TO EXPIRY DATE  
NONPARTICIPATING**

## Disposition for CNSC-126997100

<b>SERFF Tracking Number:</b>	CNSC-126997100	<b>State:</b>	Arkansas
<b>Filing Company:</b>	Washington National Insurance Company	<b>State Tracking Number:</b>	48016
<b>Company Tracking Number:</b>	WNIC-3002		
<b>TOI:</b>	L04I Individual Life - Term	<b>Sub-TOI:</b>	L04I.500 Other
<b>Product Name:</b>	WNIC-3002 & WNIC-3003R		
<b>Project Name:</b>			

**Disposition Date:**

02/24/2011

**Implementation Date:****Status:** \*

Approved-Closed

**Comments:**

## Schedule Items

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statements of Variability		Yes
Form	WNIC-3002-AR, Policy/Contract/Fraternal Certificate, Renewable Term Life Insurance to Age 98		Yes
Form	WNIC-3003R-AR, Policy/Contract/Fraternal Certificate, Renewable Term Life Insurance To Age 98 with Return of Premium Available		Yes
Form	WNIC-8001-GI, Application/Enrollment Form, Application for Life		Yes
Form	WNIC-8001-EOI, Application/Enrollment Form, Life Application Supplement		Yes

**WASHINGTON NATIONAL INSURANCE COMPANY**

DATE: 11/26/2012

**STATEMENT OF VARIABILITY  
FOR  
REVISED PAGE 3 OF POLICY WNIC-3002-AR**

Policy form WNIC-3002-AR is Renewable Term Life Insurance To Age 98 with partial return of premium to be issued by Washington National Insurance Company. The language that is bracketed in the policy specifications page 3 is intended to be illustrative and variable, and may be modified by Washington National Insurance Company as described below.

Bracketed Item	Description
<i>Page 3</i>	
Policy Number	Policy Number for that particular issue
Policy Effective Date	Policy Effective Date for that particular issue
Expiry Date	Expiry Date for that particular issue.  The Expiry Date will be the Policy Anniversary date coinciding with or next following the Insured's 98 <sup>th</sup> birthday.
Initial Annual Premium	Initial Annual Premium for that particular issue
Premium Mode	Premium Mode for that particular issue.  Premium Mode is elected at time of application. <ul style="list-style-type: none"> <li>• Current Direct Bill premium modes are: Annual, Semi-Annual, Quarterly; Monthly (Electronic Funds Transfer only).</li> <li>• Current Payroll premium modes are: 9-pay, 10-pay, 12-pay, 13-pay, 24-pay; 26-pay and 52-pay</li> </ul>
Issue Date	Issue Date for that particular issue
Insured	Name of Insured for that particular issue
Age	Age of that particular Insured Issue Ages: <ul style="list-style-type: none"> <li>• Ages 18 - 65 / 15 yr. level premium period</li> <li>• Ages 18 – 55 / To-Age-65 level premium period</li> </ul>
Rating Class	Rating class for that particular issue.  There are two risk classification: non-tobacco and tobacco
Level Premium Period	Level Premium Period for that particular issue.  At time of application, the applicant elects either a 15 Year Level Premium Period or To-Age-65 Level Premium Period.
Death Benefit	Death Benefit for that particular issue  Minimum Face Amount: \$5,000 Maximum Face Amount: \$250,000
Payroll Deduction Mode:	Payroll Deduction Mode for that particular issue  We will only show the payroll deduction mode that is chosen for the policy, The payroll deduction mode will only appear if the policy premium is paid by payroll deduction. Current Payroll Deduction Modes: 9-pay, 10-pay, 12-pay, 13-pay, 24-pay, 26-pay, and 52-pay.

Bracketed Item	Description
<i>Page 3 (cont'd)</i>	
Payroll Deduction Modal Factor:	This information is bracketed, as it will be specific to the policy issued. We will only show the payroll deduction mode factor if the policy premium is paid by payroll deduction. Current Model Factors for Payroll Deduction is: 9-pay – 0.11111 10-pay – 0.10 12-pay – 0.08333 13-pay – 0.07692 24-pay – 0.04167 26-pay – 0.3846 52-pay – 0.01923
Premium / Payroll Deduction	Premium shown for the payroll deduction mode. This premium will only be shown if the policy premium is paid by payroll deduction.
Modal Factors	Annual – 1.00; Semiannual – 0.50; quarterly – 0.25; monthly (EFT) – 0.08333
Annual Premium	Premium shown for the Annual Premium mode
Semiannual Premium	Premium shown for the Semiannual Premium Mode
Quarterly Premium	Premium shown for the Quarterly Premium Mode
Monthly (EFT) Premium	Premium shown for the Monthly (electronic funds transfer) Premium Mode
**Footnote on Policy Specification	The following footnote will appear on the Policy Specification Page if the policy premium is paid by payroll deduction .... **IF PREMIUM CEASES TO BE REMITTED THROUGH A VALID PAYROLL GROUP, YOU MAY CONTINUE YOUR INSURANCE BY REMITTING PREMIUM THROUGH ONE OF OUR OTHER PAYMENT METHODS SHOWN ABOVE.
Policy/Rider Benefit Schedule Form Number Column	The form number column is bracketed as is will show the optional benefit riders form numbers the applicant has elected to have on his/her policy. Each rider's form number will appear in this column,
Policy/Rider Benefit Schedule – Description of Benefit Column	This column will show the description of the optional benefit riders the applicant has elected for his/her policy.
Policy/Rider Benefit Schedule - Insurance Amount	This column will show the insurance amount, if applicable, for each optional benefit rider elected.
Policy/Rider Benefit Schedule – Annual Premium column	This column will show the annual premium, if applicable, for each optional benefit rider elected.
Policy/Rider Benefit Schedule - Years Payable column	This column will show the number of years premiums are payable, if applicable, for each optional benefit rider elected.