

State: Arkansas **Filing Company:** Forethought Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.111 Single Premium - Single Life
Product Name: Whole Life Insurance Application
Project Name/Number: A4156-01 Freedom/A4156-01

Filing at a Glance

Company: Forethought Life Insurance Company
Product Name: Whole Life Insurance Application
State: Arkansas
TOI: L071 Individual Life - Whole
Sub-TOI: L071.111 Single Premium - Single Life
Filing Type: Form
Date Submitted: 10/03/2012
SERFF Tr Num: FRTH-128712980
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: A4156-01

Implementation: On Approval
Date Requested:
Author(s): Beth Witte
Reviewer(s): Linda Bird (primary)
Disposition Date: 11/01/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Forethought Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.111 Single Premium - Single Life
Product Name: Whole Life Insurance Application
Project Name/Number: A4156-01 Freedom/A4156-01

General Information

Project Name: A4156-01 Freedom Status of Filing in Domicile: Pending
Project Number: A4156-01 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: 11/01/2012
State Status Changed: 11/01/2012
Deemer Date: Created By: Beth Witte
Submitted By: Beth Witte Corresponding Filing Tracking Number:

Filing Description:

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

The form provided with this submission is very similar to the previously approved form A4150-01. This application was originally approved by the state on January 4, 2012, SERFF tracking #FRTH-127705890.

Since the state's approval of the prior application filing, Forethought Life Insurance Company ("Forethought") has reviewed and streamlined its operations and processes with respect to this product offering. One of the processes reviewed was the forms used. As a result, the application was restructured and reformatted, resulting in this filing submission.

A red-lined version comparing the previously approved application wording (Form A4150-01) to this filing is attached for your reference.

Changes include:

1. Page 1. Section 4. Eligible Grandchildren. (Previously Section 7). Clarifying wording was added, specifically, "(natural or legally adopted grandchildren....)"
2. Page 2. Health Questions. All of the questions remain essentially the same, with the exceptions of question 9c (depression deleted) and 9d (asthma deleted) and of question 13, which was previously Section 8.
3. Page 3. Bank Draft Authorization. (Previously Section 5). We have included as a variable, reference to Direct Express. We expect to make this payment option available in 2013 and when it is available, we will then be able to include this option in the application.
4. Section 11. Authorization to Obtain and Disclose Information, includes the new MIB Inc. wording. It also now includes the HIPAA authorization language in the application, when previously it was a separate form the prospective insured needed to sign.

The bracketed item noted in #3 is variable and may be modified on a non-discriminatory basis. A Statement of Variability describing the bracketing parameters has been enclosed for the application.

The application form contains no unusual or controversial features or language that deviate from normal insurance industry standards.

State: Arkansas **Filing Company:** Forethought Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.111 Single Premium - Single Life
Product Name: Whole Life Insurance Application
Project Name/Number: A4156-01 Freedom/A4156-01

If you have any questions regarding this submission, please contact me via SERFF, or call direct at 812-933-6769. We look forward to receiving your approval of this form.

Company and Contact

Filing Contact Information

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

Filing Company Information

Forethought Life Insurance CoCode: 91642 State of Domicile: Indiana
 Company Group Code: 1266 Company Type: Insurance
 300 North Meridian Street Group Name: State ID Number:
 Suite 1800 FEIN Number: 06-1016329
 Indianapolis, IN 47204
 (317) 223-2700 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form
 Per Company: No

Company	Amount	Date Processed	Transaction #
Forethought Life Insurance Company	\$50.00	10/03/2012	63358834

SERFF Tracking #:

FRT-128712980

State Tracking #:

Company Tracking #:

A4156-01

State: Arkansas

Filing Company:

Forethought Life Insurance Company

TOI/Sub-TOI: L071 Individual Life - Whole/L071.111 Single Premium - Single Life

Product Name: Whole Life Insurance Application

Project Name/Number: A4156-01 Freedom/A4156-01

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/01/2012	11/01/2012

Objection Letters and Response Letters

Objection Letters

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

Response Letters

Responded By	Created On	Date Submitted
Beth Witte	10/23/2012	11/01/2012

SERFF Tracking #:

FRTH-128712980

State Tracking #:

Company Tracking #:

A4156-01

State:

Arkansas

Filing Company:

Forethought Life Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.111 Single Premium - Single Life

Product Name:

Whole Life Insurance Application

Project Name/Number:

A4156-01 Freedom/A4156-01

Disposition

Disposition Date: 11/01/2012

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		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	STATEMENT OF VARIABILITY		Yes
Supporting Document	REDLINE APPLICATION		Yes
Form (revised)	APPLICATION FOR LIFE INSURANCE		Yes
Form	APPLICATION FOR LIFE INSURANCE	Replaced	Yes

State: Arkansas **Filing Company:** Forethought Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.111 Single Premium - Single Life
Product Name: Whole Life Insurance Application
Project Name/Number: A4156-01 Freedom/A4156-01

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 Kasey Poettker,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments:

Please refer to Section 7. Insurance Plan Information under Automatic selection insurance amount and premium adjustment. The reference to a Graded Death Benefit policy issued with a return of premium death benefit is in violation of Bulletin 8-85 Guideline One. Please review the bulletin and make the necessary corrections.

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*

State: Arkansas

Filing Company:

Forethought Life Insurance Company

TOI/Sub-TOI: L071 Individual Life - Whole/L071.111 Single Premium - Single Life

Product Name: Whole Life Insurance Application

Project Name/Number: A4156-01 Freedom/A4156-01

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/23/2012
Submitted Date	11/01/2012

Dear Linda Bird,

Introduction:

Please see our attached response.

Response 1

Comments:

The "Automatic selection, insurance amount and premium adjustment" information has been updated.

Related Objection 1

Comments:

Please refer to Section 7. Insurance Plan Information under Automatic selection insurance amount and premium adjustment. The reference to a Graded Death Benefit policy issued with a return of premium death benefit is in violation of Bulletin 8-85 Guideline One. Please review the bulletin and make the necessary corrections.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	APPLICATION FOR LIFE INSURANCE	A4156-01-AR	AEF	Initial		48.000	A4156-01-AR Application for LI Freedom 102312.pdf	Date Submitted: 11/01/2012 By: Beth Witte
<i>Previous Version</i>								
1	APPLICATION FOR LIFE INSURANCE	A4156-01-AR	AEF	Initial		48.000	A4156-01-AR Application for LI Freedom 091812.pdf	Date Submitted: 10/03/2012 By: Beth Witte

No Rate/Rule Schedule items changed.

SERFF Tracking #:

FRTH-128712980

State Tracking #:

Company Tracking #:

A4156-01

State:

Arkansas

Filing Company:

Forethought Life Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.111 Single Premium - Single Life

Product Name:

Whole Life Insurance Application

Project Name/Number:

A4156-01 Freedom/A4156-01

Conclusion:

Thank you for your time in this matter.

Sincerely,

Beth Witte

State: Arkansas

Filing Company:

Forethought Life Insurance Company

TOI/Sub-TOI: L071 Individual Life - Whole/L071.111 Single Premium - Single Life

Product Name: Whole Life Insurance Application

Project Name/Number: A4156-01 Freedom/A4156-01

Form Schedule

Lead Form Number: A4156-01

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		APPLICATION FOR LIFE INSURANCE	A4156-01-AR	AEF	Initial		48.000	A4156-01-AR Application for LI Freedom 102312.pdf

Form Type Legend:

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



APPLICATION FOR LIFE INSURANCE

Reference Number _____

Forethought Life Insurance Company

One Forethought Center

Batesville, IN 47006-0148

1. PROPOSED INSURED

(Please Print Using Black Ink)

First Name		Middle Initial	Last Name	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Are You a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	State of Birth
Mailing Address			Social Security Number - -	
Residential Address (if different than Mailing Address)				
City		State	Zip Code	Occupation
Phone Number (home) ()		Phone Number (work/cell) ()		E-mail Address

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

First Name		Middle Initial	Last Name	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Relationship to Proposed Insured	Are You a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number - -
Mailing Address			Residential Address (if different than Mailing Address)	
City			State	Zip Code
Phone Number (home) ()		Phone Number (work/cell) ()		E-mail Address

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

Primary

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

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

Contingent

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

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

4. ELIGIBLE GRANDCHILDREN *(natural or legally adopted grandchildren, to be eligible for Grandchildren's Benefit)*

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

5. HEALTH QUESTIONS

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

6. REPLACEMENT INFORMATION

1. Does the proposed insured currently have any life insurance in force? Yes No

2. Will this insurance replace, reduce coverage or modify premiums paid for any life insurance in force? Yes No
 If Yes, complete #3 and submit replacement forms required by your state.

3. Company Name _____ Face Amount _____ Policy Number _____

7. INSURANCE PLAN INFORMATION

Payor is: Proposed Insured Owner Other

Plan of Insurance: Level Death Benefit Graded Death Benefit

Billing Mode: Monthly EFT only Quarterly Semi-Annually Annually

Insurance Amount Applied for \$ _____

{Riders: { _____ } { _____ } { _____ }}

Initial Premium \$ _____ Check with Application (Make check payable to Forethought Life Insurance Company)
 Draft First Premium via EFT on _____. (1st thru 28th of the month)

Subsequent Premium \$ _____ Draft Subsequent Premium via EFT on _____. (1st thru 28th of the month)

Automatic selection, insurance amount and premium adjustment – Owner agrees that if: (i) selecting but not qualifying for, based on the information in this application, Forethought Freedom (with a Level Death Benefit) the proposed insured is instead automatically applying in this application for Forethought Freedom (with a Graded Death Benefit); (ii) the proposed insured qualifies for the policy selected above but the premium amount paid with this application is not sufficient for the insurance amount shown above, Forethought shall issue that policy type for a reduced insurance amount based on the above, or modified if necessary according to the applicable rates, premium amount for that reduced insurance amount. If the premium amount shown above is more or less than the amount required for the policy type issued, Forethought will increase or decrease the insurance amount and/or premium for that policy.

8. BANK DRAFT AUTHORIZATION

Electronic Funds Transfer (EFT): Checking (Please attach voided personal check) Savings { Direct Express® }

Account # _____ ABA Routing/Transit # _____

ACH # (if applicable) _____

() _____

Name of Financial Institution _____ Phone # of Financial Institution _____

Automatic Payment Authorization – Must be completed for EFT
 I, as Payor, verify that I am the account holder of this account and I am permitted to provide this authorization, and agree that Forethought Life Insurance Company (“FLIC”) is authorized to deduct my insurance premium from this account or another account later identified or substituted by me. This authorization is effective immediately and will continue until terminated, which either FLIC or I may do at any time by written notice to the other.

Payor’s Printed Name (as on account) _____ Social Security Number of Account Holder _____

Payor’s Signature _____ Date Signed _____

9. FRAUD WARNING/NOTICE

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

STATE REQUIRED NOTICES

AR Residents - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

10. AGREEMENT

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

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

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

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

A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of this policy.

11. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may no longer be protected under federal privacy rules.

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

Authorization to Release Confidential Medical Information: Records and information obtained will be disclosed to Forethought Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the Proposed Insured, hereby authorize any and all medical practitioners, physicians, pharmacists, pharmacy benefit managers, hospitals, clinics, nurses, records custodians, the MIB, Inc., the Veterans Administration, other insurance companies, or anyone else to release any and all records and information to be exchanged between Forethought Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and its assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, testing, treatment, or advice for the following: alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, mental disease, genetic disorders, pharmacy prescriptions, HIV or AIDS, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. I understand Forethought Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Forethought Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Forethought Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

SIGNATURE SECTION (FOR PURPOSES OF SECTIONS 1 TO 11. REVIEW ENTIRE APPLICATION BEFORE SIGNING.)

Proposed Insured Signature

Date

Signed At (City, State)

Owner Signature (if other than Proposed Insured)

Date

Signed At (City, State)

Licensed Agent Signature

Date

Signed At (City, State)

12. AGENT DECLARATIONS AND SIGNATURES

Agent Name (Print)	Agent Number		
Address	City	State	Zip Code
Business Phone Number ()	E-mail Address		

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

- Did you personally see the Proposed Insured? If No, explain below. **Yes** **No**
 If Yes, what type of photo identification was used to verify?
 Drivers license **Passport** **Other** _____

- Will this policy replace or change any existing life insurance or annuities? If Yes, complete the appropriate state Replacement form and submit it with the application. **Yes** **No**
- Did you give the Proposed Insured a copy of the Information Practices and MIB Disclosure? **Yes** **No**
- If the Owner is other than the Proposed Insured, what type of photo ID was used to verify the Owner's identity?
 Drivers license **Passport** **Other** _____ **Not Applicable**
- What is the best time and phone number to contact the Proposed Insured?
 Time _____ Time Zone _____ Phone Number () _____
- Mail completed policy to: **Agent** **Policyowner**
- Are commissions on this policy to be split with another agent? **Yes** **No**

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

SERFF Tracking #:

FRT-128712980

State Tracking #:

Company Tracking #:

A4156-01

State:

Arkansas

Filing Company:

Forethought Life Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.111 Single Premium - Single Life

Product Name:

Whole Life Insurance Application

Project Name/Number:

A4156-01 Freedom/A4156-01

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
A4156-01 Readability Cert 0912.pdf			

		Item Status:	Status Date:
Satisfied - Item:	STATEMENT OF VARIABILITY		
Comments:			
Attachment(s):			
A4156-01 Freedom App SOV 0912.pdf			

		Item Status:	Status Date:
Satisfied - Item:	REDLINE APPLICATION		
Comments:			
Attachment(s):			
A4156-01 Application for LI Freedom REDLINE 0912.pdf			

CERTIFICATION OF READABILITY

FORM #	FORM NAME	FLESCH SCORE
A4156-01	APPLICATION FOR LIFE INSURANCE	48.0

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



David K. Mullen, Senior Vice President

September 20, 2012

FORETHOUGHT LIFE INSURANCE COMPANY
Statement of Variability for Form A4156-01

The variable data in the subject form is denoted by variable brackets.

FORM NUMBER	FORM DESCRIPTION	SECTION/PAGE	VARIABLE TEXT
A4156-01	Application for Life Insurance	Section 7., INSURANCE PLAN INFORMATION	"Riders" is variable text. As Riders are developed and approved for use in the respective state(s), Riders will be offered on a non-discriminatory basis.
A4156-01	Application for Life Insurance	Section 8., BANK DRAFT AUTHORIZATION, Page 3	"Direct Express" is variable text. When this payment option is made available in 2013, "Direct Express" will be included as a payment option.



APPLICATION FOR LIFE INSURANCE

Reference Number _____

Forethought Life Insurance Company

One Forethought Center

Batesville, IN 47006-0148

1. PROPOSED INSURED

(Please Print Using Black Ink)

First Name		Middle Initial	Last Name		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Are You a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	State of Birth	Social Security Number - -
Mailing Address			Residential Address (if different than Mailing Address)		
City		State	Zip Code	Occupation	
Phone Number (home) ()		Phone Number (work/cell) ()		E-mail Address	

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

First Name		Middle Initial	Last Name		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Relationship to Proposed Insured	Are You a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number - -	
Mailing Address			Residential Address (if different than Mailing Address)		
City		State	Zip Code		
Phone Number (home) ()		Phone Number (work/cell) ()		E-mail Address	

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

Primary

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

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

Contingent

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

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

Previously Section 7 on A4150-01:

4. ELIGIBLE GRANDCHILDREN *(natural or legally adopted grandchildren, to be eligible ~~covered~~ for Grandchildren's Benefit)*

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

5. HEALTH QUESTIONS

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

6. REPLACEMENT INFORMATION

1. Does the proposed insured currently have any life insurance in force? Yes No

2. Will this insurance replace, reduce coverage or modify premiums paid for any life insurance in force? Yes No
 If Yes, complete #3 and submit replacement forms required by your state.

3. Company Name _____ Face Amount _____ Policy Number _____

7. INSURANCE PLAN INFORMATION [Previously Section 4 on A4150-01]

Payor is: **[new question]** Proposed Insured Owner Other

Plan of Insurance: Level Death Benefit Graded Death Benefit Return of Premium

Billing Mode: **[reordered sequence]** Monthly EFT only Quarterly Semi-Annually Annually

Face Insurance Amount Applied for \$ _____
 {Riders: { _____ } { _____ } { _____ }}

Initial Premium \$ _____ Check with Application (*Make check payable to Forethought Life Insurance Company*)
 Draft First Premium via EFT on _____ . (1st thru 28th of the month)

Subsequent Premium \$ _____ Draft Subsequent Premium via EFT on _____ . (1st thru 28th of the month)

Automatic selection, insurance amount and premium adjustment – Owner agrees that if: (i) selecting but not qualifying for, based on the information in this application, Forethought Freedom (with a Level Death Benefit) the proposed insured is instead automatically applying in this application for Forethought Freedom (with a Graded Death Benefit); (ii) selecting or applying as per (i) above but not qualifying for, based on the information in this application, Forethought Freedom (with a Graded Death Benefit), the owner is instead automatically applying in this application for Forethought Freedom (with a Return of Premium Death Benefit); (iii) the proposed insured qualifies for the policy selected above but the premium amount paid with this application is not sufficient for the insurance amount shown above, Forethought shall issue that policy type for a reduced insurance amount based on the above, or modified if necessary according to the applicable rates, premium amount for that reduced insurance amount. If the premium amount shown above is more or less than the amount required for the policy type issued, Forethought will increase or decrease the insurance amount and/or premium for that policy.

8. BANK DRAFT AUTHORIZATION [Previously Section 5]

Electronic Funds Transfer (EFT): Checking (Please attach voided personal check) Savings { Direct Express® }

Account # _____ ABA Routing/Transit # _____
 ACH # (if applicable) _____

Name of Financial Institution _____ Phone # of Financial Institution _____

Automatic Payment Authorization – Must be completed for EFT [Expanded version from A4150-01, p. 2]
 I, as Payor, verify that I am the account holder of this account and I am permitted to provide this authorization, and agree that Forethought Life Insurance Company (“FLIC”) is authorized to deduct my insurance premium from this account or another account later identified or substituted by me. This authorization is effective immediately and will continue until terminated, which either FLIC or I may do at any time by written notice to the other.

Payor’s Printed Name (as on account) _____ Social Security Number of Account Holder _____

Payor’s Signature _____ Date Signed _____

9. FRAUD WARNING/NOTICE

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

STATE REQUIRED NOTICES

AR, KY, LA, MD, NH, NM, RI, TX and WV Residents - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AK, DE, OH, and OK Residents - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ID and IN Residents - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

ME, TN, and WA Residents - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

CA Residents – Reg. 789.8 - The sale or liquidation of any asset in order to buy insurance, either life insurance or an annuity contract, may have tax consequences. Terminating any life insurance policy or annuity contract may have early withdrawal penalties or other costs or penalties, as well as tax consequences. You may wish to consult independent legal or financial advice before the sale or liquidation of any asset and before the purchase of any life insurance or annuity contract.

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO Residents - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

MN Residents - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NJ Residents - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

10. AGREEMENT (Previously Section 11)

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

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

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

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

~~A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of this policy. All statements made by me or on behalf of me shall be deemed to be representations and not warranties.~~

11. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the Proposed Insured, authorize Forethought Life Insurance Company, and its authorized persons, to obtain protected health information including prescription history, for the purpose of determining my eligibility for insurance, from any licensed physician, medical practitioner, hospital, clinic, the Veteran's Administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the MIB Inc., [used previous MIB wording] insurance companies, consumer reporting agencies and authorize said persons, firms or entities to furnish such information to Forethought Life Insurance Company. I authorize Forethought Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB Inc.

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may not be ~~no longer be~~ protected under federal privacy rules.

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

[The wording below was previously a separate form the proposed insured signed and returned]

Authorization to Release Confidential Medical Information: Records and information obtained will be disclosed to Forethought Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the Proposed Insured, hereby authorize any and all medical practitioners, physicians, pharmacists, pharmacy benefit managers, hospitals, clinics, nurses, records custodians, the MIB, Inc., the Veterans Administration, other insurance companies, or anyone else to release any and all records and information to be exchanged between Forethought Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and its assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, testing, treatment, or advice for the following: alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, mental disease, genetic disorders, pharmacy prescriptions, HIV or AIDS, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. I understand Forethought Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Forethought Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Forethought Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

SIGNATURE SECTION (FOR PURPOSES OF SECTIONS 1 TO 11. REVIEW ENTIRE APPLICATION BEFORE SIGNING.)

Proposed Insured Signature

Date

Signed At (City, State)

Owner Signature (if other than Proposed Insured)

Date

Signed At (City, State)

Licensed Agent Signature

Date

Signed At (City, State)

12. AGENT DECLARATIONS AND SIGNATURES

Agent Name (Print)	Agent Number		
Address	City	State	Zip Code
Business Phone Number ()	E-mail Address		

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

- Did you personally see the Proposed Insured? **If No, explain below.** Yes No
 If Yes, what type of photo identification was used to verify?
 Drivers license Passport Other _____
- Will this policy replace or change any existing life insurance or annuities? If Yes, complete the appropriate state Replacement form and submit it with the application. Yes No
- Did you give the Proposed Insured a copy of the Information Practices and MIB Disclosure? Yes No
- If the Owner is other than the Proposed Insured, what type of photo ID was used to verify the Owner's identity?
 Drivers license Passport Other _____ Not Applicable
- What is the best time and phone number to contact the Proposed Insured?
 Time _____ Time Zone _____ Phone Number () _____
- Mail completed policy to: Agent Policyowner
- Are commissions on this policy to be split with another agent?** Yes No

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

SERFF Tracking #:

FRTH-128712980

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

A4156-01

State:

Arkansas

Filing Company:

Forethought Life Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.111 Single Premium - Single Life

Product Name:

Whole Life Insurance Application

Project Name/Number:

A4156-01 Freedom/A4156-01

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 Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/03/2012	Replaced 11/01/2012	Form	APPLICATION FOR LIFE INSURANCE	10/23/2012	A4156-01-AR Application for LI Freedom 091812.pdf (Superseded)



APPLICATION FOR LIFE INSURANCE

Reference Number _____

Forethought Life Insurance Company

One Forethought Center

Batesville, IN 47006-0148

1. PROPOSED INSURED

(Please Print Using Black Ink)

First Name		Middle Initial	Last Name		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Are You a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	State of Birth	Social Security Number - -
Mailing Address			Residential Address (if different than Mailing Address)		
City		State	Zip Code	Occupation	
Phone Number (home) ()		Phone Number (work/cell) ()		E-mail Address	

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

First Name		Middle Initial	Last Name		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Relationship to Proposed Insured	Are You a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number - -	
Mailing Address			Residential Address (if different than Mailing Address)		
City		State	Zip Code		
Phone Number (home) ()		Phone Number (work/cell) ()		E-mail Address	

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

Primary

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

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

Contingent

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

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

4. ELIGIBLE GRANDCHILDREN *(natural or legally adopted grandchildren, to be eligible for Grandchildren's Benefit)*

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

5. HEALTH QUESTIONS

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

6. REPLACEMENT INFORMATION

1. Does the proposed insured currently have any life insurance in force? Yes No

2. Will this insurance replace, reduce coverage or modify premiums paid for any life insurance in force? Yes No
 If Yes, complete #3 and submit replacement forms required by your state.

3. Company Name _____ Face Amount _____ Policy Number _____

7. INSURANCE PLAN INFORMATION

Payor is: Proposed Insured Owner Other

Plan of Insurance: Level Death Benefit Graded Death Benefit

Billing Mode: Monthly EFT only Quarterly Semi-Annually Annually

Insurance Amount Applied for \$ _____

{Riders: { _____ } { _____ } { _____ }}

Initial Premium \$ _____ Check with Application (Make check payable to Forethought Life Insurance Company)
 Draft First Premium via EFT on _____. (1st thru 28th of the month)

Subsequent Premium \$ _____ Draft Subsequent Premium via EFT on _____. (1st thru 28th of the month)

Automatic selection, insurance amount and premium adjustment – Owner agrees that if: (i) selecting but not qualifying for, based on the information in this application, Forethought Freedom (with a Level Death Benefit) the proposed insured is instead automatically applying in this application for Forethought Freedom (with a Graded Death Benefit); (ii) selecting or applying as per (i) above but not qualifying for, based on the information in this application, Forethought Freedom (with a Graded Death Benefit), the owner is instead automatically applying in this application for Forethought Freedom (with a Return of Premium Death Benefit); (iii) the proposed insured qualifies for the policy selected above but the premium amount paid with this application is not sufficient for the insurance amount shown above, Forethought shall issue that policy type for a reduced insurance amount based on the above, or modified if necessary according to the applicable rates, premium amount for that reduced insurance amount. If the premium amount shown above is more or less than the amount required for the policy type issued, Forethought will increase or decrease the insurance amount and/or premium for that policy.

8. BANK DRAFT AUTHORIZATION

Electronic Funds Transfer (EFT): Checking (Please attach voided personal check) Savings { Direct Express® }

Account # _____ ABA Routing/Transit # _____

ACH # (if applicable) _____

() _____

Name of Financial Institution _____ Phone # of Financial Institution _____

Automatic Payment Authorization – Must be completed for EFT
 I, as Payor, verify that I am the account holder of this account and I am permitted to provide this authorization, and agree that Forethought Life Insurance Company (“FLIC”) is authorized to deduct my insurance premium from this account or another account later identified or substituted by me. This authorization is effective immediately and will continue until terminated, which either FLIC or I may do at any time by written notice to the other.

Payor’s Printed Name (as on account) _____ Social Security Number of Account Holder _____

Payor’s Signature _____ Date Signed _____

9. FRAUD WARNING/NOTICE

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

STATE REQUIRED NOTICES

AR Residents - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

10. AGREEMENT

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

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

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

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

A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of this policy.

11. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may no longer be protected under federal privacy rules.

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

Authorization to Release Confidential Medical Information: Records and information obtained will be disclosed to Forethought Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the Proposed Insured, hereby authorize any and all medical practitioners, physicians, pharmacists, pharmacy benefit managers, hospitals, clinics, nurses, records custodians, the MIB, Inc., the Veterans Administration, other insurance companies, or anyone else to release any and all records and information to be exchanged between Forethought Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and its assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, testing, treatment, or advice for the following: alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, mental disease, genetic disorders, pharmacy prescriptions, HIV or AIDS, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. I understand Forethought Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Forethought Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Forethought Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

SIGNATURE SECTION (FOR PURPOSES OF SECTIONS 1 TO 11. REVIEW ENTIRE APPLICATION BEFORE SIGNING.)

Proposed Insured Signature

Date

Signed At (City, State)

Owner Signature (if other than Proposed Insured)

Date

Signed At (City, State)

Licensed Agent Signature

Date

Signed At (City, State)

12. AGENT DECLARATIONS AND SIGNATURES

Agent Name (Print)	Agent Number		
Address	City	State	Zip Code
Business Phone Number ()	E-mail Address		

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

- Did you personally see the Proposed Insured? If No, explain below. Yes No
 If Yes, what type of photo identification was used to verify?
 Drivers license Passport Other _____

- Will this policy replace or change any existing life insurance or annuities? If Yes, complete the appropriate state Replacement form and submit it with the application. Yes No
- Did you give the Proposed Insured a copy of the Information Practices and MIB Disclosure? Yes No
- If the Owner is other than the Proposed Insured, what type of photo ID was used to verify the Owner's identity?
 Drivers license Passport Other _____ Not Applicable
- What is the best time and phone number to contact the Proposed Insured?
 Time _____ Time Zone _____ Phone Number () _____
- Mail completed policy to: Agent Policyowner
- Are commissions on this policy to be split with another agent? Yes No

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