

State: Arkansas **Filing Company:** Gerber Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Simplified Whole Life Application
Project Name/Number: Simplified Whole Life MIB application/

Filing at a Glance

Company: Gerber Life Insurance Company
Product Name: Simplified Whole Life Application
State: Arkansas
TOI: L071 Individual Life - Whole
Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Filing Type: Form
Date Submitted: 11/16/2012
SERFF Tr Num: GLIN-128770315
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation
Date Requested:
Author(s): Jennifer Wittmann
Reviewer(s): Linda Bird (primary)
Disposition Date: 11/28/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Gerber Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Simplified Whole Life Application
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General Information

Project Name: Simplified Whole Life MIB application Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Informational Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: Resubmission Previous Filing Number: GLIN-128626069
 Individual Market Type: Overall Rate Impact:
 Filing Status Changed: 11/28/2012
 State Status Changed: 11/28/2012 Deemer Date:
 Created By: Jennifer Wittmann Submitted By: Jennifer Wittmann
 Corresponding Filing Tracking Number:

Filing Description:

Your department previously approved form AWLTL-12 on 8/21/2012 - SERFF Tr. # GLIN-128626069. We resubmit the form as an informational filing to address the correction of a technical error discovered after approval.

After form AWLTL-12 was approved, a technical error was discovered on the approved form. Language incorporated in our previously approved MIB provision that authorized Gerber Life Insurance to release information to its reinsurers was inadvertently omitted. The attached form has been corrected to add back the omitted language in the MIB authorization section so the sentence now reads:

Gerber Life Insurance Company may release information obtained by this Authorization to its reinsurers or to other insurers with whom I have policies or to whom I may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me, or as may otherwise be lawfully required.

The corrected form and the redlined version of the form that shows the correction are attached.

On behalf of the Company, I certify no other changes were made to this form.

Company and Contact

Filing Contact Information

Jennifer Wittmann, Legal & Compliance jennifer.wittmann@us.nestle.com
 Associate
 1311 Mamaroneck Avenue 914-272-4000 [Phone]
 White Plains, NY 10605 914-272-4099 [FAX]

Filing Company Information

Gerber Life Insurance Company CoCode: 70939 State of Domicile: New York
 1311 Mamaroneck Avenue Group Code: Company Type: Life and
 White Plains, NY 10605 Group Name: Health Insurance
 (914) 272-4000 ext. [Phone] FEIN Number: 13-2611847 State ID Number:

Filing Fees

State: Arkansas **Filing Company:** Gerber Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
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Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: 1 form =\$20
 Per Company: No

Company	Amount	Date Processed	Transaction #
Gerber Life Insurance Company	\$20.00	11/16/2012	64983287
Gerber Life Insurance Company	\$30.00	11/26/2012	65156839

SERFF Tracking #:

GLIN-128770315

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Gerber Life Insurance Company

TOI/Sub-TOI:

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

Product Name:

Simplified Whole Life Application

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/28/2012	11/28/2012

SERFF Tracking #:

GLIN-128770315

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

Arkansas

Filing Company:

Gerber Life Insurance Company

TOI/Sub-TOI:

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

Product Name:

Simplified Whole Life Application

Project Name/Number:

Simplified Whole Life MIB application/

Disposition

Disposition Date: 11/28/2012

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		No
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	redlined version of form		Yes
Form	Application for Individual Life Insurance		Yes

SERFF Tracking #:

GLIN-128770315

State Tracking #:

Company Tracking #:

State: Arkansas **Filing Company:** Gerber Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
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Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Individual Life Insurance	AWLTL-12	AEF	Other	Informational		AWLTL-12.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



Gerber Life Insurance Company

Home Office: [White Plains, New York]
Administrative Office: [445 State Street, Fremont MI 49412]
www.gerberlife.com

I. PERSONAL INFORMATION

PROPOSED INSURED: (Give full legal name)

First Name _____ Last Name _____ Middle Initial _____

Gender Male Female Date of Birth _____ Place of Birth (State/Country) _____

(Month Day Year)

Social Security Number _____ Driver's License Number _____ State _____

Legal Residence Address _____ City _____ State _____ Zip _____

Email Address _____

Primary Phone _____ Cell: Yes No Secondary Phone _____ Cell: Yes No

Occupation(s) _____ Employer or Business Name _____

Annual Earned Income \$ _____ How long with current employer? _____ Type of business where currently employed _____

Are you a United States citizen or do you have Permanent Legal Resident (Green Card) status?..... Yes No

COVERAGE APPLIED FOR:

Whole Life Level Term Period (select one)..... 10 Years 15 Years 20 Years 30 Years

Face Amount Applied For (must be from \$25,000-\$1,000,000) \$ _____,000

OWNERSHIP:

Will someone other than the insured own the policy being applied for?..... Yes No

BENEFICIARY INFORMATION:

Primary Beneficiary(ies) _____ Relationship to the Insured _____

Contingent Beneficiary(ies) _____ Relationship to the Insured _____

II. AUTHORIZATION TO OBTAIN INFORMATION

I authorize any insurance company, employer, physician, medical professional, hospital, medical facility, pharmacy, consumer reporting agency, MIB, Inc., or any other person or organization that has any record of information about me to give to Gerber Life Insurance Company, its reinsurers or its authorized representatives, (together, the Company) information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including drug and alcohol treatment information, or other information the Company requires to determine insurability, eligibility for benefits, investigate claims, or support the business operations of the Company related thereto. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB, Inc. (MIB). I further authorize the sources listed above except MIB, Inc. to give such information to a consumer reporting agency acting on behalf of Gerber Life Insurance Company. Gerber Life Insurance Company may release information obtained by this Authorization to its reinsurers or other insurers with whom I have policies or to whom I may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me, or as may otherwise be lawfully required.

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.

I have received a copy of the Notice of Insurance Information Practices. I or my authorized representative may obtain a copy of this Authorization on request. This Authorization will be valid for 24 months from the date signed. It is the Company's practice to prohibit third parties who lawfully receive nonpublic health information from re-disclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I understand that a copy of this authorization will be provided, upon request, to me or a person authorized on my behalf. I understand that disclosure of information to the Company may subject the information to re-disclosure in accordance with the Company's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Gerber Life Insurance Company at the address above.

Signature of Proposed Insured _____ Date _____

Signature of Policyowner (if other than Proposed Insured or Applicant) _____ Date _____

Signed at (City, State) _____

III. QUESTIONS OF THE PROPOSED INSURED

Height _____ Weight _____ Has your weight changed by more than 10 pounds in the past year?..... Yes No
(Feet) (Inches) (Pounds) (Pounds)

In the past 36 months, have you smoked or used tobacco in any form?..... Yes No

MEDICAL AND BACKGROUND QUESTIONS:

1. To the best of your knowledge and belief, has the Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
 - a. Heart disorder, including a heart attack (myocardial infarction), angina, irregular heart beat or abnormal heart rhythm (arrhythmia), chest pain, hypertension (high blood pressure), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (TIA or mini-stroke) or rheumatic fever?..... Yes No
 - b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders (excluding HIV), elevated cholesterol, liver disease, hemophilia, kidney disease (other than kidney stones), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, bladder or prostate, other intestinal or digestive tract disease or pancreatitis?..... Yes No
 - c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes?..... Yes No
 - d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation, including Down's Syndrome, multiple sclerosis (MS), muscular dystrophy (MD), Parkinson's disease, amyotrophic lateral sclerosis (ALS), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy?..... Yes No
 - e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive lung disease (COPD), shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (including lupus or scleroderma)?..... Yes No
 - f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder?..... Yes No
 - g. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints or muscles?..... Yes No
 - h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia?..... Yes No
 - i. Any disease or disorder of the eyes, ears, nose or throat?..... Yes No
 - j. Any other illness or injury requiring medical attention or blood transfusions?..... Yes No
2. To the best of your knowledge and belief, has the Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age 60?..... Yes No
3. To the best of your knowledge and belief, has the Proposed Insured ever been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or antibodies to human T-lymphotropic virus type III (HTLV)?..... Yes No
4. During the past 5 years, has the proposed insured:
 - a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?..... Yes No
 - b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens, or any other controlled substance not prescribed by a physician?..... Yes No
 - c. Been treated by a physician or been advised by a physician to seek treatment for drug or alcohol use?..... Yes No
 - d. Been advised to have any test (except HIV tests), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed or for which results have not been received?..... Yes No
 - e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests or urine tests (other than AIDS-related blood tests)?..... Yes No
 - f. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined or had insurance renewal or reinstatement refused?..... Yes No
 - g. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits?..... Yes No
5. a. To the best of your knowledge and belief, has the Proposed Insured ever had any disorder of any genital or reproductive organ? Yes No
b. To the best of your knowledge and belief, is the proposed insured currently pregnant?..... Yes No
6. a. During the past 5 years, has the Proposed Insured had their driver's license suspended or revoked, been convicted of or pled "guilty" to driving under the influence (OWI/DUI/DWI) or to more than 3 moving violations?..... Yes No
b. During the past 5 years, has the Proposed Insured been convicted of a felony, or been on probation/parole, or currently have charges pending?..... Yes No
7. During the next 12 months, does the Proposed Insured contemplate residence or travel outside of the U.S.A.?..... Yes No
8. Does the Proposed Insured belong to or intend to join the National Guard or Military?..... Yes No
9. a. Within the past 5 years has the Proposed Insured flown other than as a fare-paying passenger, or is the Proposed Insured contemplating or planning to fly, as a pilot, crew member or student?..... Yes No
b. Within the past 5 years has the Proposed Insured participated in, or contemplating or planning participation in any hazardous sport or activities?..... Yes No

ADDITIONAL INFORMATION

OTHER COVERAGE

Do you have any life insurance or annuities in force or is any application for life insurance or reinstatement now pending?..... Yes No
If "Yes", please complete below.

Company Name _____ City, State _____

Face Amount _____ Month/Year Issued _____ Is Coverage to be Replaced?..... Yes No

Company Name _____ City, State _____

Face Amount _____ Month/Year Issued _____ Is Coverage to be Replaced?..... Yes No

If this policy is issued, will any other life, accident or health insurance or annuity be cancelled, terminated, lapsed or not renewed? ... Yes No

RIDERS

Would you like to purchase:

[(a) Waiver of Premium Rider?..... Yes No]

[(b) Guaranteed Insurability Benefit Rider?..... Yes No]

IV. ACKNOWLEDGEMENT OF INFORMATION PROVIDED

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Other than as stated in any conditional receipt, any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

Signature of Proposed Insured _____ Date _____

Signature of Policyowner (if other than Proposed Insured or Applicant) _____ Date _____

Signed at (City, State) _____



Gerber Life Insurance Company

445 State Street, Fremont MI 49412
www.gerberlife.com

PRODUCER CERTIFICATION Must be Completed by Producer if applicable

To the best of your knowledge,

1. Does the Proposed Insured have any life insurance or annuities in force or is any application for life insurance or reinstatement now pending? (If Yes, complete appropriate replacement forms)..... Yes No

2. Will the coverage applied for replace any life insurance or annuity coverage now in force or pending on the life of the Proposed Insured? (If Yes, complete appropriate replacement forms)..... Yes No

Is this a 1035 Exchange? Yes No

Is this an internal term conversion? Yes No

I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein Yes No

Agent ID _____ Date _____

Signature of Licensed Agent _____ Printed Name of Licensed Agent _____

SERFF Tracking #:

GLIN-128770315

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Gerber Life Insurance Company

TOI/Sub-TOI:

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

Product Name:

Simplified Whole Life Application

Project Name/Number:

Simplified Whole Life MIB application/

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification		
Bypass Reason:	Not applicable		

		Item Status:	Status Date:
Satisfied - Item:	redlined version of form		
Comments:			
Attachment(s):			
AWLTL-12-REDLINED.pdf			



Gerber Life Insurance Company

Home Office: [White Plains, New York]
Administrative Office: [445 State Street, Fremont MI 49412]
www.gerberlife.com

I. PERSONAL INFORMATION

PROPOSED INSURED: (Give full legal name)

First Name _____ Last Name _____ Middle Initial _____

Gender Male Female Date of Birth _____ Place of Birth (State/Country) _____
(Month Day Year)

Social Security Number _____ Driver's License Number _____ State _____

Legal Residence Address _____ City _____ State _____ Zip _____

Email Address _____

Primary Phone _____ Cell: Yes No Secondary Phone _____ Cell: Yes No

Occupation(s) _____ Employer or Business Name _____

Annual Earned Income \$ _____ How long with current employer? _____ Type of business where currently employed _____

Are you a United States citizen or do you have Permanent Legal Resident (Green Card) status?..... Yes No

COVERAGE APPLIED FOR:

Whole Life Level Term Period (select one)..... 10 Years 15 Years 20 Years 30 Years

Face Amount Applied For (must be from \$25,000-\$1,000,000) \$ _____,000

OWNERSHIP:

Will someone other than the insured own the policy being applied for?..... Yes No

BENEFICIARY INFORMATION:

Primary Beneficiary(ies) _____ Relationship to the Insured _____

Contingent Beneficiary(ies) _____ Relationship to the Insured _____

II. AUTHORIZATION TO OBTAIN INFORMATION

I authorize any insurance company, employer, physician, medical professional, hospital, medical facility, pharmacy, consumer reporting agency, MIB, Inc., or any other person or organization that has any record of information about me to give to Gerber Life Insurance Company, its reinsurers or its authorized representatives, (together, the Company) information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including drug and alcohol treatment information, or other information the Company requires to determine insurability, eligibility for benefits, investigate claims, or support the business operations of the Company related thereto. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB, Inc. (MIB). I further authorize the sources listed above except MIB, Inc. to give such information to a consumer reporting agency acting on behalf of Gerber Life Insurance Company. Gerber Life Insurance Company may release information obtained by this Authorization to its reinsurers or other insurers with whom I have policies or to whom I may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me, or as may otherwise be lawfully required.

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.

I have received a copy of the Notice of Insurance Information Practices. I or my authorized representative may obtain a copy of this Authorization on request. This Authorization will be valid for 24 months from the date signed. It is the Company's practice to prohibit third parties who lawfully receive nonpublic health information from re-disclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I understand that a copy of this authorization will be provided, upon request, to me or a person authorized on my behalf. I understand that disclosure of information to the Company may subject the information to re-disclosure in accordance with the Company's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Gerber Life Insurance Company at the address above.

Signature of Proposed Insured _____ Date _____

Signature of Policyowner (if other than Proposed Insured or Applicant) _____ Date _____

Signed at (City, State) _____

III. QUESTIONS OF THE PROPOSED INSURED

Height _____ Weight _____ Has your weight changed by more than 10 pounds in the past year?..... Yes No
(Feet) (Inches) (Pounds) (Pounds)

In the past 36 months, have you smoked or used tobacco in any form?..... Yes No

MEDICAL AND BACKGROUND QUESTIONS:

1. To the best of your knowledge and belief, has the Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
 - a. Heart disorder, including a heart attack (myocardial infarction), angina, irregular heart beat or abnormal heart rhythm (arrhythmia), chest pain, hypertension (high blood pressure), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (TIA or mini-stroke) or rheumatic fever?..... Yes No
 - b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders (excluding HIV), elevated cholesterol, liver disease, hemophilia, kidney disease (other than kidney stones), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, bladder or prostate, other intestinal or digestive tract disease or pancreatitis?..... Yes No
 - c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes?..... Yes No
 - d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation, including Down's Syndrome, multiple sclerosis (MS), muscular dystrophy (MD), Parkinson's disease, amyotrophic lateral sclerosis (ALS), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy?..... Yes No
 - e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive lung disease (COPD), shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (including lupus or scleroderma)?..... Yes No
 - f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder?..... Yes No
 - g. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints or muscles?..... Yes No
 - h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia?..... Yes No
 - i. Any disease or disorder of the eyes, ears, nose or throat?..... Yes No
 - j. Any other illness or injury requiring medical attention or blood transfusions?..... Yes No
2. To the best of your knowledge and belief, has the Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age 60?..... Yes No
3. To the best of your knowledge and belief, has the Proposed Insured ever been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or antibodies to human T-lymphotropic virus type III (HTLV)?..... Yes No
4. During the past 5 years, has the proposed insured:
 - a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?..... Yes No
 - b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens, or any other controlled substance not prescribed by a physician?..... Yes No
 - c. Been treated by a physician or been advised by a physician to seek treatment for drug or alcohol use?..... Yes No
 - d. Been advised to have any test (except HIV tests), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed or for which results have not been received?..... Yes No
 - e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests or urine tests (other than AIDS-related blood tests)?..... Yes No
 - f. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined or had insurance renewal or reinstatement refused?..... Yes No
 - g. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits?..... Yes No
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b. To the best of your knowledge and belief, is the proposed insured currently pregnant?..... Yes No
6. a. During the past 5 years, has the Proposed Insured had their driver's license suspended or revoked, been convicted of or pled "guilty" to driving under the influence (OWI/DUI/DWI) or to more than 3 moving violations?..... Yes No
b. During the past 5 years, has the Proposed Insured been convicted of a felony, or been on probation/parole, or currently have charges pending?..... Yes No
7. During the next 12 months, does the Proposed Insured contemplate residence or travel outside of the U.S.A.?..... Yes No
8. Does the Proposed Insured belong to or intend to join the National Guard or Military?..... Yes No
9. a. Within the past 5 years has the Proposed Insured flown other than as a fare-paying passenger, or is the Proposed Insured contemplating or planning to fly, as a pilot, crew member or student?..... Yes No
b. Within the past 5 years has the Proposed Insured participated in, or contemplating or planning participation in any hazardous sport or activities?..... Yes No

ADDITIONAL INFORMATION

OTHER COVERAGE

Do you have any life insurance or annuities in force or is any application for life insurance or reinstatement now pending?..... Yes No
If "Yes", please complete below.

Company Name _____ City, State _____

Face Amount _____ Month/Year Issued _____ Is Coverage to be Replaced?..... Yes No

Company Name _____ City, State _____

Face Amount _____ Month/Year Issued _____ Is Coverage to be Replaced?..... Yes No

If this policy is issued, will any other life, accident or health insurance or annuity be cancelled, terminated, lapsed or not renewed? ... Yes No

RIDERS

Would you like to purchase:

[(a) Waiver of Premium Rider?..... Yes No]

[(b) Guaranteed Insurability Benefit Rider?..... Yes No]

IV. ACKNOWLEDGEMENT OF INFORMATION PROVIDED

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Other than as stated in any conditional receipt, any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

Signature of Proposed Insured _____ Date _____

Signature of Policyowner (if other than Proposed Insured or Applicant) _____ Date _____

Signed at (City, State) _____



Gerber Life Insurance Company

445 State Street, Fremont MI 49412
www.gerberlife.com

PRODUCER CERTIFICATION Must be Completed by Producer if applicable

To the best of your knowledge,

1. Does the Proposed Insured have any life insurance or annuities in force or is any application for life insurance or reinstatement now pending? (If Yes, complete appropriate replacement forms)..... Yes No

2. Will the coverage applied for replace any life insurance or annuity coverage now in force or pending on the life of the Proposed Insured? (If Yes, complete appropriate replacement forms)..... Yes No

Is this a 1035 Exchange? Yes No

Is this an internal term conversion? Yes No

I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein Yes No

Agent ID _____ Date _____

Signature of Licensed Agent _____ Printed Name of Licensed Agent _____