Filing at a Glance

Company:	Investors Heritage Life Insurance Company
Product Name:	HYP APP 2012
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	11/08/2012
SERFF Tr Num:	IHLI-128760804
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	2012 HYP APP
Implementation Date Requested:	On Approval
Author(s):	Julie Hunsinger, Karen Jones, Brad Shepherd
Reviewer(s):	Linda Bird (primary)
Disposition Date:	11/14/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Investors Heritage Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *HYP APP 2012*
Project Name/Number: *2012 HYP & Reinst. APP/*

General Information

Project Name: 2012 HYP & Reinst. APP
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Deemer Date:
Submitted By: Karen Jones

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filed in KY with the IIPRC pending approval
Market Type: Individual
Individual Market Type:
Filing Status Changed: 11/14/2012
State Status Changed: 11/14/2012
Created By: Karen Jones
Corresponding Filing Tracking Number:

Filing Description:

We are submitting the attached Application forms for your consideration for approval. The Reinstatement Application has previously been filed and approved in Arkansas under SERFF Tracking Number IHLI-125851427 and the attached form replaces the current form. Form ICC12-HYP-APP replaces form ICC09-29901-IH (03-2009) which was approved in Arkansas on May 12, 2009, SERFF Tracking Number IHLI-126142774. These forms will not be marketed with illustrations.
Form ICC12-21001 will be used to reinstate any lapsed policy issued by Investors Heritage Life Insurance Company.
Application form ICC12-HYP-APP will be used to apply for our Heritage Youth Protector policy. There are no variable items and no innovative or unique features.

Company and Contact

Filing Contact Information

Karen Jones, Filing Administrator
P.O. Box 717
Frankfort, KY 40602-0717

kjones@ihlic.com
800-422-2011 [Phone] 1007 [Ext]
502-875-7084 [FAX]

Filing Company Information

Investors Heritage Life Insurance Company
P.O. Box 717
200 Capital Avenue
Frankfort, KY 40602-0717
(502) 209-1007 ext. [Phone]

CoCode: 64904
Group Code:
Group Name:
FEIN Number: 61-0574893

State of Domicile: Kentucky
Company Type: LAH
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $100.00
Retaliatory? No
Fee Explanation: $50 per application form
Per Company: No

Company	Amount	Date Processed	Transaction #
Investors Heritage Life Insurance Company	$100.00	11/08/2012	64704623

State: *Arkansas*
Filing Company: *Investors Heritage Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *HYP APP 2012*
Project Name/Number: *2012 HYP & Reinst. APP/*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/14/2012	11/14/2012

State: *Arkansas* **Filing Company:** *Investors Heritage Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *HYP APP 2012*
Project Name/Number: *2012 HYP & Reinst. APP/*

Disposition

Disposition Date: 11/14/2012
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
Form	Heritage Youth Protector Application		Yes
Form	Reinstatement Application		Yes

State: *Arkansas*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *HYP APP 2012*
Project Name/Number: *2012 HYP & Reinst. APP/*
Filing Company: *Investors Heritage Life Insurance Company*

Form Schedule

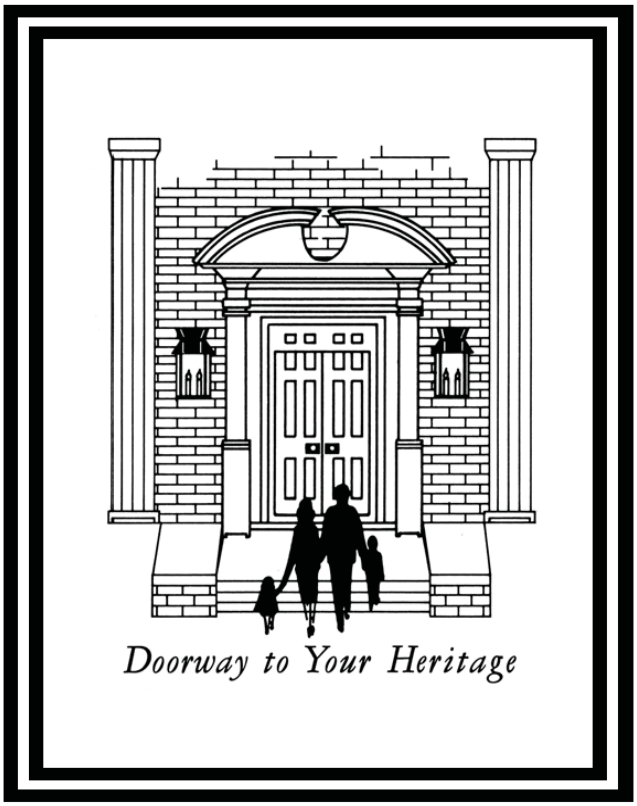
Lead Form Number: ICC12-HYP-APP

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		Heritage Youth Protector Application	ICC12-HYP-APP	AEF	Revised	Previous Filing Number:	IHLI-126142774	50.000	ICC12-HYP-APP Letter Size.pdf
						Replaced Form Number:	ICC09-29901-IH (03-2009)		
2		Reinstatement Application	ICC12-21001	AEF	Revised	Previous Filing Number:	IHLI-125851427	51.100	ICC12-21001-Reinstatement.pdf
						Replaced Form Number:	21001 (5-2001) Revised 7/2008		

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

HERITAGE YOUTH PROTECTOR



Juvenile Modified Whole Life Insurance

Whole Life Insurance Policy With Increased Premium At Age 25

Guaranteed Policy Benefits
Guaranteed Premiums

INVESTORS HERITAGE

Life Insurance Company

P.O. Box 717 • Frankfort KY 40602-0717

Telephone: 800-422-2011
Fax: 502-875-7084
E-Mail: ihlic@ihlic.com
Web Site: www.investorsheritage.com

Investors Heritage
Life Insurance Company
PO Box 717 • Frankfort KY 40602-0717
phone: 800.422.2011• fax: 502.875.7084
ihlic@ihlic.com • www.investorsheritage.com

HERITAGE YOUTH PROTECTOR

Juvenile Modified Whole Life Insurance Application
Whole Life Insurance Policy With Increased Premium At Age 25

Children Proposed

1 (a) Last Name	(b) First Name	(c) MI	(d) Sex
(e) Age	(f) Birth Date (Mo/Day/Yr)	(g) Height/Weight	(h) Social Security No.

2 (a) Last Name	(b) First Name	(c) MI	(d) Sex
(e) Age	(f) Birth Date (Mo/Day/Yr)	(g) Height/Weight	(h) Social Security No.

3 (a) Last Name	(b) First Name	(c) MI	(d) Sex
(e) Age	(f) Birth Date (Mo/Day/Yr)	(g) Height/Weight	(h) Social Security No.

4 (a) Last Name	(b) First Name	(c) MI	(d) Sex
(e) Age	(f) Birth Date (Mo/Day/Yr)	(g) Height/Weight	(h) Social Security No.

Beneficiary(s)

Primary Beneficiary's full name

Beneficiary Relationship | Social Security # | Birth Date

Primary Phone #: ( )

E-mail Address:

Beneficiary Complete Address:

❑ Primary ❑ Contingent Beneficiary's full name

Beneficiary Relationship | Social Security # | Birth Date

Primary Phone #: ( )

E-mail Address:

Beneficiary Complete Address:

Policy Owner

Last Name | First Name | MI | Relationship to Children

Street Address | City | State | Zip Code

Social Security Number | Home Phone # | Work Phone # | Mobile Phone # | E-Mail Address

a. Do you have insurable interest in all Proposed Insureds?..... ☐YES ☐NO
b. Do you have complete knowledge of the health information on all Proposed Insureds? ..... ☐YES ☐NO
c. Are all your children or grandchildren being insured? If not, please explain..... ☐YES ☐NO

Policy Co-Owner

Last Name | First Name | MI | Relationship to Children

Street Address | City | State | Zip Code

Social Security Number | Home Phone # | Work Phone # | Mobile Phone # | E-Mail Address

a. Do you have insurable interest in all Proposed Insureds?..... ☐YES ☐NO
b. Do you have complete knowledge of the health information on all Proposed Insureds? ..... ☐YES ☐NO
c. Are all your children or grandchildren being insured? If not, please explain..... ☐YES ☐NO

Premium Payor

Complete only if different from Policy Owner:

Last Name | First Name | MI | Social Security Number

Street Address | City | State | Zip Code | Relationship to Children

Policy Information

Amount of Insurance per child: ❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000

Riders: ❑ Waiver of Premium ❑ Guaranteed Insurability

Premium: Child 1 = $_____ Child 2 = $_____ Child 3 = $_____ Child 4 = $_____

Payment Mode: ❑ Annual Direct ❑ Monthly PAT ❑ Single Premium to Age 25

Automatic Premium Loan Option (if there is cash value)? ☐YES ☐NO

Total Premium Collected $ _____

Does any Proposed Insured have any life insurance or annuity (includes personal, business or group life)
a. in force or applications pending in any company?..... ☐YES ☐NO
b. which will be replaced, changed, or borrowed against because of this application?..... ☐YES ☐NO

Provide details to "Yes" answers below and submit appropriate replacement forms.

Name of Company	Date of Issue	Life Amount	Personal/Business	Accidental Death Amount	To be replaced?

HERITAGE YOUTH PROTECTOR

NOTICE OF INFORMATION PRACTICES

This Notice Must be Given to Applicant at Time of Application.
This Notice is not Part of the Application.

INSURANCE INFORMATION PRACTICES. We will rely primarily on the information you give to us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

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

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Investors Heritage Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

PERSONAL HISTORY INTERVIEW. We may conduct a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the information on the application is correct. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to help determine your eligibility for insurance.

CONTESTABILITY. You are strongly urged to review the completed application for accuracy. A claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost or denied.

YOUR RIGHTS TO ACCESS AND CORRECTION. You can obtain access to personal information about you contained in our policy files, including a copy of any investigative consumer report, by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

FRAUD 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.

Payment Receipt

Received from _____

this ____ day of _____,_____ **(month, year)** the sum of $_____ being the payment of _____ month(s) premium. The insurance applied for shall not take effect until payment of the first full premium, approval by the Company, delivery of the policy or policies while the health condition of any Proposed Insured and other factors affecting insurability are as stated in this application, all of which must occur during the lifetime of the Insured. In the event the application is declined, any payment made by the applicant will be returned.

Agent's Signature: _____

Make checks or money orders payable to Investors Heritage Life Insurance Company.
Do not make checks or money orders payable to agent or leave payee blank.

Medical

1. Within the past 10 years, has any Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:
   a. Any birth defects or mental abnormality? ☐YES ☐NO
   b. Heart Murmur, Diabetes, Cerebral Palsy, Cystic Fibrosis, Muscular Dystrophy, or Multiple Sclerosis ? ☐YES ☐NO
   c. Any other illness or condition, which requires periodic medical care other than regular medical examinations, immunizations, or treatment of childhood diseases? ☐YES ☐NO
2. Has any Proposed Insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐YES ☐NO
3. Is any Proposed Insured hospitalized, confined to any mental or medically related institution or hospice, or awaiting surgery; or has any Proposed Insured been hospitalized in the past six months? ☐YES ☐NO

If any answer is "Yes", please provide details below, identifying the child by name. (Attach additional sheet if more space is needed)

_____

_____

Agreement and Medical Authorization

I have read, or had read to me, the above questions and my answers to them. To the best of my knowledge and belief, my answers are complete, true, and accurate. All questions were asked of me and if applicable, the parent(s) or guardian(s) of any children listed in this application.
I understand a separate policy will be issued for each approved Insured.
I understand that Investors Heritage Life Insurance Company, hereafter called "Company", does not give any agent or person other than an officer of the Company authority to waive any answer or otherwise modify this application.

Medical Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB, Inc. or other organization, institution, or person, that has any record or knowledge of any proposed insured's health, to give to Company or its representative or its reinsurers any such information. I understand that the information will be used to determine a Proposed Insured's eligibility for insurance. I authorize the Insurance Company or its reinsurers to disclose personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program.

A copy of this authorization shall be as valid as the original. This authorization is valid for 24 months from the date signed. My authorized representative or I may request a copy of this authorization, and I can revoke this authorization by written notice to the Company.

Fraud 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.

AGENT'S STATEMENT:
Does any Proposed Insured now have any life insurance or annuity in force with any company? ❑ Yes ❑ No
(If "Yes", complete and submit appropriate replacement forms)

I, the undersigned agent, certify (1) I have witnessed the signature of the Applicant and any Proposed Insured, if different. (2) I have asked all questions and truthfully and accurately recorded all the answers contained herein.

X_____
Signature of Agent — Agent Number

_____ _____
Printed Name of Agent — Date: (MM/DD/YYYY)

INSURED/OWNER'S STATEMENT: This application has been completed in my presence and all questions have been asked by the Agent and answered by me to the best of my knowledge and belief.

X_____
Signature of Owner/Applicant

X_____
Signature of Co-Owner/Applicant

X_____
Signature of Any Proposed Insured at or above the age of majority

_____
Signed in City and State — Date: (MM/DD/YYYY)

PREAUTHORIZED TRANSFER (PAT)

I hereby request and authorize Investors Heritage Life Insurance Company, Frankfort, Kentucky ("Investors Heritage") to make preauthorized transfers from my bank account by way of draft, check, or electronic transfer for the payment of premiums for this policy. This authorization shall be subject to the following conditions:

1. The preauthorized transfer shall occur on or after the premium due dates unless otherwise specified;
2. Investors Heritage shall not incur any liability on any transfer returned by the bank;
3. Amounts not honored by the bank after initial deposit shall constitute non-payment of premium and coverage shall lapse subject to all provisions of each policy;
4. This authorization may be revoked by either party upon 30 days advance written notice, and Investors Heritage may immediately revoke this request if any preauthorized transfer is dishonored by the bank when presented.

Renewal premiums will be debited on MONTHLY mode.

Date — **Depositor's Printed Name as it appears on bank records** — **Depositor's Signature**

Name of Bank — **Bank or branch address**

Complete the following OR submit a voided check.

Account Type:
❑ Checking
❑ Savings

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Routing Number ☐☐☐☐☐☐☐☐☐☐☐☐

APPLICATION FOR REINSTATEMENT

Instructions: Complete separate reinstatement application for each covered person.

INVESTORS HERITAGE *Life Insurance Company*

PO Box 717 ▪ Frankfort, KY 40602-0717 ▪ Phone: 800.422.2011 ▪ Fax: 502.875.7084
E-mail: ihlic@ihlic.com ▪ www.investorsheritage.com

INSURED INFORMATION

Insured's Name (First, Middle Initial, Last)

Policy Number(s): | E-mail Address

Primary Mailing Address | City | State | Zip Code

Phone Number Including Area Code ☐ Home ☐ Work ☐ Mobile | Phone Number Including Area Code ☐ Home ☐ Work ☐ Mobile | Best Time To Call ☐ AM ☐ PM | Time Zone

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, SINCE THE POLICY DATE OF THIS POLICY:

1. Have you been diagnosed by a member of the medical profession as having a terminal illness or a life expectancy of 12 months or less? ☐ YES ☐ NO
2. Do you need assistance performing any activities of daily living such as eating, bathing, dressing, or toileting or are you currently hospitalized or confined to a wheelchair, bed, nursing home, or long-term care facility or receiving Hospice care? ☐ YES ☐ NO
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)? ☐ YES ☐ NO
4. Have you had a heart, lung, or liver transplant or has one been recommended to you? ☐ YES ☐ NO
5. Are you currently receiving kidney dialysis or using oxygen to assist in breathing, or have you been advised by a member of the medical profession to have any medical test (except those tests related to the Human Immunodeficiency Virus (AIDS virus)), hospital or nursing facility confinement, or psychiatric or home health care and not done so? ☐ YES ☐ NO
6. Have you been diagnosed by a licensed member of the medical profession as having a brain tumor, heart attack, stroke, transient ischemic attack (TIA), or have you been treated for or been advised by a member of the medical profession to have brain, heart or circulatory surgery? ☐ YES ☐ NO
7. Within the past 5 years, have you been admitted to or confined in a hospital? ☐ YES ☐ NO
8. Have you been diagnosed or been treated by a member of the medical profession or, are you taking medication for any of the following:
   a. Alzheimer's disease, dementia, Parkinson's disease, Down's Syndrome, Lou Gehrig's disease (ALS), Multiple Sclerosis (MS), seizure disorder, depression, neurological disorders or any other disorder of the brain or nervous system? ☐ YES ☐ NO
   b. Stroke, transient ischemic attack (TIA), heart disease or disorder, heart attack, chest pain, angina, irregular heartbeat, high blood pressure, congestive heart failure (CHF) or any procedure to improve circulation to the heart or brain? ☐ YES ☐ NO
   c. Liver disease, renal insufficiency, kidney transplant, or kidney failure? ☐ YES ☐ NO
   d. Diabetes with uncontrolled blood pressure, diabetes requiring more than 60 units of insulin daily, or any complication of diabetes including amputation, numbness, eye or kidney disorder, coma or insulin shock, or uncontrolled blood sugars? ☐ YES ☐ NO
   e. Emphysema, chronic lung disease, chronic bronchitis, chronic asthma, Chronic Obstructive Pulmonary Disease (COPD), black lung or Tuberculosis? ☐ YES ☐ NO
9. Have you had a member of the medical profession diagnose, treat, prescribe medication, or recommend treatment including office visits, inpatient treatment, medications, or surgery for alcohol or drug abuse, internal cancer, Leukemia or melanoma (excluding basal/squamous cell skin cancers)? ☐ YES ☐ NO
10. Have you used tobacco products or products containing nicotine in the past 12 months? ☐ YES ☐ NO
11. Are you currently receiving disability payments? If "Yes", indicate reason: _____
12. Have you plead guilty to or been convicted of a felony? ☐ YES ☐ NO
13. Within the past 24 months, have you received two or more citations for moving traffic violations or been convicted of driving under the influence of alcohol or drugs? ☐ YES ☐ NO
14. Driver's License Number _____ State of: _____
15. Have you been engaged in or expect to engage in within the next two (2) years: aviation activities other than a fare paying passenger on commercial airlines, motor racing in any form, scuba diving, hang-gliding, cave exploration, parachuting, mountain climbing, rodeo, bungee jumping or ballooning? ☐ YES ☐ NO
16. Height: _____ft. and ____ inches Weight: _____ lbs.
17. Consulted or been treated by any physician or practitioner or had any physical impairment, sickness, injury, surgery or mental disorder not mentioned above? ☐ YES ☐ NO
18. Had any life or health insurance declined, postponed, or rated or refused reinstatement or renewal? ☐ YES ☐ NO
19. Within the past 12 months, have you been continuously at work, and able to perform all the duties of your normal occupation (except for normal pregnancy)? If "No", provide details on reverse side. ☐ YES ☐ NO

GIVE COMPLETE DETAILS FOR "YES" #1-18 ANSWERS ON FRONT PAGE AND DETAILS IF #19 ANSWERED "NO":

Question Number	Date(s)	DETAILS: Condition, operations performed, hospitalization, medications, or any other details	Names and address of doctors, hospitals, clinics or other medical professionals

CONTESTABILITY

You are strongly urged to review the completed reinstatement application for accuracy. A claim may be denied if the reinstatement application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost or denied.

AGREEMENT & AUTHORIZATION

I (We) represent that all statements and answers in this application are full, complete and true to the best of my (our) knowledge and belief. I (we) understand that said statements and answers are submitted as evidence of insurability of each person insured under the policy. It is agreed that this policy will not be reinstated and the company will have no liability until (1) all money required for reinstatement of this policy has been paid; (2) this application has been approved by Investors Heritage Life Insurance Company during the lifetime of all persons who would be insured under this policy if reinstated. It is further agreed that with regard to the statements and answers provided above, any period of contestability provided in the policy shall run anew from the effective date of reinstatement.

I authorize any licensed physician, doctor, medical practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, MIB, Inc., viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other organization, institution or person, that has any records or information about me to release such records or information to the Insurance Company, reinsurers or its authorized representative when this authorization or a copy of it is shown. All sources but the MIB, Inc. may give such records or information to agencies that the Insurance Company has hired to retrieve the information. The purpose for which this information is being collected is to consider your application for reinstatement of insurance. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by you or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment or enrollment on whether this Authorization is signed.

I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program.

This authorization shall be valid for 24 months from the date shown below. A photographic copy shall be as valid as the original. I have the right to revoke this authorization at anytime by sending a revocation in writing to Investors Heritage Life Insurance Company, Underwriting Department, PO Box 717, Frankfort, KY 40602-0717. I have received a copy of the Notice of Information Practices.

FRAUD 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.

SIGNATURES OF INSURED / OWNER (S)

X) _____
Signature of Insured (or Parent if Insured is minor)

Signed at _____ _____
(City, State) (Month, Day, Year)

X) _____
Signature of Witness (Required if Insured is also sole Owner)

X) _____
Printed name of Witness (Required if Insured is also sole Owner)

X) _____
Signature of Owner if other than Insured (Always Required)

X) _____
Signature of Co-Owner if other than Insured
(Always Required if applicable)

NOTICE OF INFORMATION PRACTICES

This Notice is to be Retained by Insured
(Including MIB Notice and Fair Credit Reporting Act Notice)

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

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Investors Heritage Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

We or our reinsurer(s), may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom a claim is submitted.

In addition, we may get an investigative report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report. Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

If you need any assistance, please feel free to contact your agent or call or write to us at Investors Heritage Life Insurance Company, Underwriting Department, PO Box 717, Frankfort, KY 40602-0717.

Doorway to Your Heritage

INVESTORS HERITAGE LIFE INSURANCE COMPANY
200 Capital Avenue Post Office Box 717
Frankfort, KY 40602-0717
Phone: 800.422.2011 Fax: 502.875.7084
Email: ihlic@ihlic.com Web: www.investorsheritage.com

State: *Arkansas* **Filing Company:** *Investors Heritage Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *HYP APP 2012*
Project Name/Number: *2012 HYP & Reinst. APP/*

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	see attached		
Attachment(s):			
AR Compliance Certification.pdf AR Readability Certification.pdf			

INVESTORS HERITAGE *Life Insurance Company*
PO Box 717 Frankfort KY 40602-0717
1-800-422-2011
investorsheritage@ihlic.com

Certificates of Compliance

Re: Form ICC12-HYP-APP
Form ICC12-21001

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

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

Julie A. Hunsinger, FSA, MAAA
Vice President & Chief Actuary
November 8, 2012

READABILITY CERTIFICATION

INVESTORS HERITAGE LIFE INSURANCE COMPANY
SERFF Tracking Number IHLI-128760804
NAIC Number 64904

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

Form Number	Description	Flesch Score
ICC12-HYP-APP	Heritage Youth Protector Life Insurance Application	50.0
ICC12-21001	Reinstatement Application	51.1

November 8, 2012
Date

Signature of President or designated representative

Julie Hunsinger, FSA, MAAA
Name of Person signing above

Vice President & Chief Actuary
Title of person signing above