

**State:** Arkansas **Filing Company:** Monumental Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** ADR10 AR, CR13, L122 1012M, L123 1012M  
**Project Name/Number:** Senior Market Final Expense/L086-2

### Filing at a Glance

Company: Monumental Life Insurance Company  
Product Name: ADR10 AR, CR13, L122 1012M, L123 1012M  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 12/17/2012  
SERFF Tr Num: AEGB-128806459  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: ADR10 AR, CR13, L122 1012M, L123 1012M  
  
Implementation: On Approval  
Date Requested:  
Author(s): Theresa Meyers, Jenny Larsen  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 12/19/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

State: Arkansas  
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
Product Name: ADR10 AR, CR13, L122 1012M, L123 1012M  
Project Name/Number: Senior Market Final Expense/L086-2

Filing Company: Monumental Life Insurance Company

**General Information**

Project Name: Senior Market Final Expense  
Project Number: L086-2  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: filed concurrently  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 12/19/2012  
State Status Changed: 12/19/2012  
Created By: Jenny Larsen  
Corresponding Filing Tracking Number: 3Y001008

Deemer Date:  
Submitted By: Jenny Larsen

Filing Description:  
Commissioner of Insurance  
Arkansas Department of Insurance

Attn.: Policy Examination Division (Individual Life)

RE: NEW SUBMISSION  
MONUMENTAL LIFE INSURANCE COMPANY NAIC#: 468-66281  
Form Numbers: ADR10 AR - Accidental Death Benefit Rider  
CR13 – Child/Grandchild Rider  
L 122 1012M – Individual Life Application  
L 122 1013M – Individual Life Application

Dear Sir/Madam:

Please find attached copies of the above referenced forms. These are new forms and are not intended to replace any forms previously approved by your Department. These forms have been submitted in final printed form in which they will be distributed to Insureds. These forms are subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officers' signatures.

ADR10 AR, Accidental Death Benefit Rider – This rider will be available only on the WL08 AR Whole Life Insurance Policy when the applicant chooses the level to age 121 premium paying period. This rider must have a face amount equal to the base policy. Accidental Death is defined as loss of life that, directly and independently of all other causes, results solely from an accidental bodily injury. The death must occur prior to termination of this rider and within 90 days of the accidental bodily injury.

CR13, Child/Grandchild Rider – This rider will be available only on the WL08 AR Whole Life Insurance Policy when the applicant chooses the level to age 121 premium paying period. This rider provides term insurance on each child and/or grandchild named in the application. The issue age of the Insured must be between 15 days and 17 years, and the issue age of the parent/grandparent must be between issue ages 18-75. The face amount must be the same for all children/grandchildren covered under this rider. The rider terminates on the rider anniversary following the child/grandchild's 25th birthday.

Individual Life Application – Form L 122 1012M is for applicant ages 45 and up and will be used with the WL08 AR Whole Life Insurance Policy and WL09 AR Whole Life Insurance Policy with Graded Death Benefit concurrently filed here, and also with

---

**State:** Arkansas **Filing Company:** Monumental Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** ADR10 AR, CR13, L122 1012M, L123 1012M  
**Project Name/Number:** Senior Market Final Expense/L086-2

our life portfolio..

Individual Life Application – Form L 123 1012M is for applicant ages 0-44 and will be used with the WL08 AR Whole Life Insurance Policy and WL09 AR Whole Life Insurance Policy with Graded Death Benefit concurrently filed here, and also with our life portfolio.

We also plan to make these application forms available electronically. It is our intent to use these application forms in a variety of electronic environments, including a laptop and web based application process. Regardless of the application process used, we intend to adopt measures to secure both the integrity of the documents once signed, and the confidentiality of any information transmitted, including transmission of information via a secured socket layer/secured line. The information contained in the applications will be transmitted to our administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions act, and to the extent applicable, the Federal ESIGN Act.

We hereby certify that any electronic signature we obtain will be linked to the date on the electronic applications in such a manner that the electronic signatures are invalidated if any of the data on the applications is changed. We also certify that such electronic signature intended for use with these applications will not be affixed to or duplicated on any other document.

A copy of the application, identical to the filed form, will be printed and made part of any policy issued.

These policies will be marketed through our agent field force, and are designed for clients who desire and will benefit from the purchase of a fixed premium whole life policy. We have not identified any specific market for these products.

We would appreciate your review and approval of these forms.

Sincerely,

MONUMENTAL LIFE INSURANCE COMPANY

Jenny Larsen  
Supervisor  
Contract Development  
Phone: (319) 355-7430 (collect)  
Fax: (213) 355-2501  
Jenny.larsen@transamerica.com

## Company and Contact

### Filing Contact Information

Jenny Larsen, jenny.larsen@transamerica.com  
4333 Edgewood Road NE 319-355-7430 [Phone]  
Cedar Rapids, IA 52499 319-355-8320 [FAX]

**State:** Arkansas **Filing Company:** Monumental Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** ADR10 AR, CR13, L122 1012M, L123 1012M  
**Project Name/Number:** Senior Market Final Expense/L086-2

**Filing Company Information**

Monumental Life Insurance Company  
 4333 Edgewood Road NE  
 Cedar Rapids, IA 52499  
 (319) 355-7888 ext. [Phone]

CoCode: 66281  
 Group Code: 468  
 Group Name:  
 FEIN Number: 52-0419790

State of Domicile: Iowa  
 Company Type:  
 State ID Number:

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? No  
 Fee Explanation: AR Filing fee is \$50.00 per form X 4 forms = \$200.00  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Monumental Life Insurance Company	\$200.00	12/17/2012	65841249

---

**SERFF Tracking #:** AEGB-128806459      **State Tracking #:**      **Company Tracking #:** ADR10 AR, CR13, L122 1012M, L123 1012M

---

**State:** Arkansas      **Filing Company:** Monumental Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** ADR10 AR, CR13, L122 1012M, L123 1012M  
**Project Name/Number:** Senior Market Final Expense/L086-2

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/19/2012	12/19/2012

**SERFF Tracking #:**

AEGB-128806459

**State Tracking #:****Company Tracking #:**ADR10 AR, CR13, L122 1012M, L123  
1012M**State:**

Arkansas

**Filing Company:**

Monumental Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

ADR10 AR, CR13, L122 1012M, L123 1012M

**Project Name/Number:**

Senior Market Final Expense/L086-2

## Disposition

Disposition Date: 12/19/2012

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	Actuarial Memorandum		No
Supporting Document	ADR10 AR and CR13 Premium Rates		Yes
Supporting Document	Statement of Variability		Yes
Form	Accidental Death Benefit Rider		Yes
Form	Children's and Grandchildren's Benefit Rider		Yes
Form	Individual Life Application		Yes
Form	Individual Life Application		Yes

SERFF Tracking #:

AEGB-128806459

State Tracking #:

Company Tracking #:

ADR10 AR, CR13, L122 1012M, L123  
1012M

State:

Arkansas

Filing Company:

Monumental Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

ADR10 AR, CR13, L122 1012M, L123 1012M

Project Name/Number:

Senior Market Final Expense/L086-2

## Form Schedule

Lead Form Number: ADR10 AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Accidental Death Benefit Rider	ADR10 AR	POLA	Initial		50.800	ADR10 AR (ML).pdf
2		Children's and Grandchildren's Benefit Rider	CR13	POLA	Initial		53.200	CR13 (M).pdf
3		Individual Life Application	L122 1012M	AEF	Initial		50.700	L122 1012M.pdf
4		Individual Life Application	L123 1012M	AEF	Initial		50.700	L123 1012M.pdf

### Form Type Legend:

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



Monumental Life Insurance Company  
Home Office: Cedar Rapids, IA  
Administrative Office:  
[4333 Edgewood Rd NE  
Cedar Rapids, IA 52499]  
[(800) 238-4302]

(Referred to as the Company, we, our or us)

### ACCIDENTAL DEATH BENEFIT RIDER

<b>Rider Benefit</b>	If the Insured dies while insured under this rider and the death is an Accidental Death as defined in this rider, we will pay the face amount of this rider as set forth below. The face amount of this rider is shown in the Policy Data. Payments are subject to the provisions of the policy and this rider.
<b>Payment of Proceeds</b>	Any proceeds payable under this rider will be paid to the Beneficiary under the policy. Any proceeds may be applied under the Settlement Provisions of the policy.
<b>Definitions</b>	<p><b>Accidental Bodily Injury</b> means an injury that is the direct cause, independently of sickness or disease, of the Insured's Accidental Death.</p> <p><b>Accidental Death</b> means loss of life that, independently of sickness or disease, results solely from an Accidental Bodily Injury. The death must occur within 90 days of the Accidental Bodily Injury.</p> <p><b>Insured</b> means only the Insured under the policy to which this rider is attached. It does not include any other individuals covered under other riders.</p>
<b>Risks Not Covered</b>	<p>No benefits will be payable under this rider if the Insured's Accidental Bodily Injury or death is caused by or contributed to by, or results directly or indirectly, wholly or in part, from:</p> <ol style="list-style-type: none"><li>1. Suicide or any attempted suicide or self-inflicted injury, while sane or insane.</li><li>2. Intoxication as defined by the jurisdiction in which the accident occurred.</li><li>3. An infection except when caused directly by Accidental Bodily Injury.</li><li>4. Disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity.</li><li>5. The voluntary intake or use by any means of:<ol style="list-style-type: none"><li>a. Any drug, unless administered in accordance with a physician's advice and written instruction; or</li><li>b. Any poison or gas voluntarily or involuntarily, accidentally or otherwise taken, administered, absorbed or inhaled.</li></ol></li><li>6. The commission of, or attempt to commit, a felony.</li><li>7. Travel in or descent from any kind of aircraft except as a passenger on a regularly scheduled commercial aircraft.</li><li>8. Active participation in a riot, insurrection or terrorist activity.</li><li>9. War, declared or undeclared, or any act of war.</li><li>10. Riding or driving an air, land or water vehicle in a race, speed or endurance contest.</li><li>11. Participation in an illegal occupation or activity.</li><li>12. Bungee jumping or mountain or rock climbing.</li><li>13. Hang-gliding, skydiving, parachuting, ultra light soaring, ballooning, or parasailing.</li></ol>

Any defense of a claim under this rider based on the Risks Not Covered shall not be construed to be a contest of this rider.

<b>Notice of Claim</b>	Notice of claim must be given to us at our Administrative Office. Such notice should be made within 30 days after any loss covered by the rider unless it is not reasonably possible to give notice within that time period.
<b>Proof of Loss</b>	Written proof of loss must be given to us at our Administrative Office. Proof must be sent within 90 days after the date of such loss. If it was not reasonably possible to give notice and/or written proof in the time required, we shall not reduce or deny the claim for this reason if the notice and/or proof are filed as soon as reasonably possible. In any event, the notice and proof required must be given no later than one year after the date of such loss unless the claimant was legally incapacitated.
<b>Autopsy</b>	We have the right to have an autopsy performed at our expense, unless prohibited by law.
<b>Non-Convertible</b>	This rider is not convertible.
<b>Termination</b>	This rider will terminate on the earliest of the following dates or events: <ol style="list-style-type: none"> <li>1. The Policy Anniversary at the Insured's Age 80.</li> <li>2. The death of the Insured.</li> <li>3. The next Monthly Anniversary Date following the date you request termination of this rider</li> <li>4. The date the policy Lapses.</li> <li>5. The date the policy is surrendered or continued under any nonforfeiture option.</li> <li>6. The date the policy matures or terminates.</li> </ol> <p>Any premium paid for any period after the date of termination of this rider shall create no liability for us, nor will it constitute a waiver of the termination. Any premium paid for this rider following its termination will be refunded to you.</p>
<b>Reinstatement</b>	If the policy is Reinstated, this rider may be reinstated at the same time.
<b>Consideration</b>	We have issued this rider in consideration of the application and the payment of the premium for this rider.
<b>Premiums</b>	The charges for this rider are shown in the Policy Data and are payable as provided in the policy. No charges for this rider will be payable after this rider terminates.
<b>Incontestability</b>	The provisions of the policy relating to incontestability apply to this rider. However, if this rider is added after the Date of Issue of the policy, the contestable period will be measured from the later of the Rider Date or the date this rider is reinstated.
<b>No Dividends are Payable</b>	This rider does not participate in our profits or surplus.
<b>Nonforfeiture Values</b>	This rider does not have cash values or loan values.

**Rider Date**

The Rider Date of this rider will be the Policy Date, unless we inform you in writing of a different date.

Signed for us at our home office.



[

[Secretary]



[

[President]



Monumental Life Insurance Company  
Home Office: Cedar Rapids, IA  
Administrative Office:  
[4333 Edgewood Rd NE  
Cedar Rapids, IA 52499]  
[(800) 238-4302]

(Referred to as the Company, we, our or us)

### CHILDREN'S AND GRANDCHILDREN'S BENEFIT RIDER

We have issued this rider as a part of the policy to which it is attached. Except as otherwise specifically set forth below, it is subject to all of the terms of the policy.

**Rider Benefit** If a covered child dies while insured under this rider, we will pay the face amount of this rider as set forth below. The face amount of this rider is shown in the Policy Data. Payments are subject to the provisions of the policy and this rider.

**Limitation of Coverage** The maximum amount payable on the life of one covered child under all riders issued by us or our affiliates covering children or grandchildren of an insured is limited to \$5,000. If we reduce the amount payable under this rider because of this limitation, we will refund the premiums attributable to the amount of the reduction.

**Payment of Proceeds** Unless you request otherwise, any proceeds payable under this rider will be paid to you. You may request that any proceeds will be paid to a beneficiary other than you by:

1. Naming the beneficiary in accordance with the How to Change a Beneficiary provision of the policy; and
2. Specifically stating that the beneficiary designation is applicable to insurance provided under this rider.

Any proceeds may be applied under the Settlement Provisions of the policy.

**Definitions** **Age** has the meaning described in the policy.

**Insured** means the Insured under the policy to which this rider is attached. It does not include any other individuals covered under other riders.

**Child or grandchild of the Insured** means a person who is the natural child, stepchild or legally adopted child (a) of the Insured, or (b) of a natural child, stepchild or legally adopted child of the Insured.

**Covered child** means a child or grandchild of the Insured who is named on the application for this rider and who:

1. is between the age of 15 days old and 17 years old on the date coverage is effective under this rider; and
2. is not excluded by us.

Covered child also includes a person who becomes a child or grandchild of the Insured after the Rider Date, if you meet all of the requirements of the Adding a Covered Child provision and we approve such coverage.

No coverage is provided under this rider for any person unless that person is named in the application for this rider or we confirm to you in writing that the person has been added as a covered child.

No coverage is provided for any person we exclude.

**Adding a Covered Child**

If a person becomes a child or grandchild of the Insured after the Rider Date, you may request that he or she be included as a covered child under this rider. To add a covered child, you must send us a Written Request to us within 60 days of the date the person becomes a child or grandchild of the Insured, together with such additional information as we may require in order to confirm the child is then living and is eligible for coverage under this rider.

In order to be approved by us as a covered child, a person must be at least 15 days old but not yet 18 years old at the time of your Written Request. The effective date of coverage for any person added as a covered child is the date of our confirmation of your request to add such person.

No more than nine children or grandchildren of the Insured may be covered under this rider.

**Conversion**

You may convert the coverage on a covered child to a new policy of permanent insurance we make available at that time for such purpose as follows:

1. At any time after coverage for that covered child has been in effect for at least two years and prior to the covered child's 22nd birthday; or
2. On the death of the Insured while this rider is in effect and prior to the covered child's 22nd birthday.

**Request and Payment of Premium** – The new policy will be issued upon Written Request for conversion and payment of the required premium. The Written Request must be made by the owner of the policy to which this rider is attached, if living; otherwise, it must be signed by the person who is to be the owner of the new policy. We must receive the Written Request for conversion and payment of the required premium before, or within 31 days after the covered child's 22nd birthday; or within 90 days after the death of the Insured.

**Face Amount** – The face amount of the new policy may not exceed the face amount of this rider and may not be less than our published minimum for the plan selected. There will always be a plan available in an amount to which you can convert.

**Effective Date** - The new policy will be dated as of the date of the conversion. Coverage under this rider will terminate when coverage under the new policy begins. If this rider or insurance on a covered child has terminated and has not yet been converted, no insurance will be in effect under this rider or any new policy during the period between the date coverage terminates and the effective date of the new policy.

**Ownership** – The child or grandchild will be the owner of the new policy unless the child or grandchild is a minor as defined under the laws of the child's or grandchild's state of residence at the time of the conversion request. If the child or grandchild is a minor at the time of the conversion request, you will be the owner of the new policy unless you request otherwise. If you are not living at the time of conversion, the legal guardian of the child or grandchild will be the owner.

**Premiums** – The premiums for each new policy will be at our published rate for the plan selected and the child's or grandchild's age at the time of conversion. Even if premiums for this rider are being waived under a rider attached to the policy at the time of conversion, the premiums under any new policy will not be waived.

**Additional Terms** – If coverage under this rider is converted in accordance with these conditions, the amount of insurance converted will not be subject to the new policy's suicide and contestability periods.

<b>Termination</b>	<p>This rider will terminate on the earliest of the following dates or events:</p> <ol style="list-style-type: none"> <li>1. The death of the Insured; or</li> <li>2. The next Monthly Anniversary Date following the date you request termination of this rider; or</li> <li>3. The date the policy Lapses; or</li> <li>4. The date the policy is surrendered or continued under any nonforfeiture option; or</li> <li>5. The date the policy matures or terminates; or</li> <li>6. The date the policy is converted to another policy.</li> </ol> <p>Insurance on a covered child under this rider will terminate on the earliest of the following dates or events:</p> <ol style="list-style-type: none"> <li>1. The Policy Anniversary on or following such child's or grandchild's 25th birthday; or</li> <li>2. The date insurance for that child is converted to a new policy; or</li> <li>3. The death of that child or grandchild.</li> </ol> <p>Any premium paid for any period after the date of termination of this rider or insurance on a covered child shall create no liability for us, nor will it constitute a waiver of the termination. Any premium paid for this rider following its termination or termination of insurance on a covered child will be refunded to you.</p>
<b>Reinstatement</b>	If the policy is reinstated, this rider may be reinstated at the same time.
<b>Consideration</b>	We have issued this rider in consideration of the application and payment of the premiums.
<b>Premiums</b>	Separate charges are payable for each covered child. These charges are shown in the Policy Data or in the letter we send confirming coverage for a covered child. No charges for this rider will be payable after this rider terminates.
<b>Incontestability</b>	The provisions of the policy relating to incontestability apply to this rider. However, if this rider is added after the Date of Issue of the policy, the contestable period will be measured from the later of the Rider Date or the date this rider is reinstated.
<b>Suicide</b>	The suicide provision of the policy will not apply to death of a covered child by suicide.
<b>Misstatement of Age</b>	If a child's or grandchild's date of birth is not correctly stated and the correct date of birth would have affected that person's eligibility for coverage under this rider or would have resulted in termination of that person's coverage prior to that person's death, our liability under this rider for that person will be limited to an amount equal to the premiums paid for such person during the period of ineligibility.
<b>No Dividends are Payable</b>	This rider does not participate in our profits or surplus.
<b>Nonforfeiture Values</b>	This rider does not have cash values or loan values.

**Rider Date**

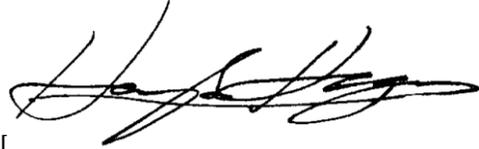
The Rider Date of this rider will be the Policy Date, unless we inform you in writing of a different date.

Signed for us at our home office.



[

[Secretary]



[

[President]

<b>Part A1 – Producer</b>				
Name	Producer ID	Split %	Profile	
Name	Producer ID	Split %	Profile	
Name	Producer ID	Split %	Profile	
<b>Part A2 – Plan &amp; Rider Information</b>				
Plan	Face Amount \$	Total Premium \$		
Rate Class applied for:				
<input type="checkbox"/> Preferred Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Standard Non-Tobacco <input type="checkbox"/> Standard Tobacco <input type="checkbox"/> Graded				
Accidental Death Benefit Rider? (If yes, Accidental Death Benefit Rider will equal base amount) <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				
Child / Grandchild Rider? \$ _____ (Add Child / Grandchild information to the Supplemental Information to the Application for Life Insurance) <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				
<b>Part A3 – Proposed Insured</b>				
Name (First, M.I., Last, Suffix)			Address, City, State, Zip Code (cannot be a P.O. Box)	
D.O.B. (MM/DD/YYYY)		U.S. State or Country of Birth		Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No
				If "NO," what Country? _____
Gender	SSN	Phone Number for Interview (    )	Best time to call a.m.                      p.m.	If "NO," are you a legal U.S. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
				If "YES," VISA type and number _____
				If "NO," you are not eligible for coverage.
<b>Part A4 – Owner (If Other Than Proposed Insured)</b>				
Name (First, M.I., Last, Suffix)			Address, City, State, Zip Code (cannot be a P.O. Box)	
Phone Number (    )	D.O.B. (MM/DD/YYYY)	Gender	Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				If "NO," what Country? _____
SSN	Relationship to Insured		If "NO," are you a legal U.S. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				If "YES," VISA type and number _____
				If "NO," you are not eligible for coverage.
<b>Part A5 – Beneficiary (Please use the Supplemental Information form if additional room is needed)</b>				
Primary Name (First, M.I., Last, Suffix)		D.O.B. (MM/DD/YYYY)	SSN	Percentage
				Relationship to Insured
Contingent Name (First, M.I., Last, Suffix)		D.O.B. (MM/DD/YYYY)	SSN	Percentage
				Relationship to Insured
<b>Part A6 – Existing Insurance</b>				
Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				
Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				
If yes, submit the state required forms and please provide company name and policy number. _____				
Is this to be a 1035 exchange? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				



<b>Part C1</b>	
Within the last 12 months has the proposed Insured used tobacco products in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If a policy cannot be issued as applied for, would you accept a rated policy if available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes,' adjust face amount to premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Part C2 – If Any Question In This Section Is Answered “Yes”, The Proposed Insured Is Not Eligible For Any Coverage.</b>	
1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care, or has the proposed Insured been advised or is the proposed Insured planning to have inpatient surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Has the proposed Insured <b>ever</b> :	
a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's, dementia, memory loss, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, cystic fibrosis, cerebral palsy or been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Received or been advised to receive an organ transplant other than corneal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Within the past <b>2 years</b> has the proposed Insured:	
a) Had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Undergone testing by a medical professional for which the results have not been received or been advised to have any surgical operation, diagnostic testing other than for routine screening purposes, treatment, hospitalization or other procedure which has not been done?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Part C3</b>	
4) Has the proposed Insured been diagnosed with diabetes (other than gestational diabetes) before the age of 18?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Within the past <b>4 years</b> has the proposed Insured had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Within the past <b>1 year</b> has the proposed Insured:	
a) Used illegal drugs or been diagnosed with, been treated for or been advised to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs), or muscular dystrophy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Had more than 12 seizures; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Had, been diagnosed with, been treated for or advised to receive treatment for aneurysm or angina; or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Had a heart attack, stroke (CVA) or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Used oxygen to assist in breathing (including Sleep Apnea); received kidney dialysis; or had, been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7) Within the past 2 years has the proposed Insured used a wheelchair or electric scooter? If answering yes to this question and the reason(s) for the wheelchair or scooter use was/is for a reason that is expected to resolve, please provide details on the Supplemental Information to the Application for Life Insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>• If all questions in Part C3 are answered “No,” proceed to Part C4.</li> <li>• If one question in Part C3 is answered “Yes,” the proposed Insured is potentially eligible for the Graded Death Benefit product, proceed to Part C5.</li> <li>• If two or more questions in Part C3 are answered “Yes,” the proposed Insured is not eligible for any coverage.</li> </ul>	
<b>Part C4</b>	
8) Within the past <b>2 years</b> has the proposed Insured:	
a) Had, been diagnosed with, been treated for or advised to receive treatment for angina (chest pain); aneurysm; vascular, circulatory or blood disorder; heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or irregular heart rhythm such as atrial fibrillation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Had a heart attack, stroke (CVA) or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Had more than 12 seizures; used insulin; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Used illegal drugs or been diagnosed with, been treated for or been advised to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9) Within the past <b>4 years</b> has the proposed Insured had, been diagnosed with, been treated for or advised to receive treatment for kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10) Has the proposed Insured <b>ever</b> been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>• If all questions in Part C4 are answered “No,” the proposed Insured is potentially eligible for the Preferred product, proceed to Part C5.</li> <li>• If one question in Part C4 is answered “Yes,” the proposed Insured is potentially eligible for the Standard product, proceed to Part C5.</li> <li>• If two or more questions in Part C4 are answered “Yes,” the proposed Insured is potentially eligible for the Graded Death Benefit product.</li> </ul>	
<b>Part C5 – Nursing Home Option - If The Following Question Is Answered “Yes”, The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.</b>	
Does the proposed Insured need any assistance from other persons in performing any activities of daily living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**AGREEMENT / AUTHORIZATION**

**ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S)** –Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company, or its reinsurers, any such information. I authorize the Company, or its reinsurers, to make a brief report of my personal/protected health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization will be valid for 30 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force.

**I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.**

**FRAUD WARNING:** 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.

Signed Date \_\_\_\_\_ Signed at City \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_  
Proposed Insured Signature

\_\_\_\_\_  
Owner Signature (If Owner other than Insured)

\_\_\_\_\_  
Producer Signature

**If the EFT premium payment method is chosen, please tape a voided check in this box.**

### NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

### MONUMENTAL LIFE INSURANCE COMPANY

Home Office: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]

### MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Monumental 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 (TTY 866-346-3642). 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, MA 02184-8734.

Monumental 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](http://www.mib.com).

01/13

### CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

#### Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required must be paid and any check, Authorization for Electronic Funds Transfer (EFT), payroll deduction or allotment given in payment must be honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium rates or amount of coverage.

#### Effective Date

If all of the above conditions are met, insurance in the amount applied for or \$50,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed Insured dies prior to a future date selected for draft of the initial premium or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

**Agent Instructions: Please leave this page with the Proposed Insured/Owner**

## Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### Additional Information

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers

### Additional Information

### Child / Grandchild Rider Information

Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN

### Contingent Owner

Name (First, M.I., Last, Suffix)	SSN	Gender	Relationship to Insured	Phone Number ( )	D.O.B. (MM/DD/YYYY)
Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)				Are you a citizen of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what country?	

Signed Date \_\_\_\_\_ Signed at City \_\_\_\_\_ State \_\_\_\_\_

Proposed Insured Signature \_\_\_\_\_

Owner Signature (If Owner other than Insured) \_\_\_\_\_

Producer Signature \_\_\_\_\_

<b>Part A1 – Producer</b>			
Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile

<b>Part A2 – Plan &amp; Rider Information</b>		
Plan	Face Amount \$	Total Premium \$
Rate Class applied for: <input type="checkbox"/> Preferred Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Preferred Juvenile <input type="checkbox"/> Standard Non-Tobacco <input type="checkbox"/> Standard Tobacco <input type="checkbox"/> Standard Juvenile <input type="checkbox"/> Graded		
Accidental Death Benefit Rider? (If yes, Accidental Death Benefit Rider will equal base amount) <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
Child / Grandchild Rider? \$ _____ (Add Child / Grandchild information to the Supplemental Information to the Application for Life Insurance) <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		

<b>Part A3 – Proposed Insured</b>					
Name (First, M.I., Last, Suffix)			Address, City, State, Zip Code (cannot be a P.O. Box)		
D.O.B. (MM/DD/YYYY)		U.S. State or Country of Birth		Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If "NO," what Country? _____	
Gender	Height	Weight	SSN	If "NO," are you a legal U.S. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.	
Driver's License Number		State	Phone Number for Interview (    )		Best time to call a.m.                      p.m.
Occupation					

<b>Part A4 – Owner (If Other Than Proposed Insured)</b>					
Name (First, M.I., Last, Suffix)			Address, City, State, Zip Code (cannot be a P.O. Box)		
Phone Number (    )		D.O.B. (MM/DD/YYYY)		Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If "NO," what Country? _____	
SSN		Relationship to Insured		If "NO," are you a legal U.S. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.	

<b>Part A5 – Beneficiary (Please use the Supplemental Information form if additional room is needed)</b>					
Primary Name (First, M.I., Last, Suffix)		D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured
Contingent Name (First, M.I., Last, Suffix)		D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured

<b>Part A6 – Existing Insurance</b>	
Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, submit the state required forms and please provide company name and policy number. _____	
Is this to be a 1035 exchange?	<input type="checkbox"/> Yes <input type="checkbox"/> No



<b>Part C1</b>	
Within the last 12 months has the proposed Insured used tobacco products in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If a policy cannot be issued as applied for, would you accept a rated policy if available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes,' adjust face amount to premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Part C2 – If Any Question In This Section Is Answered “Yes”, The Proposed Insured Is Not Eligible For Any Coverage.</b>	
1) Is the proposed insured currently:	
a. Hospitalized or bedridden; or been advised, planning or scheduled to have inpatient surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. On parole or probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Within the past <b>2 years</b> has the proposed insured:	
a. Had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than Basal Cell carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Had a stroke (CVA), transient ischemic attack (TIA), heart attack, cardiovascular surgery including bypass, angioplasty, stent implant or pacemaker implant; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Used a wheelchair or electric scooter? If answering yes to this question and the reason(s) for the wheelchair or scooter use was/is for a reason that is expected to resolve, please provide details on the Supplemental Information to the Application for Life Insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Used oxygen to assist in breathing (including oxygen use for Sleep Apnea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Used illegal drugs (other than marijuana); or been diagnosed with, been treated for or advised to receive treatment for alcoholism, alcohol use/abuse or drug use/abuse (including prescription drugs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Undergone testing by a medical professional for which the results have not been received; or been advised to have any surgical operation, diagnostic testing (other than for routine screening purposes), treatment, hospitalization or other procedure that has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Resided in a nursing home, assisted or long term care facility; or received hospice or home health care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Been diagnosed with Crohn's disease, Multiple Sclerosis or Parkinson's disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Had, been diagnosed with, been treated for or advised to receive treatment for Hepatitis C, Tuberculosis (TB) or Lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Been incarcerated; or been convicted of a felony or misdemeanor; or been convicted of 2 or more DUI's/DWI's or 3 or more moving violations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Has the proposed insured <b>ever</b> :	
a. Had, been diagnosed with, been treated for or been advised to receive treatment for Alzheimer's, dementia, memory loss, any cognitive disorder, organic brain disease, mental incapacity, Lou Gehrig's (ALS), Downs Syndrome, Huntington's, Spina Bifida not surgically corrected, Sickle Cell anemia, Cystic Fibrosis or Cerebral Palsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Received or been advised to receive an implanted defibrillator or an organ transplant (other than corneal)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Part C3 - For All Questions Answered “Yes” In This Section Give Details On The Supplemental Information To The Application.</b>	
1) Does the proposed Insured take any prescription medication? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
2) Within the last <b>10 years</b> , has the proposed Insured had or received medical treatment for any of the following conditions:	
Any disease or disorder of the blood, heart or circulatory system such as heart attack, stroke or transient ischemic attack (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney/Liver/Digestive Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental/Nervous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer/Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, last reading: _____ / _____ Medication: _____	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, age at onset: _____ Medication: _____ Avg. blood sugar reading: _____	
3) Within the last <b>5 years</b> , has the proposed Insured:	
a) Had one or more DUI(s), been charged with, or convicted of a felony OR been on probation/parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Illegally used any drug or controlled substance or been treated/counseled for drug or alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Part C4 – Nursing Home Option - If The Following Question Is Answered “Yes”, The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.</b>	
Does the proposed Insured need any assistance from other persons in performing any activities of daily living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

**AGREEMENT / AUTHORIZATION**

**ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S)**—Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company, or its reinsurers, any such information. I authorize the Company, or its reinsurers, to make a brief report of my personal/protected health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization will be valid for 30 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force.

**I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.**

**FRAUD WARNING:** 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.

Signed Date \_\_\_\_\_ Signed at City \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_  
Proposed Insured Signature  
( Insured age 15 and over must sign)

\_\_\_\_\_  
Signature of Parent or Legal Guardian  
(if Proposed Insured is Under 18 years of age)

\_\_\_\_\_  
Owner Signature (If Owner other than Insured)

\_\_\_\_\_  
Producer Signature

**If the EFT premium payment method is chosen, please tape a voided check in this box.**

### NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

### MONUMENTAL LIFE INSURANCE COMPANY

Home Office: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]

### MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Monumental 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 (TTY 866-346-3642). 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, MA 02184-8734.

Monumental 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](http://www.mib.com).

01/13

### CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

#### Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required must be paid and any check, Authorization for Electronic Funds Transfer (EFT), payroll deduction or allotment given in payment must be honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium rates or amount of coverage.

#### Effective Date

If all of the above conditions are met, insurance in the amount applied for or \$50,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed Insured dies prior to a future date selected for draft of the initial premium or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

**Agent Instructions: Please leave this page with the Proposed Insured/Owner**

## Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### Additional Information

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers

### Additional Information

### Child / Grandchild Rider Information

Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN

### Contingent Owner

Name (First, M.I., Last, Suffix)	SSN	Gender	Relationship to Insured	Phone Number ( )	D.O.B. (MM/DD/YYYY)
Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)				Are you a citizen of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what country?	

Signed Date \_\_\_\_\_ Signed at City \_\_\_\_\_ State \_\_\_\_\_

Proposed Insured Signature  
( Insured age 15 and over must sign)

Signature of Parent or Legal Guardian  
(if Proposed Insured is Under 18 years of age)

Owner Signature (If Owner other than Insured)

Producer Signature

**SERFF Tracking #:**

AEGB-128806459

**State Tracking #:****Company Tracking #:**ADR10 AR, CR13, L122 1012M, L123  
1012M**State:**

Arkansas

**Filing Company:**

Monumental Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

ADR10 AR, CR13, L122 1012M, L123 1012M

**Project Name/Number:**

Senior Market Final Expense/L086-2

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):	Flesch Score Cert (ML).pdf AR - Bulletin 11-83.pdf AR - Cert of Compliance 23-79-138.pdf AR - Cert of Regulation 49.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	ADR10 AR and CR13 Premium Rates		
Comments:			
Attachment(s):	ADR10 Premiums - AR.pdf CR13 Child Rider Premiums.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):	ADR10 et al Statement of Variability (ML).pdf		

**MONUMENTAL LIFE INSURANCE COMPANY**  
**FLESCH READABILITY CERTIFICATION**

<b><u>Form Number (may vary by State)</u></b>	<b><u>Flesch Score</u></b>
ADR10	50.8
CR13	53.2
L 122 1012M	50.7
L 123 1012M	50.7

I certify that the machine scored Flesch Readability score(s) for the above mentioned form(s) is/are accurate.

*Cheryl Bock*

---

Cheryl Bock, Assistant Vice President of Contract Development

**MONUMENTAL LIFE INSURANCE COMPANY**

**BULLETIN 11-83  
STATE OF ARKANSAS**

Form Number: ADR10 AR, CR13, L122 1012M, L123 1012M

Date: December 15, 2012

I hereby certify that the accompanying life product is in compliance with Bulletin 11-83.

*Cheryl Bock*

\_\_\_\_\_  
Cheryl Bock, Assistant Vice President, Contract Development

12/15/12  
Date

**MONUMENTAL LIFE INSURANCE COMPANY**

**CERTIFICATION OF  
ARKANSAS INSURANCE CODE  
23-79-138**

**Policy Number:** ADR10 AR, CR13, L122 1012M, L123 1012M

**Date:** December 15, 2012

I hereby certify that the accompanying life product is in compliance with Arkansas Insurance Code 23-79-138.

*Cheryl Bock*

---

Cheryl Bock, Assistant Vice President, Contract Development

MONUMENTAL LIFE INSURANCE COMPANY

CERTIFICATION OF REGULATION 49  
STATE OF ARKANSAS

Form Number: ADR10 AR, CR13, L122 1012M, L123 1012M

Date: December 15, 2012

This is submitted in Compliance with Regulation 49 of the Arkansas Insurance Code.

I hereby certify that the accompanying life product is in compliance with Regulation 49 in that a Life and Health Guaranty Association notice will be given to each policy owner at the time of issue.

*Cheryl Bock*

---

Cheryl Bock, Assistant Vice President, Contract Development

10/11/2012

**Accidental Death Benefit ( ADR10 ) Annual Premium Rates per Unit**

<u>Issue Age</u>	<u>Male</u>	<u>Female</u>
18	2.20	2.20
19	2.21	2.21
20	2.22	2.22
21	2.23	2.23
22	2.24	2.24
23	2.26	2.26
24	2.27	2.27
25	2.28	2.28
26	2.29	2.29
27	2.30	2.30
28	2.31	2.31
29	2.32	2.32
30	2.33	2.33
31	2.34	2.34
32	2.35	2.35
33	2.37	2.37
34	2.38	2.38
35	2.39	2.39
36	2.41	2.41
37	2.43	2.43
38	2.45	2.45
39	2.48	2.48
40	2.50	2.50
41	2.52	2.52
42	2.54	2.54
43	2.56	2.56
44	2.59	2.59
45	2.61	2.61
46	2.63	2.63
47	2.65	2.65
48	2.67	2.67
49	2.71	2.71
50	2.73	2.73
51	2.76	2.76
52	2.79	2.79
53	2.84	2.84
54	2.89	2.89
55	2.95	2.95
56	3.01	3.01
57	3.08	3.08
58	3.16	3.16
59	3.25	3.25
60	3.33	3.33
61	3.44	3.44
62	3.56	3.56
63	3.71	3.71
64	3.86	3.86
65	4.03	4.03
66	4.24	4.24

67	4.49	4.49
68	4.79	4.79
69	5.09	5.09
70	5.46	5.46

**Children's Benefit Rider (CR13) Annual Premium Rates per Unit**

10/21/2012

<u>Issue Age</u>	<u>Male</u>	<u>Female</u>
0-17	2.00	2.00

**MONUMENTAL LIFE INSURANCE COMPANY  
STATEMENT OF VARIABILITY**

**FORM: L122 1012M, L123 1012M, ADR10, and CR13**

We have bracketed the variable items in these forms. No change in the variability will be made which in any way expands the scope of the wording. Stonebridge Life Insurance Company and Monumental Life Insurance Company reserve the right to correct, at any time, any and all typographical errors that do not impact the benefits or intent of language.

**L122 1012M – Application for Individual Life Insurance**

1. **Mailing Address** (page 1): This may change to another location in the future.
2. **Underwriting Department Address** (page 5): This may change to another location in the future.
3. **No Debit Cards Please** (page 2): This option may be available in the future.

**L123 1012M – Application for Individual Life Insurance**

1. **Mailing Address** (page 1): This may change to another location in the future.
2. **Underwriting Department Address** (page 5): This may change to another location in the future.
3. **No Debit Cards Please** (page 2): This option may be available in the future.

**ADR10 – Accidental Death Benefit Rider**

1. **Home Office Address** (page 1, header): This may change to another location in the future.
2. **Administrative Office Address** (page 1, header): This may change to another location.
3. **Telephone Number** (page 1, header): This may change to another number.
4. **Signed for the Company at** (page 2, last paragraph): This may change to another location.
5. **Officer Signatures and Titles** (page 2): These may change in the future. In the event the title of an officer signing the rider form changes, any new title will be the title of an officer of the company.

**CR13 – Children’s and Grandchildren’s Benefit Rider**

1. **Administrative Office Address** (page 1, header): This may change to another location.
2. **Telephone Number** (page 1, header): This may change to another number.
3. **Officer Signatures and Titles** (page 4): These may change in the future. In the event the title of an officer signing the rider form changes, any new title will be the title of an officer of the company.