

State: Arkansas **Filing Company:** Reassure America Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: RALIC Plan Change Reinst Appl
Project Name/Number: RALIC Plan Change Reinst Appl/RALIC Plan Change Reinst Appl

Filing at a Glance

Company: Reassure America Life Insurance Company
Product Name: RALIC Plan Change Reinst Appl
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 12/17/2012
SERFF Tr Num: CMPL-128816510
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: RALIC PLAN CHANGE REINST APPL

Implementation
Date Requested:
Author(s): Nancy French
Reviewer(s): Linda Bird (primary)
Disposition Date: 12/20/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: Reassure America Life Insurance Company
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General Information

Project Name: RALIC Plan Change Reinst Appl Status of Filing in Domicile:
Project Number: RALIC Plan Change Reinst Appl Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 12/20/2012
State Status Changed: 12/19/2012
Deemer Date: Created By: Nancy French
Submitted By: Nancy French Corresponding Filing Tracking Number:

Filing Description:
Re: Reassure America Life Insurance Company
NAIC #70211-0181
FEIN #23-6200031

Individual Life Insurance Forms:
RPCR APP 2.0 Application
UND QST 2.0 Supplemental Underwriting Questionnaire
Life SOI 2.0 Statement of Insurability

Dear Commissioner/Director:

Compliance Research Services is pleased to submit the enclosed forms on behalf of Reassure America Life Insurance Company. A letter of filing authorization is enclosed.

Approval is requested on a general basis. These are new forms and will not replace any existing forms on file with your Department. The forms will be used with individual life insurance policies previously approved by your Department. The policies comprise a closed block of business. The enclosed forms will be used to administer changes in the closed block. They will be used to request changes in policies or for policy reinstatement. They include an application for plan change or reinstatement, a statement of insurability and a supplemental underwriting questionnaire.

The underlined and bracketed language is intended to be variable. We will insert the Company's administrative office address and telephone number in the address and telephone number fields. All "John Doe" information that may vary from applicant to applicant is intended to be variable. The Fair Credit Reporting Act and Authorization for Release of Personal Information (HIPAA) Notices are filed as variable so they may be revised based upon revised federal law or regulation impacting such notices. The MIB, Inc. Notice is filed as variable so it may be revised in accordance with changes required by the MIB, Inc. The fraud notices are also submitted as variable so that they may be changed without refiling in the event a state-specific notice requires modification due to a change in law or regulation.

We have included any certifications and transmittals required by your state. If you have any questions concerning this filing, please contact me at the phone number or email address shown below.

Sincerely,

State: Arkansas Filing Company: Reassure America Life Insurance Company
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J. David Simon, CLU
 President
 513-984-6050
 dsimon@crssolutionsgroup.com

Company and Contact

Filing Contact Information

Nancy French, Product Manager nfrench@crssolutionsgroup.com
 10921 Reed Hartman Highway 513-984-6050 [Phone]
 Suite 334 513-984-7212 [FAX]
 Cincinnati, OH 45242

Filing Company Information

(This filing was made by a third party - complianceresearchservicesllc)
 Reassure America Life Insurance CoCode: 70211
 Company Group Code:
 1670 Magnavox Way Group Name: Swiss Re
 Fort Wayne, IN 46804 FEIN Number: 23-6200031
 (513) 984-6050 ext. [Phone]

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: \$50 per fomr x 3 forms
 Per Company: No

Company	Amount	Date Processed	Transaction #
Reassure America Life Insurance Company	\$150.00	12/17/2012	65843823

SERFF Tracking #:

CMPL-128816510

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

RALIC PLAN CHANGE REINST APPL

State:

Arkansas

Filing Company:

Reassure America Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/20/2012	12/20/2012
Approved-Closed	Linda Bird	12/19/2012	12/19/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Flesch Certification	Nancy French	12/20/2012	12/20/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Please re-open this filing	Note To Filer	Linda Bird	12/20/2012	12/20/2012
Please re-open this filing	Note To Reviewer	Nancy French	12/20/2012	12/20/2012

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Disposition

Disposition Date: 12/20/2012

Implementation Date:

Status: Approved-Closed

Comment: Company has updated the certification form on the original submission.

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		No
Supporting Document	Authorization Letter		Yes
Form	Application Form		Yes
Form	Supplemental Underwriting Questionnaire		Yes
Form	Statement of Insurability		Yes

SERFF Tracking #:

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

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Disposition

Disposition Date: 12/19/2012

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Comment:

Rate data does NOT apply to filing.

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Supporting Document (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		No
Supporting Document	Authorization Letter		Yes
Form	Application Form		Yes
Form	Supplemental Underwriting Questionnaire		Yes
Form	Statement of Insurability		Yes

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Amendment Letter

Submitted Date: 12/20/2012

Comments:

We have attached updated certification forms for this submission, signed by a current officer of the insurer. Please let us know if you have any questions.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes

Satisfied - Item:	Flesch Certification
Comments:	
Attachment(s):	
General Readability Cert.pdf.pdf	
<i>Previous Version</i>	
<i>Satisfied - Item:</i>	<i>Flesch Certification</i>
<i>Comments:</i>	
<i>Attachment(s):</i>	
<i>READABILITY CERTIFICATION - signed - g.pdf</i>	

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Note To Filer

Created By:

Linda Bird on 12/20/2012 11:55 AM

Last Edited By:

Linda Bird

Submitted On:

12/20/2012 11:55 AM

Subject:

Please re-open this filing

Comments:

Filing has been re-opened in order for correction to be made.

State: Arkansas **Filing Company:** Reassure America Life Insurance Company
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Note To Reviewer

Created By:

Nancy French on 12/20/2012 11:33 AM

Last Edited By:

Nancy French

Submitted On:

12/20/2012 11:33 AM

Subject:

Please re-open this filing

Comments:

We respectfully request this filing be re-opened so that we may attach an updated certification form. Please let us know if you have any questions.

State: Arkansas

Filing Company:

Reassure America Life Insurance Company

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Form Schedule

Lead Form Number: RPCR App 2.0

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application Form	RPCR App 2.0	AEF	Initial		45.000	RPCR App 2_0 - John Doe-Clean 10082012.pdf
2		Supplemental Underwriting Questionnaire	UND QST 2.0	AEF	Initial		71.000	UND QST 2_0 - Chgs Marked.pdf
3		Statement of Insurability	Life SOI 2.0	AEF	Initial		54.000	Life SOI 2.pdf

Form Type Legend:

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

POLICYOWNER PLAN CHANGE / REQUEST FOR REINSTATEMENT

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana
 Administrative Office:
 [Post Office Box 9000]
 [Coppell, Texas 75019-9000]

PART I

INSTRUCTIONS:

- Check for Action Requested
- Indicate to what address items should be returned.
- Mail this form (and policy if required) to Administrative Office.
- For Change of Beneficiary or Owner, complete a separate form

SIGNATURE REQUIREMENTS:

- Insured, if age 16 or older
- Owner, if other than the Insured
- Spouse, if Community Property State
- Assignee, if policy is assigned
- Corporate officer with title, if policy is corporate-owned

Policy Number 1234567		Insured (you, your) Jane Doe			
Insured's Address 123 Main Street Anytown, USA 99999		Date of Birth January 1, 1950		Gender	SSN¹ 123-45-6789
		Place of Birth Anytown, USA		<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	
Owner (if other than Insured)		Relationship	Address	City	State Zip Code
Owner SSN¹					
Phone Number of Proposed Insured and Owner (if other than Insured)					
Assignee		Address	City	State	Zip Code Assignee SSN¹ / TIN¹
<i>i. This application will not be processed without a valid Insured's Social Security Number (SSN) & Owner's SSN or Tax ID Number.</i>					
Beneficiary		Relationship	Address	City	State Zip Code
Contingent Beneficiary		Relationship	Address	City	State Zip Code
Return all items to: <input checked="" type="checkbox"/> Owner <input type="checkbox"/> General Agency <input type="checkbox"/> Other (specify)					
Type of Original Policy			Action Requested		
<input checked="" type="checkbox"/> Traditional Term or Whole Life Insurance <input type="checkbox"/> Flexible Premium Adjustable Life Insurance (Universal Life) <input type="checkbox"/> Interest Sensitive Whole Life Insurance <input type="checkbox"/> Other _____			<input type="checkbox"/> Face Amount Increase \$ _____ to \$ _____ <input type="checkbox"/> Face Amount Decrease \$ _____ to \$ _____ <input type="checkbox"/> Rate Class Change - Non-Smoker class <input checked="" type="checkbox"/> Policy Reinstatement <input type="checkbox"/> Add Rider (if permitted under terms of original policy) <input type="checkbox"/> Delete Rider <input type="checkbox"/> Change Death Benefit Option from _____ to _____ <input type="checkbox"/> Other		
Copy of Policy			Billing Type		
<input checked="" type="checkbox"/> Attached <input type="checkbox"/> Original Policy has been lost or destroyed.			<input checked="" type="checkbox"/> Direct <input type="checkbox"/> List bill <input type="checkbox"/> Bank Draft <input type="checkbox"/> Government Allotment <input type="checkbox"/> Non-bill		
Billing Mode			Relationship to Owner and Insured		
<input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly					
Payor (if other than Owner)					
Payor Address and Phone Number					

Special Instructions

PART II – (Not required for Face Amount Decreases and/or Deleting Rider)

Print first name, middle initial, & last name	Relationship To Proposed Insured	Date of Birth			Age Nearest Birthday	State of Birth	Sex	Height		Weight	
		Mo	Day	Yr				Ft	In	Now	Yr ago
1. a. Proposed Insured: Jane Doe	n/a	01	01	50	59	IL	F	5	9	125	125
b. Second Proposed Insured:											
2. Proposed Insured's Occupation:	Occupational Duties:										

3. Riders Available (If checked below ^{ii.})	Elect Coverage	Delete	Increase	Decrease	New Account
<input type="checkbox"/> Accidental Death & Dismemberment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> Waiver of Premium for Total Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> Other Insured Term Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> Children's Term Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$

ii. You may only elect Riders that were available under the terms of your original Policy.

Complete for Other Insured Term Rider or Children's Term Rider.

Print first name, middle initial, and last name.	Relationship To Proposed Insured	Date of Birth			Age Nearest Birthday	State of Birth	Sex	Height		Weight	
		Mo	Day	Yr				Ft	In	Now	Yr ago
4. a. John Doe	Spouse										
b. Sally Doe	Child										
c. Tommy Doe	Child										

Beneficiary Designation for Other Insured Rider (if applicable) Relationship Address City State Zip Code

Beneficiary Designation for Children's Term Rider (if applicable) Relationship Address City State Zip Code

5. Does any person proposed for coverage currently use any tobacco product?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If "YES", what form of tobacco product? ^{iii.} <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine Patch/Gum Name: _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine Patch/Gum Name: _____
Has any person proposed for coverage ever used any tobacco product?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If "YES", what form of tobacco product? ^{iii.} <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine Patch/Gum Name: _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine Patch/Gum Name: _____ What date were tobacco products last used? ^{iii.} Name: _____ Date: _____ Name: _____ Date: _____

iii. Tobacco questions must be answered for the Proposed Insured and each person proposed for coverage. If responding on behalf of more than 2 proposed insureds, include additional information in the comment section on page 4.

PART II – Continued

Give details in “Comments” section following the questions for any ‘YES’ answers to questions 5 through 18.

6. Within the past 5 years, has any person proposed for coverage:	
a. Been treated, examined or advised by member of the medical profession?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
b. Been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. Been an inpatient or outpatient in a hospital, clinic or medical facility, or any similar entity?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
d. Had any surgical operations or procedures?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
e. Had diagnostic tests such as: an electrocardiogram (EKG) or X-ray, except those related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
f. Made a claim for or received benefits or compensation for any injury, sickness, disability or impaired condition. <i>If “YES”, provide the date claim filed, type of benefits claimed, amounts and dates of payments received, contact information for the payor of the benefits, type of injury, sickness, disability or impaired condition, duration of these, and contact information for treating physician.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
g. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home? <i>If “YES”, provide explanation of inability or confinement; name, address and telephone number of medical professional or facility consulted; diagnosis; treatment prescribed; medications prescribed; date of onset and recovery.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. Has any person proposed for coverage ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:	
a. Any disease or disorder of the brain or nervous system, including but not limited to, severe headaches, fainting spells, dizziness, vertigo, syncope, epilepsy, nervousness, paralysis, mental disorder or depression?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. Any disease or disorder of the heart, blood vessels or circulatory system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. Any disease or disorder of the respiratory system, including but not limited to, tuberculosis, asthma, pleurisy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
d. Any disease or disorder of the stomach, liver, intestines, rectum, gall bladder, pancreas, spleen or abdominal organs?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
e. Any disease or disorder of the genito-urinary organs, including but not limited to, albumin, pus, blood or sugar in urine, urinary stone, or other disease of the kidneys, bladder or prostate, the reproductive organs?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
f. Any disease or disorder of the muscles, joints or skeletal system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
g. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
h. Any disease or disorder of the blood, skin, thyroid, lump or other glands?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
i. Rheumatic or other fever, diabetes, syphilis, gout, arthritis or goiter?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
j. Hernia or rupture, hemorrhoids or varicose veins?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
k. Any psychiatric or mental health disorder or disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
l. Any gynecological disorders or diseases?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
m. Any cancer, tumor, cyst or nodule?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
n. Any sexually transmitted disorders or diseases?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
o. Any disorders or diseases of the immune system except those related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. Has any person proposed for coverage:	
a. Been diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi’s Sarcoma or Pneumocystis Carinii Pneumonia?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. Been diagnosed by a member of the medical profession as having Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
[Residents of Delaware and South Dakota need not respond]	
c. Tested positive for Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9. Is any person proposed for coverage now pregnant? - <i>If “YES”, provide the child’s expected due date in “Comments”.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10. Is any person proposed for coverage now under medical treatment, taking any prescription drugs or on a prescribed diet?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11. Does any person proposed for coverage have any intention to travel outside the United States or Canada within the next two years?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

PART II – Continued

12. Does any person proposed for coverage have any intention to reside outside the United States or Canada within the next two years? For purposes of this application, the term “reside” means an individual who is absent from the United States or Canada for more than 180 consecutive days and has established a residence in a foreign country during that period.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13. Has any person proposed for coverage ever flown, or intends within the next two years to fly, other than as a fare paying passenger on a scheduled airline?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
14. Has any person proposed for coverage engaged in, or intend to engage in, underwater diving, hang gliding or parachuting, mountain or rock climbing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
15. Has any person proposed for coverage engaged in, or intend to engage in, competitive racing of any kind?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16. Has a proposed insured ever:	
a. Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, marijuana, or other habit forming drugs, except as prescribed by a physician;	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs; or	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
17. Has any person proposed for coverage:	
a. Had a driver’s license suspended or revoked?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. Plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of alcohol or any drug?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. Within the last 5 years, plead guilty to or been convicted of any moving violation or been involved in any accident in which the proposed insured was found to be at fault?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
18. Has any person proposed for coverage ever plead guilty to or been convicted of a felony or misdemeanor or do they have such charge currently pending against them?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
19. Does any person proposed for coverage have a parent or sibling diagnosed or treated by a member of the medical profession for certain conditions, such as heart or vascular disease, cancer, diabetes, high blood pressure, kidney disease, attempted suicide or mental illness? <i>If “YES”, provide details below.</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Family Member	Age(s) (if living)	Condition Treated	Age(s) at Death	Cause of Death
Father	77	Heart Disease		
Mother	73	Cancer		
Sister	54	Diabetes		
Brother	47	High Blood Pressure		
Sister	45	Kidney Disease		

COMMENTS:

If you answered “YES” to any of questions shown above, list the question number and item(s) that you are referring to, dates/duration, diagnosis, physician name and address, phone number & name of the health care facility.

6a. Routine Physical – September, 2012; Dr. George Smith, 444 Main St., Anytown, USA 00000

11. Employment transferred to Cancun, Mexico

HOME OFFICE CHANGES:

This section is for Home Office use only and may include amendments, corrections or additions. Any change in plan of insurance, amount, age at issue, gender, class or benefits shall require completion of a new application.

IMPORTANT NOTICES

For purposes of this application, Reassure America Life Insurance Company will be referred to as “the Company”, “we”, “us” or “our”.

NOTICE TO UNITED STATES RESIDENTS UNDER FAIR CREDIT REPORTING ACT

We would like to explain a part of our underwriting process that is frequently misunderstood. You are entitled to know that, as part of our routine selection procedure, we may request an investigative consumer report (“report”) concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured.

If we request a report and you want: 1) additional information about the nature and scope of the report; or 2) to be interviewed in connection with the report; or 3) to receive a copy of the report; please make a written request to the **Servicing Office, [insert address]**. Please include the name of your agent as well as your own full name, date of birth and return address.

In order to provide the best possible products on the most favorable basis, it is necessary for us to be somewhat selective in issuing our policies. We sincerely believe that the consumer investigative report is an essential and proper tool to assist us in meeting these mutual objectives. We will do our best to serve you both now and in the future. Please call us any time at our toll-free number: **[insert toll free number]**. You may obtain a written summary of your rights under the Fair Credit Reporting Act online at www.ftc.gov/credit or by writing to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580.]

NOTICE REGARDING MIB, INC.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. ("MIB") 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 about you 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 (TTY 886 346-3642). If you question the accuracy of the 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.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you 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.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.]

FRAUD NOTICE

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

AGREEMENT

I declare to the best of my knowledge and belief the foregoing statements and answers are complete and true and have been made to induce the Company to issue, change or reinstate the above referenced policy. No information will be considered to have been given to the Company unless it is included herein or on a Supplemental Underwriting Questionnaire.

I agree that the policy shall not be changed until the Company has received payment of all premiums in arrears and has formally approved the application. I further agree to accept a return of any payments made in connection with this application for change or reinstatement should the Company decline any policy change or reinstatement.

I further agree that if the Company approves this application for issue, change or reinstatement, such approval shall be based upon the above statements and answers, which shall be deemed to be representations and not warranties. I further agree as an express condition of such change, that if any such representation is untrue in whole or in part, and is material, the Company shall be under no liability by reason of any change or reinstatement, except to return all premiums paid in connection with and subsequent to any such change or reinstatement; but on the condition that any change or reinstatement shall be incontestable after the same period following any such change or reinstatement and with the same conditions and exceptions as provided in the policy with respect to the incontestability thereof. It is understood that, unless otherwise provided, the reinstatement of a policy reinstates interests of any assignees, beneficiaries or owners.

I understand that if making a policy change, unless the change will be to the same plan of insurance, no disability benefits will be allowed for any condition existing at the present time. If the above policy is to be surrendered with this service request, I hereby surrender the policy for cancellation and agree that this request together with the application for the original policy shall constitute the application for any new policy and that the original application shall be changed only to the extent provided by this service request.

I request that all transactions marked above be completed by the Company and agree on behalf of myself and all of my heirs, beneficiaries, assignees and any others claiming under the above policy to release, indemnify and hold the Company harmless from any liability incurred because of completing the above transactions.

I expressly warrant that all persons signing below are of legal age and that no proceedings in bankruptcy are pending against any of them.

[AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

This authorization complies with the HIPAA Privacy Rule and applies to each undersigned. Please read carefully and sign below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers"), to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Reassure America Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

I also authorize any insurance or reinsuring company, the MIB, Inc., employer or any other organization, institution, person, consumer reporting agency, or insurance support organization that has any personal (medical or non medical) information of mine or my minor children to release such information, including the entire medical record without restriction if requested, to the Company, its agents, employees and representatives. I also authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health insurance.

This authorization shall remain valid for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at [insert address]. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization, which I have signed and will retain for my records.]

SIGNATURES

I have read this Policyowner Plan Change / Request for Reinstatement Application and all notices included herein, and all statements and answers are true and complete to the best of my knowledge and belief.

Dated at (City and State) Anytown, USA, this 12th Day of September, 2012.

Proposed Insured (if age 16 or over) or Legal Representative &
Legal Representative's Authority / Relationship to Proposed Insured

Owner (if not Proposed Insured) and relationship & Title of
Officer Signing as Owner if Owner is Corporation, Partnership, Trust

Witness (not related) or Agent

Assignee

Spouse (Required if Community Property State)

Telephone Number of Proposed Insured (day) (555) 555-9999 (night) (555) 555-0001

An Agent does not have the Company's authorization to accept risk, approved evidence of insurability, or make, void, waive or change any conditions or provisions of this application or policy.

Servicing Agent's Name John Smith	Agency Code 00001	Agent Code 0000123	Agent's Phone Number 555-555-1234
---	-----------------------------	------------------------------	---

IMPORTANT NOTICES

Please retain this page for your records. This is your copy of the Important Notices appearing on the Plan Change / Request for Reinstatement Application. For purposes of this application, Reassure America Life Insurance Company will be referred to as "the Company", "we", "us" or "our".

NOTICE TO UNITED STATES RESIDENTS UNDER FAIR CREDIT REPORTING ACT

We would like to explain a part of our underwriting process that is frequently misunderstood. You are entitled to know that, as part of our routine selection procedure, we may request an investigative consumer report ("report") concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured.

If we request a report and you want: 1) additional information about the nature and scope of the report; or 2) to be interviewed in connection with the report; or 3) to receive a copy of the report; please make a written request to the **Servicing Office, [insert address]**. Please include the name of your agent as well as your own full name, date of birth and return address.

In order to provide the best possible products on the most favorable basis, it is necessary for us to be somewhat selective in issuing our policies. We sincerely believe that the consumer investigative report is an essential and proper tool to assist us in meeting these mutual objectives. We will do our best to serve you both now and in the future. Please call us any time at our toll-free number: **[insert toll free number]**. You may obtain a written summary of your rights under the Fair Credit Reporting Act online at www.ftc.gov/credit or by writing to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580.]

NOTICE REGARDING MIB, INC.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. ("MIB") 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 about you 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 (TTY 886 346-3642). If you question the accuracy of the 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.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you 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.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.]

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION - This authorization complies with the HIPAA Privacy Rule and applies to each undersigned. Please read carefully and sign below.

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers"), to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Reassure America Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

I **also authorize** any insurance or reinsuring company, the MIB, Inc., employer or any other organization, institution, person, consumer reporting agency, or insurance support organization that has any personal (medical or non medical) information of mine or my minor children to release such information, including the entire medical record without restriction if requested, to the Company, its agents, employees and representatives. I **also authorize** the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health insurance.

This authorization shall remain valid for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original.

I **have the right to revoke this Authorization in writing**, at any time, by sending a written request for revocation to the Company at **[insert address]**. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization, which I have signed and will retain for my records.]

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE
Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana
Administrative Office:
[Post Office Box 9000]
[Coppell, Texas 75019-9000]

To be completed in full by the Proposed Insured: John Doe

Policy Number: 1234567

The following questions must be fully answered and become part of the evidence of your insurability. This Supplemental Underwriting Questionnaire will become part of your application for insurance.

Attending Physician Questionnaire

Certain medical factors play an important role in our evaluation of your application. To best assess your current medical status, our information has to be as accurate as possible. Therefore, we require further medical information from the physician who treated you or is currently treating you for _____ . Please provide this physician's name, address and telephone number below. Upon receipt of this information, we will contact the physician to request the necessary records.

What is your Doctor's name, address and telephone number?

Doctor's Name

Address

(_____) _____
Telephone

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Alcohol Questionnaire

1. How often do you drink currently?
 Daily Socially Weekly Less than Weekly None

2. How many drinks (glasses, bottles, cans) do (did) you consume at a time? _____

3. What types of alcohol do (did) you drink? Wine Beer Hard Liquor

4. What is the date of last alcohol consumption (month/year): _____/_____/_____

5. Has a counselor or medical professional ever told you to reduce or stop drinking alcoholic beverages? Yes No If yes, provide details:

6. Have you ever been treated or hospitalized for alcohol use? Yes No If yes, when and where:

7. Have you been a member of an alcohol support group? Yes No If yes, provide the name of the group and the last meeting attended:

8. Have you ever had any relapses since treated? Yes No If yes, what was the date of your last relapse (month/year)? _____/_____/_____

9. Have you ever been arrested because of excessive alcohol use or been charged with driving under the influence of alcohol? Yes No If yes, provide details and dates (month/year):

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Aviation Questionnaire

A. Flying Time (Indicate hours as pilot, co-pilot, crew member, or passenger with duties aboard aircraft)

1. How many hours have you logged flying for Pay? Insert hours in the appropriate boxes below.

	1-2 Years Ago	Past 12 Months	Next 12 Months
Scheduled passenger airline			
Employer owned aircraft for employee travel			
Other freight or passenger service			
Crop dusting or aerial spraying			
Flight Instructor			
Other: _____ _____			

2. If you do not fly for Pay, how many hours have you logged for the categories below?

	1-2 Years Ago	Past 12 Months	Next 12 Months
Pleasure			
Personal business transportation			
Student Pilot			
Other: _____ _____			

3. What is your total number of solo hours flown as a pilot? _____

4. What is the date of your last flight? (month/year) ____/____

B. Licenses and Certificates

1. What type of certificate do you now have?

Student Private Commercial ATR

Other; Provide details: _____

2. What date was your certificate/license obtained? (month/year) ____/____

3. Do you have an Instrument Flight Rating (IFR)? Yes No

a) How many hours of instrument flight time have you logged in the past 12 months? _____

4. What other ratings do you have? _____

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

C. Flying Details

1. In what types of aircraft do you fly? (Provide make and model) _____

Description: Fixed-wing Rotorcraft Piston Turboprop Jet
 Single-engine Multi-engine

2. What is the seating capacity? _____

3. Have you flown or do you intend to fly any of the following? Yes No If yes, which ones:

Prototype Experimental Homebuilt/kit Ultra light
 Hang glider Balloon Sailplane

4. Do you participate in aerobatic flying? Yes No If yes, provide details and number of hours per year: _____

5. How much of your flying time is with a qualified co-pilot? _____

6. Have you ever had an aircraft accident, or been grounded, fined, or reprimanded for violation(s) of air regulation? Yes No If yes, provide details: _____

7. Have you flown, or do you intend to fly outside the United States? Yes No If yes, when and where? _____

8. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Avocation Questionnaire

A. Mountain Climbing

1. Which types of climbing do you participate in?

Mountain Climbing Hiking Trail Blazing Rock Climbing

2. Which type of climber are you?

I have a professional climber status I am an amateur climber

3. At what heights do you climb?

I do not climb mountains/rocks I do climb but: under 13,000 feet over 13,000 feet

4. What are the locations of climbs? (Past & Future):

US only (lower 48 states) Africa Alps Andes
 Alaska & Canada, excluding Mt McKinley Mt McKinley Brooks Range
 Himalayas Other; Provide details: _____

5. What is your experience level? Less than 2 years More than 2 years

6. What is your total number of climbs? Less than 6 More than 6

7. What is the date of your last climb? (month/year): ____/____

B. Sky Diving

1. What type of sky diving do you participate in?

Amateur Professional Instructor Stunt
 Other; Provide details: _____

2. What is the number of jumps per year: 0-50 51-100 101-200 201+

3. Do you jump: Static Line Free Fall Exhibition Competition

4. What is the date of your last jump (month/year): ____/____

5. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

C. Ballooning

1. Which types apply?

Tethered Free Flight

2. Do you participate in:

Record Attempts Ocean Crossing Mountain Crossing

Other; Provide details: _____

3. What is your experience level? 0 –34 hours 35+ hours

4. What is the date of your last flight? (month/year) ____/____

5. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

D. Hang Gliding

1. Are you a USGH member? Yes No

2. Are you an amateur status? Yes No

3. Are you an Instructor? Yes No

4. Do you participate in record attempts? Yes No

5. Do you use powered Hang Gliders? Yes No

If No, what are the types of gliders that you use _____

6. What is the date of your last flight? (month/year): ____/____

7. How many times a year do you glide _____

8. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

E. Ultralight

1. Are you a fully licensed airplane pilot? Yes No

2. What types of ultralight do you fly? Commercially produced

Homebuilt and/or an Experimental craft

3. At what altitudes do you fly? Under 3000 feet Over 3000 feet

4. What is the date of your last flight? (month/year): ____/____

5. If a rating is required would you prefer to have an Aviation Exclusion Rider? Yes No

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

F. Other Sports or Avocations

1. Have you in the past or do you currently participate in another sport or avocation?

Describe: _____

2. What is your experience level? Less than 1 year 1-2 years More than 2 years

3. How many times a year do you participate in each activity? _____

4. What is the date of the last activity? (month/year): ____/____

5. Location? _____

6. Do you have a certificate or license? _____

7. Are you a member of any Clubs or Associations? _____

7. Additional Details:

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana
 Administrative Office:
 [Post Office Box 9000]
 [Coppell, Texas 75019-9000]

Drug Questionnaire

1. In the past 10 years, have you used:
- | | Yes | No |
|--|--------------------------|--------------------------|
| a) Cocaine or other stimulants? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Marijuana | <input type="checkbox"/> | <input type="checkbox"/> |
| c) LSD or other Hallucinogenics? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Heroin, Demerol or other narcotics? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Barbiturates, sedatives or tranquilizers? | <input type="checkbox"/> | <input type="checkbox"/> |

2. What drugs have you taken over what time periods and with what frequency?

Drugs	Dates Used		How often
	From	To	

3. What is the date of last drug use (month/year): _____/_____/_____
4. Have you ever been treated or hospitalized for drug use? Yes No If yes, when and where?

5. Have you ever acquired a disease secondary to drug use? Yes No If yes, what disease and when was it diagnosed?

6. Have you ever been a member of a drug rehabilitation support group? Yes No If yes, provide the name of the group and the last meeting attended?

7. Have you ever been arrested because of drug use (including motor vehicle violations)?
 Yes No If yes, provide details and dates (month/year): _____

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Financial Questionnaire

1. What is your current financial situation? Please complete the financial worksheet below. This information is used as part of the evaluation of your life insurance application and is kept strictly confidential.

Assets		Liabilities	
Cash on Hand		Accounts Payable	
Personal Residence		Personal Loans	
Stocks		Mortgages	
Bonds		Other Debts	
Mutual Funds		Total Liabilities	\$
Personal Property		Net Worth <i>(Total Assets & Total Liabilities)</i>	\$
Accounts Receivable & Notes			
Other Real Estate		Earnings	
Business Ownership		Annual Earned Income	
Other Assets		Passive Income <i>(Investments, rent, etc.)</i>	
Total Assets	\$	Total Annual Income	\$

2. Are you the subject of any liens, legal judgments or pending lawsuits? Yes No
3. Have you undergone bankruptcy in the past five years? Yes No If yes, has the bankruptcy been satisfied? Yes No
4. How much life insurance do you have (all policies totaled)? \$ _____

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Foreign Travel/Residence/Citizenship Questionnaire

A. US or Canadian citizens traveling to or residing in a foreign country

1. What countries have you traveled to or resided in the last 5 years: _____

a) What were the reasons for travel/residence: Vacation Business Other _____

b) What was the length of stay? _____

c) What location(s)? (cities, region, etc.): _____

2. What countries do you plan to visit/reside in the next 2 years? _____

a) What are the reasons for travel: Vacation Business Other _____

b) What are the planned dates of departure? (month/year): _____/_____

c) What are the planned lengths of stay? _____

d) What location(s)? (cities, region, etc.) _____

3. Do you have family members who reside outside of the US and Canada Yes No
If yes, where _____

B. Foreign Nationals visiting/residing in US or Canada

1. Of which country or countries are you a citizen? _____

2. How long have you been in the US or Canada? _____

3. What type of visa or alien registration card do you have? _____

4. Do you plan to become a citizen of the US or Canada? Yes No If yes, when? _____

5. If married, is your spouse a US or Canadian citizen? Yes No

6. Do you plan to visit/reside in countries other than the US or Canada in the next 5 years?
 Yes No If yes, provide the purpose and planned length of stay: _____

7. Do you have family members who reside outside of the US and Canada? Yes No
If yes, where _____

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Tobacco Use Questionnaire

1. Do you currently use any of the following tobacco products?

	Yes	No	Number or Quantity Used Per Day
Cigarettes			
Cigars			
Pipe			
Chewing tobacco			
Other:			
_____			_____
_____			_____
_____			_____
_____			_____

2. Have you used any of these tobacco products in the past?

	Yes	No	Number or Quantity Used Daily	Date Last Used (month/year)
Cigarettes				____/____
Cigars				____/____
Pipe				____/____
Chewing tobacco				____/____
Other:				
_____				____/____
_____				____/____
_____				____/____
_____				____/____

3. Are you currently using a prescription or over-the-counter product to help you stop using tobacco?

Yes No If yes, provide the following information:

Name of Product	Length of time you have used product(s)

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE
Reassure America Life Insurance Company

Home Office: Fort Wayne, Indiana
Administrative Office:
[Post Office Box 9000]
[Coppell, Texas 75019-9000]

FRAUD NOTICES

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

[For Residents of All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

SIGNATURE

I represent that all statements and answers made in all parts of this application are complete and true to the best of my knowledge and belief. I agree that this questionnaire shall form a part of my application for insurance.

Proposed Insured

Date

SIGNATURE

I represent that all statements and answers made above are complete and true to the best of my knowledge and belief. I agree that this statement of insurability shall form a part of my application for insurance.

Dated at _____ this _____ day of _____ 20____
City/State

Signed _____ Signed _____
Proposed Insured Policyowner (if other than the proposed insured)

Signed _____
Witness

SERFF Tracking #:

CMPL-128816510

State Tracking #:

Company Tracking #:

RALIC PLAN CHANGE REINST APPL

State:

Arkansas

Filing Company:

Reassure America Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

RALIC Plan Change Reinst Appl

Project Name/Number:

RALIC Plan Change Reinst Appl/RALIC Plan Change Reinst Appl

Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	Authorization Letter		
Comments:			
Attachment(s):			
State Insurance Dept Filing Authorization 11 21 12.pdf			

READABILITY CERTIFICATION
Reassure America – Individual Life

This is to certify that the form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

Score	Form No.	Description
45	RPCR APP 2.0	Application
71	UND QST 2.0	Supplemental Underwriting Questionnaire
54	Life SOI 2.0	Statement of Insurability

REASSURE AMERICA LIFE INSURANCE COMPANY

Signature: 
Name: Julia A. Goatley
Title: Vice President and Secretary
Date: December 19, 2012

Reassure America Life Insurance Company
1670 Magnavox Way, Fort Wayne, Indiana 46791

November 21, 2012

J. David Simon, CLU
President
Compliance Research Services, LLC
10921 Reed-Hartman Highway, Suite 334
Cincinnati, OH 45242

Re: State Insurance Department Filing Authorization

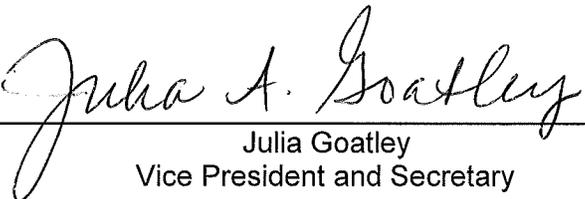
Dear Mr. Simon:

Reassure America Life Insurance Company ("Reassure") authorizes Compliance Research Services, LLC ("CRS") to file on its behalf plan change /reinstatement application forms necessary to administer its closed block of individual life insurance policies.

This letter will serve as authorization from Reassure for employees of CRS to submit insurance department filings and respond to inquiries on our behalf with all state insurance departments and jurisdictions where Reassure is authorized to do business.

Sincerely,

REASSURE AMERICA LIFE INSURANCE COMPANY

By 

Julia Goatley
Vice President and Secretary

State: Arkansas**Filing Company:**

Reassure America Life Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other**Product Name:** RALIC Plan Change Reinst Appl**Project Name/Number:** RALIC Plan Change Reinst Appl/RALIC Plan Change Reinst Appl

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/17/2012	Replaced 12/20/2012	Supporting Document	Flesch Certification	12/20/2012	READABILITY CERTIFICATION - signed - g.pdf (Superseded)

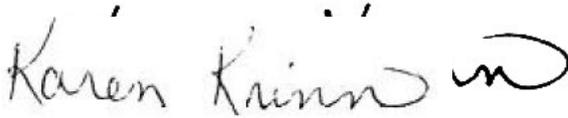
READABILITY CERTIFICATION

Reassure America – Individual Life

This is to certify that the form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

Score	Form No.	Description
45	RPCR APP 2.0	Application
71	UND QST 2.0	Supplemental Underwriting Questionnaire
54	Life SOI 2.0	Statement of Insurability

REASSURE AMERICA LIFE INSURANCE COMPANY



By _____
Assistant Secretary

Dated: 12-17-2012