

SERFF Tracking Number: GRAX-G128363198 State: Arkansas
Filing Company: Great American Life Insurance Company State Tracking Number:
Company Tracking Number: A6121512NW
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Individual Combined
Project Name/Number: Life Individual Combined/A6121512NW

Filing at a Glance

Company: Great American Life Insurance Company

Product Name: Life Individual Combined SERFF Tr Num: GRAX- State: Arkansas
G128363198
TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num:
Closed
Sub-TOI: L08.000 Life - Other Co Tr Num: A6121512NW State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird
Author: SPI Disposition Date: 05/17/2012
GreatAmericanFinancialRes
Date Submitted: 05/15/2012 Disposition Status: Approved-
Closed
Implementation Date Requested: Implementation Date:
State Filing Description:

General Information

Project Name: Life Individual Combined Status of Filing in Domicile: Pending
Project Number: A6121512NW 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: 05/17/2012
State Status Changed: 05/17/2012
Deemer Date: Created By: SPI GreatAmericanFinancialRes
Submitted By: SPI GreatAmericanFinancialRes Corresponding Filing Tracking Number:
Filing Description:

Enclosed for your review and approval, please find the forms referenced above. These forms will replace forms A6121506NW approved by your Department on 10/19/2006, under file # 34005 and A2201708NW approved 10/20/2008, under file # 40571. This submission does not contain any provisions, conditions, or concepts that are uncommon, unusual or possibly controversial from the standpoint of normal company or industry standards. These forms were filed in Ohio, our state of domicile, on 04/30/2012.

These forms have been modified to reflect a new requirement from MIB, Inc. An additional underwriting question was added to form A6121512NW only.

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Form A6121512NW will be used by policyholders to make changes such as reinstatement, increases in face amount, the addition of rider, etc to existing life insurance policies only.

Form A2201712NW will be used with our current term life insurance policies that provide an "exchange" provision which allows the policyholder to exchange their current policy for a new policy of the same plan type of insurance. A new policy could be issued for a policyholder who, at anytime after the end of their policy's initial premium guaranty period, completes the application, provides proof of insurability acceptable to us and whose age is not greater than the maximum issue age for the new policy at the time of the exchange. No agent is involved in this process.

At this time we are not currently selling "Life" policies in your state. If our position should change, these applications may be used with life insurance policies approved by your Department in the future.

Please note form A6121512NW is being filed for Loyal American Life Insurance Company and Manhattan National Life Insurance Company simultaneously under separate cover.

State Narrative:

Company and Contact

Filing Contact Information

Brenda Little, Senior Compliance Filing Analyst blittle@gafri.com
P. O. Box 5420 513-412-2725 [Phone] 12725 [Ext]
Cincinnati, OH 45201-5420 513-361-5967 [FAX]

Filing Company Information

Great American Life Insurance Company CoCode: 63312 State of Domicile: Ohio
P. O. Box 5420 Group Code: 84 Company Type:
Cincinnati, OH 45201-5420 Group Name: Great American State ID Number:
Financial Resources, Inc.
(800) 854-3649 ext. [Phone] FEIN Number: 13-1935920

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation:

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Great American Life Insurance Company	\$50.00	05/15/2012	59173320
Great American Life Insurance Company	\$50.00	05/17/2012	59233507

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/17/2012	05/17/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	05/15/2012	05/15/2012	SPI GreatAmericanFinancialRes	05/15/2012	05/15/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee	Note To Reviewer	SPI GreatAmericanFinancialRes	05/17/2012	05/17/2012
Additional filing fee	Note To Filer	Linda Bird	05/17/2012	05/17/2012

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Disposition

Disposition Date: 05/17/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Form	Policy Change Request, Part II		Yes
Form	Application for Term Life Insurance Exchange		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 05/15/2012
Submitted Date 05/15/2012
Respond By Date 06/15/2012

Dear Brenda Little,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$50.00 is received.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,
Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 05/15/2012
Submitted Date 05/15/2012

Dear Linda Bird,

Comments:

Ms. Linda Bird

Response 1

Comments: We have submitted an additional \$50.00, per regulation 57, effective January, 2010.

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$50.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you very much and please let us know if you have any questions.

Sincerely,

SPI GreatAmericanFinancialRes

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Note To Reviewer

Created By:

SPI GreatAmericanFinancialRes on 05/17/2012 09:30 AM

Last Edited By:

Linda Bird

Submitted On:

05/17/2012 11:42 AM

Subject:

Filing Fee

Comments:

Thank you for contacting me regarding the filing fee. I realized that the transaction was generated but not moved into the filing packet. This has been corrected.

Thank you very much!

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Note To Filer

Created By:

Linda Bird on 05/17/2012 08:57 AM

Last Edited By:

Linda Bird

Submitted On:

05/17/2012 11:42 AM

Subject:

Additional filing fee

Comments:

The additional filing fee of \$50.00 has not come thru on the EFT as of this date.

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Form Schedule

Lead Form Number: A6121512NW

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A6121512N	Application/	Policy Change	Initial		50.100	A6121512NW
	W	Enrollment	Request, Part II				.PDF
	A2201712N	Application/	Application for Term	Initial		50.000	A2201712NW
	W	Enrollment	Life Insurance				.PDF
		Form	Exchange				

- Great American Life Insurance Company®
 Manhattan National Life Insurance Company®
 Loyal American Life Insurance Company®

POLICY CHANGE REQUEST, Part II

Life Products: P.O. Box 5416, Cincinnati, OH 45201-5416

Name of Insured _____ Policy Number _____
 Name of Owner _____ Telephone No. of Owner _____
 Address of Owner _____ City _____ State _____ Zip _____

Reinstate Policy Face Amount Increase \$ _____ Child(ren) \$ _____
 Add Riders: Children's Term Life Insurance Rider

(Please Print – Complete Form in Full)

Full Name of Insured:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Address: _____ City: _____ State: _____ Zip: _____

Driver's License No.: _____ State Issued: _____ Social Security No.: _____

Name of Employer: _____ Address of Employer: _____

Occupation: (Describe and give active duties)

Do you contemplate changing your occupation?

Please print full name of all persons proposed for coverage. Show spouse's maiden name in parentheses, if applicable.

Spouse/Other:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Address: _____ City: _____ State: _____ Zip: _____

Driver's License No.: _____ State Issued: _____ Social Security No.: _____

Name of Employer: _____ Address of Employer: _____

Occupation: (Describe and give active duties)

Do you contemplate changing your occupation?

Child 1:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Child 2:								\$
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Does anyone proposed for coverage have any past, present or expected aviation activities or hazardous sports avocation or hobbies? Yes No (If yes, please explain.)

Has anyone proposed for coverage ever applied for insurance that was declined, postponed, rated, modified, or had any such insurance cancelled or had a renewal premium refused? Yes No

Does anyone proposed for coverage have other life insurance? Yes No If yes, please provide the following details.

Company	Plan	Amount	ADB	Year Issued

Will this policy replace or change any life insurance that is currently in force? Yes No

SMOKING HABITS: Smoked cigarettes during the last 12 months? Smoked cigarettes during the last 36 months? Use other form of tobacco? (If "yes", describe.)	Proposed Insured <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____		Spouse/Additional Insured (Complete for Spouse/ Additional Insured Term Rider) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____	
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AUTHORIZATION TO OBTAIN INFORMATION

I/we, the Proposed Insured(s), authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the MIB, Inc., consumer reporting agency, employer, or pharmacy benefit manager, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children, and any other nonmedical information of me or my minor children, to give to Great American Life Insurance Company/Manhattan National Life Insurance Company/Loyal American Life Insurance Company or its legal representative or its reinsurers any and all such information. I/we also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me or my minor children. The types of information may include my/our: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV); (10) drug and alcohol treatment; (11) other personal information; (12) Motor Vehicle record, and (13) pharmaceutical information. I/we also authorize Great American Life Insurance Company/Manhattan National Life Insurance Company/Loyal American Life Insurance Company or their reinsurers, to make a brief report of my protected health information to MIB, Inc.

I/we understand the information obtained by use of the Authorization will be used by Great American Life Insurance Company/Manhattan National Life Insurance Company/Loyal American Life Insurance Company and its reinsurers to determine eligibility or continued eligibility for insurance and eligibility for benefits under an existing policy or a policy applied for. The insurance agent, producer or broker may also use the information to help update my/our insurance program. Any information obtained will not be released by Great American Life Insurance Company/Manhattan National Life Insurance Company/Loyal American Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my/our application, claim, or as may be otherwise lawfully allowed or required or as I/we may further authorize.

I/we know I/we may request to receive a copy of this Authorization. I/we agree a photographic copy of this Authorization shall be as valid as the original. I/we agree this Authorization shall be valid for two and one-half years from the date shown below.

I ACKNOWLEDGE receipt of the Notice to Persons Applying for Insurance and Notice of Disclosure of Information/MIB, Inc. Disclosure and authorize preparation of an investigative consumer report.

NOTICES

[Alaska Residents: You have 20 days (30 for replacements) from the date you receive the policy to review it and cancel the policy, if you are not satisfied. Upon receipt of a written request, we will provide you with factual information regarding the benefits and provisions of this policy to aid you in your decision. We will respond to your request for additional information within ten (10) days of its receipt. If you cancel the policy, we will refund the premiums paid for it.]

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

[Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

Signature of Insured _____ Date _____
(Parent or guardian if Insured is under 18)

Signature of Spouse (If Applicable) _____ Date _____

Signature of Additional Insured (If Applicable) _____ Date _____



APPLICATION FOR TERM LIFE INSURANCE EXCHANGE

Administrative Address:
P.O. Box 5416, Cincinnati, Ohio 45201-5416

PART 1 (Please print)

<p>1. PROPOSED INSURED</p> <p>_____</p> <p style="text-align: center; font-size: small;">First Middle Initial Last</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone _____ Bus. Phone _____</p> <p>Soc. Sec. No. _____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Birth State/Place _____ Birth Date _____ Age _____ Marital Status _____</p> <p>Driver's License No. _____ State Issued _____</p> <p>Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, do you hold a permanent VISA or Green Card? <input type="checkbox"/> Yes, card # _____ <input type="checkbox"/> No</p> <p>Do you currently read and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No How long have you lived in the United States? _____</p> <p>Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer Name _____ Occupation/Income _____</p> <p>Send Premium Notice to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Give name/address below)</p> <p style="text-align: right;">Name _____</p> <p style="text-align: right;">Address _____</p>	<p style="text-align: center; font-size: small;">Complete only if Owner is not Proposed Insured</p> <p>2. OWNER _____</p> <p>Relationship _____ Birth Date _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Soc. Sec./Tax ID. No. _____</p>
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3. INSURANCE APPLIED FOR

Plan Name _____ Amount _____

4. PREMIUM MODE

Annual Semiannual Quarterly Monthly Bank Draft Other (Specify)

5. BENEFICIARY OF THE PROPOSED INSURED

Primary _____ Soc. Sec. No. _____ Relationship _____

Name & Address

Contingent _____ Soc. Sec. No. _____ Relationship _____

Name & Address

6. EXISTING INSURANCE

Company	Amount	Plan	Year Issued	Amount ADB	Standard	Rated
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

7. TOBACCO/NICOTINE HABITS

Have you used any form of tobacco/nicotine (e.g. cigarettes, cigars, chewing tobacco, patch, nicotine gum) in the last 3 years? Yes No

Last 5 years? Yes No

8. HAVE YOU

Yes No

- a. Ever applied for insurance or reinstatement that was declined, postponed, rated, modified or had any such insurance cancelled or a renewal premium refused?..... Yes No
- b. Ever received or claimed benefits or a payment of any kind for any injury, sickness or impaired condition?..... Yes No
- c. Ever engaged in or plan to engage in any form of motorized racing, scuba diving, parachuting, hang gliding, ballooning or mountain climbing? (If "Yes", complete avocation and/or mountain climbing questionnaire(s).)?..... Yes No
- d. Ever made any flights as a pilot, student pilot, crew member or other (except as a fare paying passenger) of any aircraft in the past three (3) years or intend to do so in the future? (If "Yes", complete aviation questionnaire.)..... Yes No
- e. Ever been convicted with a violation of any criminal law?..... Yes No
- f. Ever had in the past five (5) years any motor vehicle violations, including driving while intoxicated, or had your license suspended or revoked?..... Yes No
- g. Ever traveled or resided outside the U.S. or Canada in the last year or plan to do so in the next year?..... Yes No
- h. Ever filed for bankruptcy? If so, has it been discharged? Date of discharge _____ Yes No
- i. Ever assigned or transferred ownership of an insurance policy?..... Yes No

If answering "Yes" to any of the above, questions a. through i., please give details. _____

9. SPECIAL REQUESTS

PART II

1. PROPOSED INSURED'S Height _____ ft. _____ in. Weight _____ lbs. Weight loss in past year _____ lbs.

2. PHYSICIAN INFORMATION

Name _____ Address _____ Phone _____

Date and reason last consulted _____

Treatment given or medication prescribed _____

3. PROPOSED INSURED'S FAMILY HISTORY

	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers/Sisters			

4. HAS ANYONE PROPOSED FOR COVERAGE EVER BEEN TREATED FOR OR HAD:

Please give details below if you answer "Yes" to any of these questions:

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| a. Impairment of the eyes or ears?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headache, paralysis or stroke within the last ten (10) years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, blood spitting, bronchitis, asthma, emphysema or chronic respiratory disorder, sleep apnea or other lung disorder within the last ten (10) years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels?.. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, hepatitis, intestinal bleeding, ulcer, colitis, recurrent indigestion or any other disease of the stomach, intestines, liver, gall bladder, or pancreas?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, protein, blood, or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes, thyroid or other endocrine disorders?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Disorder of the breasts, prostate, or pelvic organs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Neuritis, arthritis or disorder of the muscles or bones, including the spine, back or joints?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, lymph glands, cyst, tumor or cancer?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Anemia or other disorder of the blood?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Alcoholism, alcohol or drug abuse or addiction to habit-forming drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Panic attacks, anxiety, depression, psychological or emotional or physical disorder not listed above?..... | <input type="checkbox"/> | <input type="checkbox"/> |

5. HAS ANYONE PROPOSED FOR COVERAGE:

- | | | |
|---|--------------------------|--------------------------|
| a. Had a physical checkup, consultation or surgery within the last five (5) years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been a patient in a hospital, clinic or other medical facility within the last five (5) years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had an electrocardiogram, X-ray or other diagnostic test within the last five (5) years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been advised to have any diagnostic test, hospitalization, or surgery, which was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

6. Are you now pregnant? (If "Yes," expected due date _____) Yes No

7. Are you now under medical observation, treatment or currently taking any medication other than as stated above?..... Yes No

Question No.	Details (Name of condition, date of onset, duration, current treatment and condition, etc.)	Complete Name, Addresses and Phone Numbers of Physicians and Hospitals

NOTICES (Please review the notice that applies to your state.)

[Alaska Residents: You have 20 days (30 for replacements) from the date you receive the policy to review it and cancel the policy, if you are not satisfied. Upon receipt of a written request, we will provide you with factual information regarding the benefits and provisions of this policy to aid you in your decision. We will respond to your request for additional information within ten (10) days of its receipt. If you cancel the policy, we will refund the premiums paid for it.]

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

[Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[Tennessee and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

AUTHORIZATION

I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the MIB, Inc., consumer reporting agency, employer, or pharmacy benefit manager, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any other nonmedical information of me, to give to Great American Life Insurance Company or its legal representative or its reinsurers any and all such information. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. The types of information may include my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC or Human Immunodeficiency Virus (HIV); (10) drug and alcohol treatment; (11) other personal information; (12) Motor Vehicle record; and (13) pharmaceutical information. I/we also authorize Great American Life Insurance Company, or its reinsurer, to make a brief report of my protected health information to MIB, Inc.

I understand the information obtained by use of the authorization will be used by Great American Life Insurance Company and its reinsurers to determine continued eligibility for insurance and eligibility for benefits under an existing policy. The insurance agent, producer, or broker may also use the information to help update my insurance program. Any information obtained will not be released by Great American Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the MIB, Inc., or other persons or organizations, performing business or legal services in connection with my application, claim, or as may be otherwise lawfully allowed or required or as I may further authorize.

Information regarding your insurability will be treated as confidential. Great American Life Insurance Company or its reinsurers may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, 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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Great American Life Insurance Company, or its reinsurers, may also release information from 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, Inc. may be obtained on its website at www.mib.com.**

I know I may request to receive a copy of this authorization. I agree a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two and one-half (2 ½) years from the date shown below.

AGREEMENT

I, the Proposed Insured, represent the statements in Part I and Part II (if Part II is required by the Company) of this application are true and complete to the best of my knowledge and belief. It is agreed: (a) the only statements that are to be considered as the basis of the policy are those contained in the application or in any amendment to the application; (b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT bearing the same date as this application; (c) the policy being applied for with this application will not take effect until the first premium is paid during the lifetime of the Proposed Insured and while his/her health and the facts and other conditions affecting his/her insurability are as described in Part I and Part II (if Part II Medical is required by the Company) of this application, and until the policy is delivered to the proposed owner; and (d) no one except the President, a Vice President or the Secretary can make, alter or discharge contracts or waive any of the Company's rights or requirements.

I have no intent to transfer ownership of the policy applied for as part of a senior, viatical or similar settlement.

I acknowledge receipt of NOTICE OF INSURANCE INFORMATION PRACTICES attached hereto and hereby authorize preparation of an investigative consumer report.

Date _____ City/State _____

Signature _____
Proposed Insured

Witness _____
Name

Signature _____
Applicant/Owner, if other than Proposed Insured

SERFF Tracking Number: GRAX-G128363198 State: Arkansas
 Filing Company: Great American Life Insurance Company State Tracking Number:
 Company Tracking Number: A6121512NW
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Life Individual Combined
 Project Name/Number: Life Individual Combined/A6121512NW

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment:		
NW - Readability Certification.PDF		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Application is under Forms Schedule Tab		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment:		
Cover Letter.PDF		



P.O. Box 5420, Cincinnati, Ohio 45201-5420

READABILITY CERTIFICATION

I, John P. Gruber, an officer of Great American Life Insurance Company, hereby certify that the following form(s) has (have) the following readability score(s) as calculated by the Flesch Reading Ease Test and that this (these) form(s) meet(s) the reading ease requirements of the laws and regulations of your state.

<u>Form</u>	<u>Readability Score</u>
A6121512NW	50.1
A2201712NW	50.0

John P. Gruber, Esq.
Senior Vice President and
General Counsel

April 30, 2012



LIFE INSURANCE COMPANY

Administrative Mailing Address: P.O. Box 5420, Cincinnati, Ohio 45201-5420

May 15, 2012

NAIC No. 0084-63312
FEIN No. 13-1935920

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Request For Approval - Great American Life Insurance Company
A6121512NW Policy Change Request, Part II
A2201712NW Application for Term Life Insurance Exchange

Dear Insurance Commissioner Bradford:

Enclosed for your review and approval, please find the forms referenced above. These forms will replace forms A6121506NW approved by your Department on 10/19/2006, under file # 34005 and A2201708NW approved 10/20/2008, under file # 40571. This submission does not contain any provisions, conditions, or concepts that are uncommon, unusual or possibly controversial from the standpoint of normal company or industry standards. These forms were filed in Ohio, our state of domicile, on 04/30/2012.

These forms have been modified to reflect a new requirement from MIB, Inc. An additional underwriting question was added to form A6121512NW only.

Form A6121512NW will be used by policyholders to make changes such as reinstatement, increases in face amount, the addition of rider, etc to existing life insurance policies only.

Form A2201712NW will be used with our current term life insurance policies that provide an "exchange" provision which allows the policyholder to exchange their current policy for a new policy of the same plan type of insurance. A new policy could be issued for a policyholder who, at anytime after the end of their policy's initial premium guaranty period, completes the application, provides proof of insurability acceptable to us and whose age is not greater than the maximum issue age for the new policy at the time of the exchange. No agent is involved in this process.

At this time we are not currently selling "Life" policies in your state. If our position should change, these applications may be used with life insurance policies approved by your Department in the future.

Please note form A6121512NW is being filed for Loyal American Life Insurance Company and Manhattan National Life Insurance Company simultaneously under separate cover.

BRENDA LITTLE , SENIOR COMPLIANCE FILING ANALYST
(800) 854-3649 (TOLL FREE - EXT. 12725)
(513) 412-2725 (DIRECT DIAL) * (513) 361-5967 FAX

With this information, I look forward to receiving a favorable response to this filing.

If you have any questions or require additional information regarding this submission, please feel free to contact me at either of the phone numbers indicated below or via e-mail at blittle@gafri.com.

Sincerely,

A handwritten signature in black ink that reads "Brenda Little". The signature is written in a cursive style with a large initial 'B'.

Brenda Little
Senior Compliance Filing Analyst