

SERFF Tracking Number: GRJR-127960748 State: Arkansas
Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
Company Tracking Number: CLI1025
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Filing at a Glance

Company: The Cincinnati Life Insurance Company

Product Name: Form CLI-1025 (1/12), SERFF Tr Num: GRJR-127960748 State: Arkansas

Individual Life Insurance Application

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num:
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: CLI1025

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Jennifer Henley, Deborah Disposition Date: 05/09/2012

Naegele, Karen Eichler

Date Submitted: 03/09/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Worksite Individual Life Insurance Application

Project Number: Worksite Individual Life Insurance Application

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: This form was filed
as part of an IIPRC filing, in our state of
domicile, Ohio. Approved March 7, 2012.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/09/2012

State Status Changed: 03/13/2012

Deemer Date:

Created By: Jennifer Henley

Submitted By: Jennifer Henley

Corresponding Filing Tracking Number:

Filing Description:

FEIN: 31-1213778

NAIC: 0244-76236

Subject:

The Cincinnati Life Insurance Company

Individual Life Insurance

SERFF Tracking Number: GRJR-127960748 State: Arkansas
Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
Company Tracking Number: CLII025
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application
Form CLI-1025 (1/12), Application for Individual Life Insurance

For Use With:

All applicable approved Life Insurance policy forms.

We are submitting the subject form for your review and approval. This form is new and does not replace any previously approved forms. The implementation date for this form will be upon your approval.

This application will be marketed by an independent agency force when marketing individual Universal Life, Term Life and Whole Life, in the worksite marketplace for general life insurance purposes. This application form will not be used in connection with the sale of variable products. There are no marketing or issue restrictions from our normal sales practices.

As common practice in individual life worksite products, the Employee is the owner and payor of the policy(ies) applied for on the subject worksite application, unless otherwise specified on the application.

Premium payments for individual life worksite insurance are generally payroll deducted; therefore, the first premium is not payable at the time of application. If desired, the Employee may choose to pay via automatic bank account withdrawals or direct billing, both of which do require the first premium at time of application.

Nothing in this filing has been previously disapproved by your Department. Please be assured that this filing contains no unusual or possibly controversial items from our normal Company practice of industry standards.

In addition to traditional paper format, we intend to use this application electronically once programming is completed by our vendor.

This form was scored for Flesch Score Readability Analysis, and the test score is 50.

Our domicile state, Ohio, was approved in our IIPRC filing on March 7, 2012.

We would appreciate your review and approval at your earliest convenience. Thank you for your usual courtesy and cooperation.

State Narrative:

Company and Contact

Filing Contact Information

Jennifer Henley, Senior Analyst

jenny_henley@cinfin.com

SERFF Tracking Number: GRJR-127960748 State: Arkansas
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 Company Tracking Number: CLII025
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
 Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

P.O. Box 145496 513-870-2251 [Phone]
 Cincinnati, OH 45250-5496 513-870-2099 [FAX]

Filing Company Information

The Cincinnati Life Insurance Company CoCode: 76236 State of Domicile: Ohio
 6200 S. Gilmore Road Group Code: 244 Company Type:
 Fairfield, OH 45014 Group Name: State ID Number:
 (513) 870-2000 ext. 4386[Phone] FEIN Number: 31-1213778

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 1 Form X \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Cincinnati Life Insurance Company	\$50.00	03/09/2012	56993748

SERFF Tracking Number: GRJR-127960748 State: Arkansas
 Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
 Company Tracking Number: CLII025
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
 Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/09/2012	05/09/2012
Approved-Closed	Linda Bird	03/13/2012	03/13/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Individual Life Insurance	Jennifer Henley	05/03/2012	05/07/2012
Supporting Document	Highlighted application showing revisions.	Jennifer Henley	05/03/2012	05/07/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to re-open	Note To Filer	Linda Bird	05/03/2012	05/03/2012
Request to re-open	Note To Reviewer	Jennifer Henley	05/02/2012	05/02/2012

SERFF Tracking Number: GRJR-127960748 State: Arkansas
Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
Company Tracking Number: CLII025
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Disposition

Disposition Date: 05/09/2012

Implementation Date:

Status: Approved-Closed

Comment: Correction made to question #47 of the application form.

Rate data does NOT apply to filing.

SERFF Tracking Number: GRJR-127960748 State: Arkansas
 Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
 Company Tracking Number: CLII025
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
 Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Highlighted application showing revisions.		Yes
Form (revised)	Application for Individual Life Insurance		Yes
Form	Application for Individual Life Insurance	Replaced	Yes

SERFF Tracking Number: GRJR-127960748 State: Arkansas
Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
Company Tracking Number: CLII025
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Disposition

Disposition Date: 03/13/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GRJR-127960748 State: Arkansas
 Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
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 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
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 Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Highlighted application showing revisions.		Yes
Form (revised)	Application for Individual Life Insurance		Yes
Form	Application for Individual Life Insurance	Replaced	Yes

SERFF Tracking Number: GRJR-127960748 State: Arkansas
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 Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
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Amendment Letter

Submitted Date: 05/07/2012

Comments:

We certify that the approved application has not been used, issued or marketed in any way. The only change to the application is question #47. A copy of the application has been attached to the Supporting Documentation tab with the revision highlighted.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Form CLI-1025 (1/12)	Application/EApplication nrollment Form	Application for Individual Life Insurance	Initial				50.000	Form CLI-1025 1-12 Application for Individual Life Insurance REVISED 5-7-12.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Highlighted application showing revisions.

Comment:

Form CLI-1025 1-12 Application for Individual Life Insurance REVISED Highlighted 5-7-12.pdf

SERFF Tracking Number: GRJR-127960748 State: Arkansas
Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
Company Tracking Number: CLII025
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Note To Filer

Created By:

Linda Bird on 05/03/2012 10:20 AM

Last Edited By:

Linda Bird

Submitted On:

05/03/2012 10:20 AM

Subject:

Request to re-open

Comments:

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

SERFF Tracking Number: GRJR-127960748 State: Arkansas
Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
Company Tracking Number: CLII025
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Note To Reviewer

Created By:

Jennifer Henley on 05/02/2012 09:40 AM

Last Edited By:

Jennifer Henley

Submitted On:

05/02/2012 09:41 AM

Subject:

Request to re-open

Comments:

May this filing be re-opened to make a slight change on the approved application form? We assure that the only change would be to question #47, and that no other changes will be made. We certify that the approved application has not been used, issued or marketed in any way. As such, the form number and edition date will not be altered.

Sincerely,

Jenny Henley

SERFF Tracking Number: GRJR-127960748 State: Arkansas
 Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
 Company Tracking Number: CLI1025
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
 Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Form Schedule

Lead Form Number: Form CLI-1025 (1/12)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form CLI-1025 (1/12)	Application/Enrollment Form	Application for Individual Life Insurance	Initial		50.000	Form CLI-1025 1-12 Application for Individual Life Insurance REVISED 5-7-12.pdf



Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
 www.cinfin.com ■ 513-870-2000

NEW INCREASE EXISTING POLICY # _____ FOR INSURED _____

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Please print or type all information

EMPLOYEE	1. Employee (first, middle, last)		2. Employment Date		3. Employee No.	
	4. Mailing Address No. Street Apt. # City State Zip					
	5. Phone No. (H) () (W) ()		6. Soc. Sec. No.		7. Occupation	
	8. Are you actively at work and currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	9. Date of Birth		10. St./Ctry. of Birth		11. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
	12. Do you now or have you smoked cigarettes within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	13. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	14. Plan		Amount of Ins.		Premium Incl. Rider(s)	
	A. <input type="checkbox"/> Term		\$ _____		\$ _____	
	B. <input type="checkbox"/> Term ROP		\$ _____		\$ _____	
	C. <input type="checkbox"/> Universal Life		\$ _____		\$ _____	
	D. <input type="checkbox"/> Whole Life		\$ _____		\$ _____	
	15. Mode					
<input type="checkbox"/> Weekly		<input type="checkbox"/> Bi-Weekly		<input type="checkbox"/> Semi-Monthly		
<input type="checkbox"/> Other _____				<input type="checkbox"/> Monthly		
16. Optional Benefit Riders: <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> CTR - \$10,000 <input type="checkbox"/> Accidental Death Benefit						
<input type="checkbox"/> FAIR <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____						
17. Automatic Premium Loan (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
18. Primary Beneficiary			19. Contingent Beneficiary			
Name: _____			Name: _____			
Relationship: _____			Relationship: _____			
City & State: _____			City & State: _____			
OTHER PROPOSED INSURED	20. Other Proposed Insured (first, middle, last)		21. Other Proposed Insured's Soc. Sec. No.			
	22. Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Grandchild					
	23. Occupation					
	24. Mailing Address No. Street Apt. # City State Zip					
	24. Mailing Address (if different from above)					
	25. Date of Birth		26. St./Ctry. of Birth		27. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
	28. Do you now or have you smoked cigarettes within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	29. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	30. Owner, if other than Employee: (Name and Address)				31. Relationship	
	32. Contingent Owner (Name & Soc. Sec. No.)				33. Relationship	
	34. Plan		Amount of Ins.		Premium Incl. Rider(s)	
	A. <input type="checkbox"/> Term		\$ _____		\$ _____	
	B. <input type="checkbox"/> Term ROP		\$ _____		\$ _____	
C. <input type="checkbox"/> Universal Life		\$ _____		\$ _____		
D. <input type="checkbox"/> Whole Life		\$ _____		\$ _____		
35. Mode						
<input type="checkbox"/> Weekly		<input type="checkbox"/> Bi-Weekly		<input type="checkbox"/> Semi-Monthly		
<input type="checkbox"/> Other _____				<input type="checkbox"/> Monthly		
36. Optional Benefit Riders: <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> CTR - \$10,000 <input type="checkbox"/> Accidental Death Benefit						
<input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____						
37. Automatic Premium Loan (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
38. Primary Beneficiary			39. Contingent Beneficiary			
Name: _____			Name: _____			
Relationship: _____			Relationship: _____			
City & State: _____			City & State: _____			

CTR	40. CHILDREN'S TERM RIDER – All unmarried children who are less than age 19 as of date of application. The beneficiary of children's coverage is, in all cases, the owner.							
	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee

CGI	(Complete this section only as required by underwriting guidelines.)								
	41. CONTINGENT GUARANTEED ISSUE - In the past 90 days have you been hospitalized due to illness or injury or had medical treatment prescribed by a physician?						Employee Yes No		Other Proposed Insured Yes No
						<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
IF "YES", COMPLETE QUESTIONS #42 THROUGH #45 AND GIVE FULL DETAILS IN #46									

SI	SIMPLIFIED ISSUE – (Complete this section only as required by underwriting guidelines.)								
	42. Employee: Height: _____ ft. _____ in. Weight: _____ lbs.			Primary Physician:		Name: _____ Address: _____ City & State: _____			
	43. Other Proposed Insured: Height: _____ ft. _____ in. Weight: _____ lbs.			Primary Physician:		Name: _____ Address: _____ City & State: _____			
	GIVE FULL DETAILS TO ANY QUESTIONS ANSWERED "YES" IN #46								

SI	44. In the past five years, have you:										
						Employee Yes No		Other Proposed Insured Yes No		Children (as listed in #40 above) Yes No	
	a. been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for cancer, tumor, stroke, high blood pressure or disease of the heart or blood vessels, kidney disease, diabetes, depression or anxiety, been hospitalized or had hospitalization recommended?					<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
	b. been examined or treated by, any member of the medical profession not disclosed in response to the prior question (other than HIV)?					<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
45. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)?											
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											

DETAILS	46. DETAILS OF "YES" ANSWERS:			
	Name (Including Children listed in #40)	Date/Duration	Physician and/or Hospital Name and Address	Question Number, Condition, and Treatment

In Continuation of Application for Individual Life Insurance

Please print or type all information

REPLACEMENT	47. Does the Proposed Insured have any life insurance or annuities in force with The Cincinnati Life Insurance Company or any other company? (Complete any applicable replacement forms)				<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
	If "Yes," list and indicate if it is to be replaced, changed or borrowed against as a result of this application.				Replaced?			
	Proposed Insured	Insurer	Policy Number	Amount	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>		
	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>		

AGREEMENT	<p>AGREEMENT: I, the undersigned, agree that: 1. This Application will be part of any policy issued. 2. The answers and statements in this Application are the basis for any policy issued by The Cincinnati Life Insurance Company, and no information about them will be considered to have been given to The Cincinnati Life Insurance Company unless it is stated in this Application. 3. I have read this Application and to the best of my knowledge and belief, all the answers and statements that pertain to me are true and complete. 4. Upon acceptance of a policy other than as applied for, this Application and any amendments shall be for such modified policy. When required by statute or regulation, any change in A. Plan; B. Age; C. Amount; D. Classification; or E. Benefits shall be made only upon written agreement. 5. A sales representative does not have The Cincinnati Life Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this Application, policy, or receipt, as applicable. 6. The Cincinnati Life Insurance Company shall incur no liability unless: A. This Application is fully completed, dated, signed and witnessed; B. The first premium due is paid in full or the Payroll Deduction Authorization is completed while each proposed insured is alive; C. The insurability of each proposed insured remains as described in this Application and in any supplements to this Application; and D. A policy is formally approved by us and issued on this Application, and delivered to and accepted by the owner.</p> <p>I acknowledge having received and read the Important Notice to the Proposed Insured.</p> <p><input type="checkbox"/> I acknowledge that no illustration conforming to the policy applied for was provided and understand that an illustration conforming to the issued policy will be provided no later than at the time of policy delivery.</p> <p>Any person who, with intent to defraud or is knowingly facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.</p> <p>Signed at: _____ Signed On: _____</p> <p style="text-align: center;">City State Month Day Year</p> <p>_____ Signature of Employee _____ Signature of Other Proposed Insured (if required)</p> <p>_____ Signature of Owner, if other than Employee</p>							
------------------	--	--	--	--	--	--	--	--

AGENT	<p>For Agent: I certify, to the best of my knowledge and belief, that the answers to the questions in all parts of this Application are true and correct. I further certify that to the best of my knowledge and belief, this policy <input type="checkbox"/> Will <input type="checkbox"/> Will Not replace or change any existing life insurance or annuity contract now in force.</p> <p><input type="checkbox"/> I certify no illustration was presented at the time of application; or, I certify that I did not provide an illustration conforming to the policy applied for.</p>		
	_____ Signature of Enrolling Agent	_____ Enrolling Agent Name (please print)	_____ Enrolling Agent Code #

SERFF Tracking Number: GRJR-127960748 State: Arkansas
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 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
 Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR Certification of Readability.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Application is being filed for approval.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Highlighted application showing revisions.		
Comments:		
Attachment: Form CLI-1025 1-12 Application for Individual Life Insurance REVISED Highlighted 5-7-12.pdf		

ARKANSAS CERTIFICATION

This is to certify that the attached policy Form CLI-1025 (1/12), Application for Individual
Life Insurance

has achieved a Flesch Reading Ease Score of 50
respectively, and complies with the requirements of Ark. Stat. Ann. 66-3251 through
66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

March 9, 2012

Date



Signature of Officer

Roger A. Brown, FSA, MAAA

Name

Vice President and Actuary

Title



Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
 www.cinfin.com ■ 513-870-2000

NEW INCREASE EXISTING POLICY # _____ FOR INSURED _____

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Please print or type all information

EMPLOYEE	1. Employee (first, middle, last)		2. Employment Date		3. Employee No.	
	4. Mailing Address No. Street Apt. # City State Zip					
	5. Phone No. (H) () (W) ()		6. Soc. Sec. No.		7. Occupation	
	8. Are you actively at work and currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	9. Date of Birth		10. St./Ctry. of Birth		11. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
	12. Do you now or have you smoked cigarettes within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	13. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	14. Plan		Amount of Ins.		Premium Incl. Rider(s)	
	A. <input type="checkbox"/> Term		\$ _____		\$ _____	
	B. <input type="checkbox"/> Term ROP		\$ _____		\$ _____	
	C. <input type="checkbox"/> Universal Life		\$ _____		\$ _____	
	D. <input type="checkbox"/> Whole Life		\$ _____		\$ _____	
	15. Mode					
<input type="checkbox"/> Weekly		<input type="checkbox"/> Bi-Weekly		<input type="checkbox"/> Semi-Monthly		
<input type="checkbox"/> Monthly		<input type="checkbox"/> Other _____				
16. Optional Benefit Riders: <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> CTR - \$10,000 <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> FAIR <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____						
17. Automatic Premium Loan (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
18. Primary Beneficiary Name: _____ Relationship: _____ City & State: _____			19. Contingent Beneficiary Name: _____ Relationship: _____ City & State: _____			

OTHER PROPOSED INSURED	20. Other Proposed Insured (first, middle, last)		21. Other Proposed Insured's Soc. Sec. No.			
	22. Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Grandchild					
	23. Occupation					
	24. Mailing Address No. Street Apt. # City State Zip (if different from above)					
	25. Date of Birth		26. St./Ctry. of Birth		27. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
	28. Do you now or have you smoked cigarettes within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	29. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	30. Owner, if other than Employee: (Name and Address)				31. Relationship	
	32. Contingent Owner (Name & Soc. Sec. No.)				33. Relationship	
	34. Plan		Amount of Ins.		Premium Incl. Rider(s)	
	A. <input type="checkbox"/> Term		\$ _____		\$ _____	
	B. <input type="checkbox"/> Term ROP		\$ _____		\$ _____	
	C. <input type="checkbox"/> Universal Life		\$ _____		\$ _____	
D. <input type="checkbox"/> Whole Life		\$ _____		\$ _____		
35. Mode						
<input type="checkbox"/> Weekly		<input type="checkbox"/> Bi-Weekly		<input type="checkbox"/> Semi-Monthly		
<input type="checkbox"/> Monthly		<input type="checkbox"/> Other _____				
36. Optional Benefit Riders: <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> CTR - \$10,000 <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____						
37. Automatic Premium Loan (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
38. Primary Beneficiary Name: _____ Relationship: _____ City & State: _____			39. Contingent Beneficiary Name: _____ Relationship: _____ City & State: _____			

CTR	40. CHILDREN'S TERM RIDER – All unmarried children who are less than age 19 as of date of application. The beneficiary of children's coverage is, in all cases, the owner.							
	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee

(Complete this section only as required by underwriting guidelines.)

CGI	41. CONTINGENT GUARANTEED ISSUE - In the past 90 days have you been hospitalized due to illness or injury or had medical treatment prescribed by a physician?	Employee		Other Proposed Insured	
		Yes	No	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF "YES", COMPLETE QUESTIONS #42 THROUGH #45 AND GIVE FULL DETAILS IN #46

SIMPLIFIED ISSUE – (Complete this section only as required by underwriting guidelines.)

42. Employee: Height: _____ ft. _____ in. Weight: _____ lbs.	Primary Physician: Name: _____ Address: _____ City & State: _____
43. Other Proposed Insured: Height: _____ ft. _____ in. Weight: _____ lbs.	Primary Physician: Name: _____ Address: _____ City & State: _____

GIVE FULL DETAILS TO ANY QUESTIONS ANSWERED "YES" IN #46

SI	44. In the past five years, have you:	Employee		Other Proposed Insured		Children (as listed in #40 above)	
		Yes	No	Yes	No	Yes	No
	a. been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for cancer, tumor, stroke, high blood pressure or disease of the heart or blood vessels, kidney disease, diabetes, depression or anxiety, been hospitalized or had hospitalization recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. been examined or treated by, any member of the medical profession not disclosed in response to the prior question (other than HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

DETAILS	46. DETAILS OF "YES" ANSWERS:			
	Name (Including Children listed in #40)	Date/Duration	Physician and/or Hospital Name and Address	Question Number, Condition, and Treatment

REPLACEMENT	47.	Does the Proposed Insured have any life insurance or annuities in force with The Cincinnati Life Insurance Company or any other company? (Complete any applicable replacement forms).....	Yes	No		
			<input type="checkbox"/>	<input type="checkbox"/>		
		If "Yes," list and indicate if it is to be replaced, changed or borrowed against as a result of this application.	Replaced?			
	Proposed Insured	Insurer	Policy Number	Amount	Yes	No
	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

AGREEMENT		<p>AGREEMENT: I, the undersigned, agree that: 1. This Application will be part of any policy issued. 2. The answers and statements in this Application are the basis for any policy issued by The Cincinnati Life Insurance Company, and no information about them will be considered to have been given to The Cincinnati Life Insurance Company unless it is stated in this Application. 3. I have read this Application and to the best of my knowledge and belief, all the answers and statements that pertain to me are true and complete. 4. Upon acceptance of a policy other than as applied for, this Application and any amendments shall be for such modified policy. When required by statute or regulation, any change in A. Plan; B. Age; C. Amount; D. Classification; or E. Benefits shall be made only upon written agreement. 5. A sales representative does not have The Cincinnati Life Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this Application, policy, or receipt, as applicable. 6. The Cincinnati Life Insurance Company shall incur no liability unless: A. This Application is fully completed, dated, signed and witnessed; B. The first premium due is paid in full or the Payroll Deduction Authorization is completed while each proposed insured is alive; C. The insurability of each proposed insured remains as described in this Application and in any supplements to this Application; and D. A policy is formally approved by us and issued on this Application, and delivered to and accepted by the owner.</p> <p>I acknowledge having received and read the Important Notice to the Proposed Insured.</p> <p><input type="checkbox"/> I acknowledge that no illustration conforming to the policy applied for was provided and understand that an illustration conforming to the issued policy will be provided no later than at the time of policy delivery.</p> <p>Any person who, with intent to defraud or is knowingly facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.</p> <p>Signed at: _____ Signed On: _____</p> <p style="margin-left: 40px;">City State Month Day Year</p> <p>_____</p> <p style="margin-left: 40px;">Signature of Employee Signature of Other Proposed Insured (if required)</p> <p>_____</p> <p style="margin-left: 40px;">Signature of Owner, if other than Employee</p>
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AGENT		<p>For Agent: I certify, to the best of my knowledge and belief, that the answers to the questions in all parts of this Application are true and correct. I further certify that to the best of my knowledge and belief, this policy <input type="checkbox"/> Will <input type="checkbox"/> Will Not replace or change any existing life insurance or annuity contract now in force.</p> <p><input type="checkbox"/> I certify no illustration was presented at the time of application; or, I certify that I did not provide an illustration conforming to the policy applied for.</p> <p>_____</p> <p style="margin-left: 40px;">Signature of Enrolling Agent Enrolling Agent Name (please print) Enrolling Agent Code #</p>
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SERFF Tracking Number: GRJR-127960748 State: Arkansas
 Filing Company: The Cincinnati Life Insurance Company State Tracking Number:
 Company Tracking Number: CLII025
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Form CLI-1025 (1/12), Individual Life Insurance Application
 Project Name/Number: Worksite Individual Life Insurance Application/Worksite Individual Life Insurance Application

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	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/24/2012	Form	Application for Individual Life Insurance	05/03/2012	Form CLI-1025 1-12 Application for Individual Life Insurance.pdf (Superseded)



Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
 www.cinfin.com ■ 513-870-2000

NEW INCREASE EXISTING POLICY # _____ FOR INSURED _____

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Please print or type all information

EMPLOYEE	1. Employee (first, middle, last)		2. Employment Date		3. Employee No.	
	4. Mailing Address		No. Street	Apt. #	City	State Zip
	5. Phone No. (H) () (W) ()		6. Soc. Sec. No.		7. Occupation	
	8. Are you actively at work and currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	9. Date of Birth		10. St./Ctry. of Birth		11. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
	12. Do you now or have you smoked cigarettes within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	13. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	14. Plan		Amount of Ins.		Premium Incl. Rider(s)	
	A. <input type="checkbox"/> Term		\$ _____		\$ _____	
	B. <input type="checkbox"/> Term ROP		\$ _____		\$ _____	
	C. <input type="checkbox"/> Universal Life		\$ _____		\$ _____	
	D. <input type="checkbox"/> Whole Life		\$ _____		\$ _____	
	15. Mode		<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly		<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly	
		<input type="checkbox"/> Other _____				
16. Optional Benefit Riders: <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> CTR - \$10,000 <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> FAIR <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____						
17. Automatic Premium Loan (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
18. Primary Beneficiary Name: _____ Relationship: _____ City & State: _____			19. Contingent Beneficiary Name: _____ Relationship: _____ City & State: _____			

OTHER PROPOSED INSURED	20. Other Proposed Insured (first, middle, last)		21. Other Proposed Insured's Soc. Sec. No.			
	22. Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Grandchild		23. Occupation			
	24. Mailing Address		No. Street	Apt. #	City	State Zip
			(if different from above)			
	25. Date of Birth		26. St./Ctry. of Birth		27. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
	28. Do you now or have you smoked cigarettes within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	29. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	30. Owner, if other than Employee: (Name and Address)				31. Relationship	
	32. Contingent Owner (Name & Soc. Sec. No.)				33. Relationship	
	34. Plan		Amount of Ins.		Premium Incl. Rider(s)	
	A. <input type="checkbox"/> Term		\$ _____		\$ _____	
	B. <input type="checkbox"/> Term ROP		\$ _____		\$ _____	
	C. <input type="checkbox"/> Universal Life		\$ _____		\$ _____	
D. <input type="checkbox"/> Whole Life		\$ _____		\$ _____		
35. Mode		<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly		<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly		
		<input type="checkbox"/> Other _____				
36. Optional Benefit Riders: <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> CTR - \$10,000 <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____						
37. Automatic Premium Loan (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
38. Primary Beneficiary Name: _____ Relationship: _____ City & State: _____			39. Contingent Beneficiary Name: _____ Relationship: _____ City & State: _____			

CTR	40. CHILDREN'S TERM RIDER – All unmarried children who are less than age 19 as of date of application. The beneficiary of children's coverage is, in all cases, the owner.							
	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee

(Complete this section only as required by underwriting guidelines.)

CGI	41. CONTINGENT GUARANTEED ISSUE - In the past 90 days have you been hospitalized due to illness or injury or had medical treatment prescribed by a physician?	Employee Yes <input type="checkbox"/> No <input type="checkbox"/>		Other Proposed Insured Yes <input type="checkbox"/> No <input type="checkbox"/>	
	IF "YES", COMPLETE QUESTIONS #42 THROUGH #45 AND GIVE FULL DETAILS IN #46				

SIMPLIFIED ISSUE – (Complete this section only as required by underwriting guidelines.)

42. Employee: Height: _____ ft. _____ in. Weight: _____ lbs.	Primary Physician: Name: _____ Address: _____ City & State: _____
43. Other Proposed Insured: Height: _____ ft. _____ in. Weight: _____ lbs.	Primary Physician: Name: _____ Address: _____ City & State: _____

GIVE FULL DETAILS TO ANY QUESTIONS ANSWERED "YES" IN #46

SI	44. In the past five years, have you:	Employee		Other Proposed Insured		Children (as listed in #40 above)	
	a. been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for cancer, tumor, stroke, high blood pressure or disease of the heart or blood vessels, kidney disease, diabetes, depression or anxiety, been hospitalized or had hospitalization recommended?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	b. been examined or treated by, any member of the medical profession not disclosed in response to the prior question (other than HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

46. DETAILS OF "YES" ANSWERS:

DETAILS	Name (Including Children listed in #40)	Date/Duration	Physician and/or Hospital Name and Address	Question Number, Condition, and Treatment

In Continuation of Application for Individual Life Insurance

Please print or type all information

REPLACEMENT	47. Is there any intention of replacing, changing or borrowing against any insurance policy or annuity contract in force on the life of any proposed insured with The Cincinnati Life Insurance Company or any other company as a result of this Application? Yes <input type="checkbox"/> No <input type="checkbox"/>																	
	List all life insurance or annuities any proposed insured has in force, or applications pending. Indicate if it is to be replaced, changed or borrowed against as a result of this Application. Complete any applicable replacement forms. Replaced?																	
	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Proposed Insured</th> <th style="width: 20%;">Insurer</th> <th style="width: 20%;">Policy Number</th> <th style="width: 20%;">Amount</th> <th style="width: 10%; text-align: center;">Yes <input type="checkbox"/></th> <th style="width: 10%; text-align: center;">No <input type="checkbox"/></th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>	Proposed Insured	Insurer	Policy Number	Amount	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/>
Proposed Insured	Insurer	Policy Number	Amount	Yes <input type="checkbox"/>	No <input type="checkbox"/>													
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>													
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>													

AGREEMENT	<p>AGREEMENT: I, the undersigned, agree that: 1. This Application will be part of any policy issued. 2. The answers and statements in this Application are the basis for any policy issued by The Cincinnati Life Insurance Company, and no information about them will be considered to have been given to The Cincinnati Life Insurance Company unless it is stated in this Application. 3. I have read this Application and to the best of my knowledge and belief, all the answers and statements that pertain to me are true and complete. 4. Upon acceptance of a policy other than as applied for, this Application and any amendments shall be for such modified policy. When required by statute or regulation, any change in A. Plan; B. Age; C. Amount; D. Classification; or E. Benefits shall be made only upon written agreement. 5. A sales representative does not have The Cincinnati Life Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this Application, policy, or receipt, as applicable. 6. The Cincinnati Life Insurance Company shall incur no liability unless: A. This Application is fully completed, dated, signed and witnessed; B. The first premium due is paid in full or the Payroll Deduction Authorization is completed while each proposed insured is alive; C. The insurability of each proposed insured remains as described in this Application and in any supplements to this Application; and D. A policy is formally approved by us and issued on this Application, and delivered to and accepted by the owner.</p> <p>I acknowledge having received and read the Important Notice to the Proposed Insured.</p> <p><input type="checkbox"/> I acknowledge that no illustration conforming to the policy applied for was provided and understand that an illustration conforming to the issued policy will be provided no later than at the time of policy delivery.</p> <p>Any person who, with intent to defraud or is knowingly facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.</p> <p>Signed at: _____ Signed On: _____ City State Month Day Year</p> <p>_____ Signature of Employee</p> <p>_____ Signature of Other Proposed Insured (if required)</p> <p>_____ Signature of Owner, if other than Employee</p>
------------------	--

AGENT	<p>For Agent: I certify, to the best of my knowledge and belief, that the answers to the questions in all parts of this Application are true and correct. I further certify that to the best of my knowledge and belief, this policy <input type="checkbox"/> Will <input type="checkbox"/> Will Not replace or change any existing life insurance or annuity contract now in force.</p> <p><input type="checkbox"/> I certify no illustration was presented at the time of application; or, I certify that I did not provide an illustration conforming to the policy applied for.</p>
	<p>_____ Signature of Enrolling Agent</p> <p>_____ Enrolling Agent Name (please print)</p> <p>_____ Enrolling Agent Code #</p>