

SERFF Tracking Number: LHLI-128338419 State: Arkansas
Filing Company: Lincoln Heritage Life Insurance Company State Tracking Number:
Company Tracking Number: FEAPP12-AR ETAL WM
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: New applications
Project Name/Number: /

Filing at a Glance

Company: Lincoln Heritage Life Insurance Company

Product Name: New applications

SERFF Tr Num: LHLI-128338419 State: Arkansas

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: FEAPP12-AR ETAL State Status: Approved-Closed
WM

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Shirley Grossman, Cathy Disposition Date: 05/10/2012

Patterson, Wanda McNeece, Sally

Roudebush, Rodney Hartwig

Date Submitted: 05/07/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 05/04/2012

Requested Filing Mode: Review & Approval

Domicile Status Comments: Illinois is state of
domicile and part of the Interstate Insurance
Product Regulation Commission which
approved these forms on May 4, 2012

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/10/2012

State Status Changed: 05/10/2012

Deemer Date:

Created By: Wanda McNeece

Submitted By: Wanda McNeece

Corresponding Filing Tracking Number:

Filing Description:

Lincoln Heritage Life Insurance Company, NAIC # 65927

FEAPP12-AR – Application for Individual Life Insurance

REINSAPP12-AR – Reinstatement Application for Individual Life Insurance

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AGREINSAPP12-AR – Reinstatement Application for Individual Life Insurance
CHRDAPP12-AR – Application for Child Rider
AUTH12 – Authorization for Payment and Conditional Receipt
SUPAPP12-AR – Supplemental Application for Individual Life Insurance
END12 – Policy Change Endorsement
PSEND12 – Policy Change Endorsement

We are submitting the above listed forms for review and approval. These forms will not be marketed with an illustration. These are new forms and do not replace any previously filed or approved forms. Producers licensed to do business in your state will market these forms. These forms will initially be used with policy forms WL06-AR and 20P06-AR which were submitted to your department in paper form and approved on November 14, 2005.

Form FEAPP12-AR is an application form that will be used to apply for individual life coverage. We will use this form as a paper, electronic and telephonic application. There will not be any additional dropdowns, scripts, questions, questionnaires or supplements if the applicant answers yes to any of the questions on the application. The following procedures will be followed to verify the authenticity of the transaction.

When used as a paper application the agent will meet with the applicant. The applicant will complete and sign the paper application in the presence of the agent. The agent will sign the application and submit it to the home office for processing. When we receive the payment of the first premium and complete the underwriting process and a policy is issued, a paper copy of the policy, including a copy of the application, will be printed and sent to the applicant.

When used as a telephonic application the process begins with the licensed agent meeting with the applicant. The agent will call the home office to initiate the application process. The agent will state his name and agent number. He will state that John Doe is in his presence and wanting to complete an application for insurance. The home office associate will read the entire application verbatim as the paper application giving the applicant time to provide all necessary information and answer all questions. The home office associate will enter each of the applicant's responses into the policy issuance system. The signature of the applicant will be recorded as verification from the individual that they do want to apply for the individual life insurance coverage. The telephone call is recorded and stored. When we receive the payment of the first premium and complete the underwriting process and a policy is issued, a paper copy of the policy, including a paper copy of the application, will be printed and sent to the applicant. The signature line of the paper copy of the application will indicate that the signature was recorded.

When used as an electronic application the process is similar to the process used for completion of a paper application. A licensed agent will meet with the applicant and complete the application process electronically. The application will be read verbatim as the paper application. Upon completion of the application the applicant's signature will be captured electronically. The electronic application will be submitted to the company's home office for processing. When we receive the payment of the first premium and complete the underwriting process and a policy is issued, a paper copy of

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the policy, including a paper copy of the application, will be printed and sent to the applicant. The signature line of the paper copy of the application will include the electronically captured signature of the applicant.

Form REINSAPP12-AR is a reinstatement application which will be used by our service department to redate or reinstate the policies of current policyholders that have lapsed due to non-payment of premiums.

Form AGREINSAPP12-AR is a reinstatement application which will be used by our agents to redate or reinstate the policies of current policyholders that have lapsed due to non-payment of premiums.

Form CHRDAPP12-AR is an application which will be used to apply for an optional child rider to the individual whole life coverage.

Form AUTH12 is an authorization for payment and conditional receipt. This form is a separate form which will be used with the application for life insurance policies. We developed this multi-use form for checking account and savings account bank drafts, credit card payments, debit card payments and direct billing options. Form AUTH12 is a one-page form and we will image the completed original to our records. The agent will leave the conditional receipt at the bottom of the form with the applicant at the time an application is completed and signed.

Form SUPAPP12-AR is a supplemental application form which will be used to gather additional information for applicants applying for policies with a face amount of \$20,000 and above.

Form END12 is an endorsement form used to make changes to the policy. The form will use the appropriate statement from the variable statements described on the Statement of Variability for Endorsement. This form will become part of the policy on the date the form is issued.

Form PSEND12 is an endorsement form used to make changes to the policy when we receive a signed written request from the policy owner. The form will use the appropriate statement from the variable statements described on the Statement of Variability for Endorsement. This form will become part of the policy on the change is effective.

To the best of my knowledge, information and belief, this form is in compliance with the provisions of the insurance laws, rules and regulations of your state, and does not contain any controversial, unusual or previously disapproved provisions.

Sincerely
Wanda McNeece, ACS
Senior Compliance Associate

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Lincoln Heritage Life Insurance Company
 State Narrative:

Company and Contact

Filing Contact Information

Wanda McNeece, wanda.mcneece@londen-insurance.com
 4343 E Camelback Rd 800-433-8181 [Phone]
 Phoenix, AZ 85018 602-808-8845 [FAX]

Filing Company Information

Lincoln Heritage Life Insurance Company CoCode: 65927 State of Domicile: Illinois
 4343 East Camelback Road Group Code: Company Type: Life and Health
 Phoenix, AZ 85018 Group Name: State ID Number:
 (800) 433-8181 ext. [Phone] FEIN Number: 04-2314290

Filing Fees

Fee Required? Yes
 Fee Amount: \$400.00
 Retaliatory? Yes
 Fee Explanation: 8 forms @ \$50 per form = \$400 total retaliatory filing fees
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Lincoln Heritage Life Insurance Company	\$400.00	05/07/2012	58985760

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/10/2012	05/10/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Flesch Certification	Wanda McNeece	05/09/2012	05/09/2012
Supporting Document	Certificate of Compliance	Wanda McNeece	05/09/2012	05/09/2012
Form	Application for individual life insurance	Wanda McNeece	05/09/2012	05/09/2012
Form	Reinstatement application for individual life insurance	Wanda McNeece	05/09/2012	05/09/2012
Form	Reinstatement Application for individual life insurance	Wanda McNeece	05/09/2012	05/09/2012
Form	Application for child rider	Wanda McNeece	05/09/2012	05/09/2012
Form	Supplemental application for individual life insurance	Wanda McNeece	05/09/2012	05/09/2012
Form	Policy change endorsement	Wanda McNeece	05/09/2012	05/09/2012
Form	Policy change endorsement	Wanda McNeece	05/09/2012	05/09/2012
Form	Authorization for payment and conditional receipt	Wanda McNeece	05/09/2012	05/09/2012

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Disposition

Disposition Date: 05/10/2012

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 (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		No
Supporting Document (revised)	Certificate of Compliance		Yes
Supporting Document	Certificate of Compliance	Replaced	Yes
Supporting Document	Statement of Variability		Yes
Form (revised)	Application for individual life insurance		Yes
Form	Application for individual life insurance	Replaced	Yes
Form (revised)	Reinstatement application for individual life insurance		Yes
Form	Reinstatement application for individual life insurance	Replaced	Yes
Form (revised)	Reinstatement Application for individual life insurance		Yes
Form	Reinstatement Application for individual life insurance	Replaced	Yes
Form (revised)	Application for child rider		Yes
Form	Application for child rider	Replaced	Yes
Form (revised)	Supplemental application for individual life insurance		Yes
Form	Supplemental application for individual life insurance	Replaced	Yes
Form (revised)	Policy change endorsement		Yes
Form	Policy change endorsement	Replaced	Yes
Form (revised)	Policy change endorsement		Yes
Form	Policy change endorsement	Replaced	Yes
Form (revised)	Authorization for payment and conditional receipt		Yes
Form	Authorization for payment and conditional receipt	Replaced	Yes

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Amendment Letter

Submitted Date: 05/09/2012

Comments:

We have uploaded a revised Certification of Readability and a Certification of Compliance showing the new form numbers.

Thank you for your patience

Sincerely

Wanda McNeece, ACS

Senior Compliance Associate

Lincoln Heritage Life Insurance Company

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Flesch Certification

Comment:

Certification of Readability revised.pdf

User Added -Name: Certificate of Compliance

Comment:

Certification of Compliance revised.pdf

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Amendment Letter

Submitted Date: 05/09/2012

Comments:

It has been brought to our attention that we formatted the form numbers for all of these forms incorrectly.

We would like to amend the formatting of the form numbers to move the year to be at the beginning of the form number rather than at the end. This is to allow for tracking of internal statistical information.

The formatting of the form numbers is the only change.

Thank you for your continued consideration.

Sincerely
 Wanda McNeece, ACS
 Senior Compliance Associate
 Lincoln Heritage Life Insurance Company

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
12FEAPP-AR	Application/Enrollment Form	EApplication for individual life insurance	Initial				50.000	12FEAPP-AR.pdf
12REINSAPP-AR	Application/Enrollment Form	EReinstate application for individual life insurance	Initial				50.000	12REINSAPP-AR.pdf
12AGREINSA-AR	Application/Enrollment Form	EReinstate Application	Initial				50.000	12AGREINSA-AR.pdf

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		for individual life insurance		
12CHRDAP P-AR	Application/EApplication nrollment Form	Initial for child rider	50.000	12CHRDAPP- AR.pdf
12SUPAPP- AR	Application/ESupplement nrollment Form	Initial al application for individual life insurance	50.000	12SUPAPP- AR.pdf
12END	Certificate Amendment, change Insert Page, endorsement Endorsemen t or Rider	Policy Initial	50.000	12END.pdf
12PSEND	Certificate Amendment, change Insert Page, endorsement Endorsemen t or Rider	Policy Initial	50.000	12PSEND.pdf
12AUTH	Other	AuthorizationInitial for payment and conditional receipt	50.000	12AUTH.pdf

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Form Schedule

Lead Form Number: FEAPP12-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	12FEAPP-AR	Application/ Enrollment Form	Application for individual life insurance	Initial		50.000	12FEAPP-AR.pdf
	12REINSA PP-AR	Application/ Enrollment Form	Reinstatement application for individual life insurance	Initial		50.000	12REINSAPP-AR.pdf
	12AGREIN SAPP-AR	Application/ Enrollment Form	Reinstatement Application for individual life insurance	Initial		50.000	12AGREINSA PP-AR.pdf
	12CHRDA PP-AR	Application/ Enrollment Form	Application for child rider	Initial		50.000	12CHRDAPP-AR.pdf
	12SUPAPP-AR	Application/ Enrollment Form	Supplemental application for individual life insurance	Initial		50.000	12SUPAPP-AR.pdf
	12END	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Policy change endorsement	Initial		50.000	12END.pdf
	12PSEND	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Policy change endorsement	Initial		50.000	12PSEND.pdf
	12AUTH	Other	Authorization for	Initial		50.000	12AUTH.pdf

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Product Name: New applications
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payment and
conditional receipt



**APPLICATION FOR
INDIVIDUAL LIFE INSURANCE**
PLEASE PRINT LEGIBLY

Executive Offices:
4343 East Camelback Road
Phoenix, AZ 85018-2705

OWNER INFORMATION			
Name _____			
Email _____		Phone _____	
Address _____		City _____	State _____ Zip _____
APPLICANT INFORMATION – All applicants must permanently reside in the United States			
Name _____		Relationship to Owner _____	
Address _____		City _____	State _____ Zip _____
Phone _____	SSN _____	Age _____	Date of Birth _____ Sex _____
Primary Beneficiary _____		Relationship _____	
Address _____		Phone _____	Coverage Amount \$ _____
Contingent Beneficiary _____		Relationship _____	Monthly Premium \$ _____
RIDER OPTIONS			
Child Rider <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Unit(s) Per Child _____		AD&D Rider <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Unit(s) _____	
		Rider Premium \$ _____	
PLAN		PAYMENT METHOD	
<input type="checkbox"/> Final Expense <input type="checkbox"/> 20 Year Pay <input type="checkbox"/> Modified Death Benefit		<input type="checkbox"/> Monthly Draft <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly Direct	
		DUE DATE _____ <i>(1th thru 28th only)</i>	
		TOTAL MONTHLY PREMIUM \$ _____	
TOBACCO QUESTION			
In the past 12 months, has the proposed insured used any form of tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No			
UNINSURABLE CONDITIONS			
1. Has the proposed insured tested positive for HIV or been diagnosed by a physician as having a terminal illness or AIDS?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Is the proposed insured currently bedridden, hospitalized, incarcerated, in a care facility or receiving hospice care? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SIGNIFICANT HEALTH CONDITIONS-If the answer to any health question is "Yes," your death benefit will be modified			
In the past two years, has the proposed insured been diagnosed with, been treated by a physician or taken medication for any of the following conditions:			
1. Disease of the heart, including heart attack, heart surgery, or congestive heart failure? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Disease of the circulatory system, including stroke, aneurysm, or coronary artery disease? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. Cancer, other than basal cell skin cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Disease of the lungs, including COPD or Emphysema, other than asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Disease of the liver or kidney, or had an organ transplant?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Alzheimer's disease, dementia, organic brain syndrome or ALS (Lou Gehrig's disease)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. Alcohol or drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No			
REPLACEMENT			
1. Does the proposed insured have existing life insurance or annuity contracts?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Will this policy replace or change other insurance or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If question 2 is answered yes, list company and policy # _____			
AUTOMATIC PREMIUM LOAN		DELIVERY	
Is Automatic Premium Loan requested? <input type="checkbox"/> Yes <input type="checkbox"/> No		Mail Policy to: <input type="checkbox"/> Owner <input type="checkbox"/> Producer	
<p><i>I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance company</i></p> <p><i>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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the company will rely on my answers in issuing the insurance. I understand that coverage takes effect when the first premium is paid.</i></p>			
Signature of Owner _____		Signature of Applicant _____	
Signed in State _____		Date _____	
PRODUCER'S CONFIRMATION			
Are there existing life insurance and/or annuity contracts on the life of the proposed insured? <input type="checkbox"/> Yes <input type="checkbox"/> No To the best of my knowledge, replacement <input type="checkbox"/> is <input type="checkbox"/> is not involved in this transaction. if replacement is involved, I presented and read the applicant a notice regarding replacement.			
Producer's Signature _____		Printed Name _____ Producer Number _____	
FUNERAL CONSUMER GUARDIAN SOCIETY (FCGS) ENROLLMENT – Free Benefit			
Please enroll me as a non-voting FCGS member: <input type="checkbox"/> Yes <input type="checkbox"/> No			

APPLICATION FOR REINSTATEMENT

PLEASE PRINT LEGIBLY

REDATE <input type="checkbox"/>	
Insured(s)	Policy #
<p><i>I understand that said policy will not be reinstated until this application has been approved by the Company and the necessary premium has been received by the Home Office. The following representations may be used as a basis for contestability of a claim for not more than two (2) years after the date of such representation.</i></p>	
<p>1. Is any proposed insured bedridden, incarcerated, in a care facility, receiving hospice care or ever been diagnosed by a physician as having a terminal illness?</p> <p>2. Has any proposed insured been hospitalized in the past 90 days or used oxygen to assist in breathing?</p> <p>3. In the past two (2) years, has any proposed insured been diagnosed by a member of the medical profession with a disease of the heart, lungs, liver, kidney, circulatory or immune system or been diagnosed with any form of internal cancer?</p> <p>If yes to any question please explain: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><i>I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance Company.</i></p> <p><i>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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the company will rely on my answers in issuing the insurance. I understand that coverage takes effect when the first premium is paid.</i></p> <p>If previously on Automatic Payment Plan, do you wish to resume? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Signature of Owner _____ Date _____</p> <p>Signature of Insured _____ Date _____ (If 18 years or older)</p> <p>Social Security Number of Insured: _____</p>	



Executive Offices:
4343 East Camelback Road
Phoenix, AZ 85018-2705

APPLICATION FOR REINSTATEMENT

PLEASE PRINT LEGIBLY

REDATE

Insured(s) _____ Policy # _____

I understand that said policy will not be reinstated until this application has been approved by the Company and the necessary premium has been received by the Home Office. The following representations may be used as a basis for contestability of a claim for not more than two (2) years after the date of such representation.

- 1. Is any proposed insured bedridden, incarcerated, in a care facility, receiving hospice care or ever been diagnosed by a physician as having a terminal illness? Yes No
 - 2. Has any proposed insured been hospitalized in the past 90 days or used oxygen to assist in breathing? Yes No
 - 3. In the past two (2) years, has any proposed insured been diagnosed by a member of the medical profession with a disease of the heart, lungs, liver, kidney, circulatory or immune system or been diagnosed with any form of internal cancer? Yes No
- If yes to any question please explain: _____

I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance Company.

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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the company will rely on my answers in issuing the insurance. I understand that coverage takes effect when the first premium is paid.

If previously on Automatic Payment Plan, do you wish to resume? Yes No

Signature of Owner _____ Date _____

Signature of Insured _____ Date _____
(If 18 years or older)

Social Security Number of Insured: _____

I confirm that the Owner and Insured answered and completed this application for reinstatement of the policy listed.

Signature of Producer _____ Producer's Number _____



Executive Offices:
 4343 East Camelback Road
 Phoenix, AZ 85018-2705

CHILD RIDER APPLICATION

PLEASE PRINT LEGIBLY

POLICY OWNER INFORMATION

Name _____ Policy Number _____

POLICY APPLICANT INFORMATION – If different from Owner

Name _____ Relationship to Owner _____

Name all natural-born children, stepchildren and legally adopted children or grandchildren for rider of policy applicant (Insured).

Applicants for Child Rider coverage must be at least 30 days old and cannot be more than 17 years of age.

Full Name of Proposed Child / Grandchild	Sex	Date of Birth	Relationship to Policy Applicant	Beneficiary is Policy Owner unless Otherwise Stated
1.				
2.				
3.				
4.				
5.				

HEALTH INFORMATION (If any question is answered "yes" please indicate which proposed child / grandchild.)

1. Is any Proposed Insured Child / Grandchild currently institutionalized, incarcerated, or in a care facility? Yes No Ins # _____
2. Has any Proposed Insured Child / Grandchild ever been diagnosed with or been treated by a member of the medical profession for cancer, complications of diabetes, heart or circulatory disorder, cerebral palsy, muscular dystrophy, spina bifida, or cystic fibrosis? Yes No Ins # _____
3. Has any Proposed Insured Child / Grandchild ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No Ins # _____
4. Has any Proposed Insured Child / Grandchild ever used or received treatment, advice or counseling from a member of the medical profession or other licensed practitioner relating to the usage of alcohol or drugs except as prescribed by a physician? Yes No Ins # _____

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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the company will rely on my answers in issuing the insurance. I understand that coverage takes effect when the first premium is paid.

Signature of Owner _____ Date _____

Signature of Policy Applicant _____ Date _____

Producer's Name _____ Producer's Number _____

LINCOLN HERITAGE LIFE INSURANCE COMPANY

ENDORSEMENT

POLICY NUMBER: []

INSURED: []

EFFECTIVE DATE: []

It is understood and agreed this endorsement, making the following changes, is attached to and made a part of the policy listed above. The provisions of this endorsement apply in lieu of any provisions of the policy to the contrary.

[Variable]



President

Lincoln Heritage Life Insurance Company

I accept the foregoing endorsement.

Owner

Date

Please sign and return this endorsement to the Company. Payment by the Owner of further premium for the policy will be considered acceptance of this endorsement as though the endorsement had been signed as provided.

LINCOLN HERITAGE LIFE INSURANCE COMPANY

ENDORSEMENT

POLICY NUMBER: []

INSURED: []

EFFECTIVE DATE: []

It is understood and agreed this endorsement, making the following changes, is attached to and made a part of the policy listed above. The provisions of this endorsement apply in lieu of any provisions of the policy to the contrary.

[Variable]


President

Lincoln Heritage Life Insurance Company

Authority to honor payments drawn by and payable to Lincoln Heritage Life Insurance Company

4343 E. Camelback Rd. Phoenix, AZ 85018

Checking or Savings Account

Payment type: [] Checking [] Savings
Authorized payor
2nd authorized payor
Account #
Routing #
Financial Institution
City State
Telephone #

Credit Card

Payment type: [] Debit [] Credit
Card type: [] Visa [] Mastercard [] Discover
Name as it appears on card
Sequence number Expiration date
Billing Address
City
State Zip

I authorize Lincoln Heritage Life Insurance Company (hereafter "you") to collect the initial premium and any future payments for this insurance by electronic or other means from the account identified above. I agree that the treatment of such payment, and all rights with respect to it, will be the same as if it were signed and initiated by me. I further agree that if any check, draft or debit is dishonored for any reason, you will not be under any liability, even though dishonor results in the forfeiture or lapse of insurance. This authorization is to remain in effect until you receive written notice from me of its revocation, unless you end it earlier. I understand that no insurance will go into effect until Lincoln Heritage has (a) received and approved the application for life insurance, (b) issued a policy based on the application, (c) withdrawn the first premium from the designated account. The applicant(s) must be alive at the time the payment is honored.

Please withdraw my initial premium on ___/___/___ or [] Immediately upon receipt at home office.

Authorized signature Date

Please include a void check from the account to be drafted if initial payment will be a checking account draft.

Indemnification Agreement – TO: The Financial Institution named above.

"In consideration of your compliance with the authorization of the depositor named above, we agree to indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from execution of any check, draft or order, whether or not genuine, purporting to be drawn by the Lincoln Heritage Life Insurance Company to its own order and received by you in the regular course of business, and to defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan of premium collection." Authorized by a resolution adopted by the Board of Directors of the Lincoln Heritage Life Insurance Company.

12AUTH

CONDITIONAL RECEIPT COVERAGE – LINCOLN HERITAGE LIFE INSURANCE COMPANY

Void if altered, or if check or draft given in payment is not honored.

ALL CHECKS MUST BE MADE PAYABLE TO THE COMPANY – DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

Received the sum of \$ from as the initial premium payment for the life insurance application dated. This receipt is executed subject to the following conditions: Any insurance issued from the application for which this receipt is given will take effect on the date of the application as long as (1) The application has been completely filled out including all required signatures, (2) The proposed insured's health represents a risk acceptable to the Company at the rate and in the amount stated in the application, (3) The first premium is paid with the application, and (4) Any premium in excess of the equivalent of \$100,000 coverage will not be accepted.

Coverage under any policy not issued as applied for or in an amount in excess of the aforementioned maximum will not be in effect until said policy has been delivered during the lifetime of the insured and accepted by the applicant-owner.

Except as provided above, no coverage will take effect and the liability of the Company is limited to a refund of any amount paid.

Producer's Signature Producer's Code Date

Lincoln Heritage reserves the right to convert your check into an electronic payment, which will be reflected on your account as an ACH transaction. funds may be debited from your account on the same day the payment is received. Your original check will not be returned. If you do not wish for your check to be processed electronically, please contact our offices at 800-438-7180.

12AUTH

SERFF Tracking Number: LHLI-128338419 State: Arkansas
 Filing Company: Lincoln Heritage Life Insurance Company State Tracking Number:
 Company Tracking Number: FEAPP12-AR ETAL WM
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: New applications
 Project Name/Number: /

Supporting Document Schedules

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

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Certificate of Compliance		
Comments:		
Attachment: Certification of Compliance revised.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachments: Statement of Variability for Applications and Authorization.pdf Statement of Variability for Endorsement.pdf		

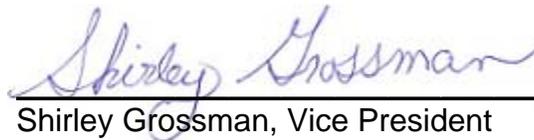
CERTIFICATION OF FLESCH READABILITY SCORE

I, Shirley Grossman, Vice President for Lincoln Heritage Life Insurance Company do hereby certify that the forms listed below have text that achieves a minimum score of 50.0 on the FLESCH reading ease test. The forms print in not less than ten (10) point type and one (1) point leaded, except for specification pages, any schedules and tables.

Policy Form(s):

12FEAPP-AR – Application for Individual Life Insurance
12REINSAPP-AR – Reinstatement Application for Individual Life Insurance
12AGREINSAPP-AR – Reinstatement Application for Individual Life Insurance
12CHRDAPP-AR – Application for Child Rider
12AUTH – Authorization for Payment and Conditional Receipt
12SUPAPP-AR – Supplemental Application for Individual Whole Life Insurance Policy
12END – Policy Change Endorsement
12PSEND – Policy Change Endorsement

LINCOLN HERITAGE LIFE INSURANCE COMPANY



Shirley Grossman, Vice President

May 9, 2012

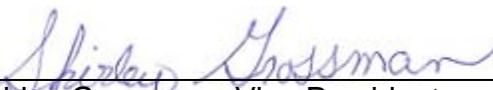
Certification of Compliance

Lincoln Heritage Life Insurance Company

As specified in the Arkansas Insurance Regulations, I do hereby certify that the Company has reviewed the contents of Arkansas Rule and Regulation 19 and to the best of its knowledge and belief this submission meets the provisions of this rule as well as all applicable requirements of the Arkansas Insurance Department.

Enclosed policy forms:

12FEAPP-AR
12AGREINSAPP-AR
12REINSAPP-AR
12CHRDAPP-AR
12AUTH
12SUPAPP-AR
12END
12PSEND



Shirley Grossman, Vice President

May 9, 2012

Date

Statement of Variability for Applications and Authorization

The only variable information associated with these forms is the information that is specific to the company or the individual completing the form or the individual applying for insurance coverage or the producer making the sale.

The owner and applicant information is variable to the extent that the information is specific to the person completing the information or the person applying for coverage.

The executive office of the company is variable to the extent that the company may at some future date change physical location of the office.

The information requested on the authorization / conditional receipt form is variable to the extent that the information is specific to the individual payor for the insurance coverage.

None of the text found in the application forms or the authorization for payment form is variable.

Statement of Variability for Endorsement

We have bracketed all variables in these forms.

The officer's signature is variable to the extent that the individual holding the position may change due to retirement or other unforeseen circumstances.

The company will use the endorsement form to make changes to the policy. The information is variable to the extent that the circumstances surrounding the need for change are specific to the individual and the policy. The following variable wording will be inserted in the form in the area designated with brackets and labeled as "Variable":

1. The above listed policy is issued without any additional Accidental Death and Dismemberment coverage on the above listed insured with a premium amount as stated on the policy schedule page.
2. The above listed policy is [issued with / changed to][1 – 8] units of additional Accidental Death and Dismemberment coverage with a premium amount as stated on the policy schedule page
3. The above listed policy is issued without Child Rider coverage for [name of child] with a premium amount as stated on the policy schedule page.
4. The above listed policy is issued without Child Rider coverage with a premium amount as stated on the policy schedule page.
5. The above listed policy is [issued with/changed to] [1 – 5] units of additional Child Rider coverage for [name of child] with a premium amount as stated on the policy schedule page.
6. The above listed policy is issued as a tobacco classification, with a premium amount as stated on the policy schedule page.
7. The above listed policy is issued as a non-tobacco classification, with a premium amount as stated on the policy schedule page.
8. The above listed policy is [issued with/ changed to] ownership vested in [name of owner].
9. The above listed policy is issued with a reduced face amount of [\$XXXXX.XX]. the premium rates have been adjusted accordingly and are reflected on the corrected policy schedule page.
10. The above listed policy is [issued with / changed to] the Insured's age as shown on the policy schedule page.
11. The above listed policy is issued with coverage on the life of [name of insured].
12. The above listed policy is issued with the application signed on [date] in [city and state].
13. The above listed policy is issued with an annual premium and face amount as shown on the policy schedule page.
14. The above listed policy is [issued with / changed to] [name of beneficiary] listed as the primary beneficiary.

SERFF Tracking Number: LHLI-128338419 State: Arkansas
 Filing Company: Lincoln Heritage Life Insurance Company State Tracking Number:
 Company Tracking Number: FEAPP12-AR ETAL WM
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: New applications
 Project Name/Number: /

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)
05/07/2012	Form	Application for individual life insurance	05/09/2012	FEAPP12-AR.pdf (Superseded)
05/07/2012	Form	Reinstatement application for individual life insurance	05/09/2012	REINSAPP12-AR.pdf (Superseded)
05/07/2012	Form	Reinstatement Application for individual life insurance	05/09/2012	AGREINSAPP12-AR.pdf (Superseded)
05/07/2012	Form	Application for child rider	05/09/2012	CHRDAPP12-AR.pdf (Superseded)
05/07/2012	Form	Supplemental application for individual life insurance	05/09/2012	SUPAPP12-AR.pdf (Superseded)
05/07/2012	Form	Policy change endorsement	05/09/2012	END12.pdf (Superseded)
05/07/2012	Form	Policy change endorsement	05/09/2012	PSEND12.pdf (Superseded)
05/07/2012	Form	Authorization for payment and conditional receipt	05/09/2012	AUTH12.pdf (Superseded)
05/07/2012	Supporting Document	Flesch Certification	05/09/2012	Certification of Readability.pdf (Superseded)
05/07/2012	Supporting	Certificate of Compliance	05/09/2012	Certification of

SERFF Tracking Number: LHLI-128338419

State: Arkansas

Filing Company: Lincoln Heritage Life Insurance Company

State Tracking Number:

Company Tracking Number: FEAPP12-AR ETAL WM

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: New applications

Project Name/Number: /

Document

Compliance.pdf (Superceded)



APPLICATION FOR INDIVIDUAL LIFE INSURANCE PLEASE PRINT LEGIBLY

Executive Offices: 4343 East Camelback Road Phoenix, AZ 85018-2705

OWNER INFORMATION
Name
Email Phone
Address City State Zip
APPLICANT INFORMATION - All applicants must permanently reside in the United States
Name Relationship to Owner
Address City State Zip
Phone SSN Age Date of Birth Sex
Primary Beneficiary Relationship
Address Phone Coverage Amount \$
Contingent Beneficiary Relationship Monthly Premium \$
RIDER OPTIONS
Child Rider Yes No Unit(s) Per Child AD&D Rider Yes No Unit(s) Rider Premium \$
PLAN PAYMENT METHOD DUE DATE
Final Expense Monthly Draft
20 Year Pay Modified Death Benefit Annual Quarterly
Semi-Annual Monthly Direct (1th thru 28th only) TOTAL MONTHLY PREMIUM \$
TOBACCO QUESTION
In the past 12 months, has the proposed insured used any form of tobacco? Yes No
UNINSURABLE CONDITIONS
1. Has the proposed insured tested positive for HIV or been diagnosed by a physician as having a terminal illness or AIDS? Yes No
2. Is the proposed insured currently bedridden, hospitalized, incarcerated, in a care facility or receiving hospice care? Yes No
SIGNIFICANT HEALTH CONDITIONS-If the answer to any health question is "Yes," your death benefit will be modified
In the past two years, has the proposed insured been diagnosed with, been treated by a physician or taken medication for any of the following conditions:
1. Disease of the heart, including heart attack, heart surgery, or congestive heart failure? Yes No
2. Disease of the circulatory system, including stroke, aneurysm, or coronary artery disease? Yes No
3. Cancer, other than basal cell skin cancer? Yes No
4. Disease of the lungs, including COPD or Emphysema, other than asthma? Yes No
5. Disease of the liver or kidney, or had an organ transplant? Yes No
6. Alzheimer's disease, dementia, organic brain syndrome or ALS (Lou Gehrig's disease)? Yes No
7. Alcohol or drug abuse? Yes No
REPLACEMENT
1. Does the proposed insured have existing life insurance or annuity contracts? Yes No
2. Will this policy replace or change other insurance or annuities? Yes No
If question 2 is answered yes, list company and policy #
AUTOMATIC PREMIUM LOAN DELIVERY
Is Automatic Premium Loan requested? Yes No Mail Policy to: Owner Producer
I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance company
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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the company will rely on my answers in issuing the insurance. I understand that coverage takes effect when the first premium is paid.
Signature of Owner Signature of Applicant
Signed in State Date
PRODUCER'S CONFIRMATION
Are there existing life insurance and/or annuity contracts on the life of the proposed insured? Yes No To the best of my knowledge, replacement is is not involved in this transaction. if replacement is involved, I presented and read the applicant a notice regarding replacement.
Producer's Signature Printed Name Producer Number
FUNERAL CONSUMER GUARDIAN SOCIETY (FCGS) ENROLLMENT - Free Benefit
Please enroll me as a non-voting FCGS member: Yes No

APPLICATION FOR REINSTATEMENT

PLEASE PRINT LEGIBLY

REDATE <input type="checkbox"/>	
Insured(s)	Policy #
<p><i>I understand that said policy will not be reinstated until this application has been approved by the Company and the necessary premium has been received by the Home Office. The following representations may be used as a basis for contestability of a claim for not more than two (2) years after the date of such representation.</i></p>	
<p>1. Is any proposed insured bedridden, incarcerated, in a care facility, receiving hospice care or ever been diagnosed by a physician as having a terminal illness?</p> <p>2. Has any proposed insured been hospitalized in the past 90 days or used oxygen to assist in breathing?</p> <p>3. In the past two (2) years, has any proposed insured been diagnosed by a member of the medical profession with a disease of the heart, lungs, liver, kidney, circulatory or immune system or been diagnosed with any form of internal cancer?</p> <p>If yes to any question please explain: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><i>I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance Company.</i></p> <p><i>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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the company will rely on my answers in issuing the insurance. I understand that coverage takes effect when the first premium is paid.</i></p> <p>If previously on Automatic Payment Plan, do you wish to resume? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Signature of Owner _____	Date _____
Signature of Insured _____ (If 18 years or older)	Date _____
Social Security Number of Insured: _____	



Executive Offices:
4343 East Camelback Road
Phoenix, AZ 85018-2705

APPLICATION FOR REINSTATEMENT

PLEASE PRINT LEGIBLY

REDATE

Insured(s) _____ Policy # _____

I understand that said policy will not be reinstated until this application has been approved by the Company and the necessary premium has been received by the Home Office. The following representations may be used as a basis for contestability of a claim for not more than two (2) years after the date of such representation.

- 1. Is any proposed insured bedridden, incarcerated, in a care facility, receiving hospice care or ever been diagnosed by a physician as having a terminal illness? Yes No
 - 2. Has any proposed insured been hospitalized in the past 90 days or used oxygen to assist in breathing? Yes No
 - 3. In the past two (2) years, has any proposed insured been diagnosed by a member of the medical profession with a disease of the heart, lungs, liver, kidney, circulatory or immune system or been diagnosed with any form of internal cancer? Yes No
- If yes to any question please explain: _____

I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance Company.

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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the company will rely on my answers in issuing the insurance. I understand that coverage takes effect when the first premium is paid.

If previously on Automatic Payment Plan, do you wish to resume? Yes No

Signature of Owner _____ Date _____

Signature of Insured _____ Date _____

(If 18 years or older)

Social Security Number of Insured: _____

I confirm that the Owner and Insured answered and completed this application for reinstatement of the policy listed.

Signature of Producer _____ Producer's Number _____



Executive Offices:
 4343 East Camelback Road
 Phoenix, AZ 85018-2705

CHILD RIDER APPLICATION

PLEASE PRINT LEGIBLY

POLICY OWNER INFORMATION

Name _____ Policy Number _____

POLICY APPLICANT INFORMATION – If different from Owner

Name _____ Relationship to Owner _____

Name all natural-born children, stepchildren and legally adopted children or grandchildren for rider of policy applicant (Insured).

Applicants for Child Rider coverage must be at least 30 days old and cannot be more than 17 years of age.

Full Name of Proposed Child / Grandchild	Sex	Date of Birth	Relationship to Policy Applicant	Beneficiary is Policy Owner unless Otherwise Stated
1.				
2.				
3.				
4.				
5.				

HEALTH INFORMATION (If any question is answered "yes" please indicate which proposed child / grandchild.)

1. Is any Proposed Insured Child / Grandchild currently institutionalized, incarcerated, or in a care facility? Yes No Ins # _____
2. Has any Proposed Insured Child / Grandchild ever been diagnosed with or been treated by a member of the medical profession for cancer, complications of diabetes, heart or circulatory disorder, cerebral palsy, muscular dystrophy, spina bifida, or cystic fibrosis? Yes No Ins # _____
3. Has any Proposed Insured Child / Grandchild ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No Ins # _____
4. Has any Proposed Insured Child / Grandchild ever used or received treatment, advice or counseling from a member of the medical profession or other licensed practitioner relating to the usage of alcohol or drugs except as prescribed by a physician? Yes No Ins # _____

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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the company will rely on my answers in issuing the insurance. I understand that coverage takes effect when the first premium is paid.

Signature of Owner _____ Date _____

Signature of Policy Applicant _____ Date _____

Producer's Name _____ Producer's Number _____

LINCOLN HERITAGE LIFE INSURANCE COMPANY

ENDORSEMENT

POLICY NUMBER: []

INSURED: []

EFFECTIVE DATE: []

It is understood and agreed this endorsement, making the following changes, is attached to and made a part of the policy listed above. The provisions of this endorsement apply in lieu of any provisions of the policy to the contrary.

[Variable]



President

Lincoln Heritage Life Insurance Company

I accept the foregoing endorsement.

Owner

Date

Please sign and return this endorsement to the Company. Payment by the Owner of further premium for the policy will be considered acceptance of this endorsement as though the endorsement had been signed as provided.

LINCOLN HERITAGE LIFE INSURANCE COMPANY

ENDORSEMENT

POLICY NUMBER: []

INSURED: []

EFFECTIVE DATE: []

It is understood and agreed this endorsement, making the following changes, is attached to and made a part of the policy listed above. The provisions of this endorsement apply in lieu of any provisions of the policy to the contrary.

[Variable]



President

Lincoln Heritage Life Insurance Company

Authority to honor payments drawn by and payable to Lincoln Heritage Life Insurance Company

4343 E. Camelback Rd. Phoenix, AZ 85018

Checking or Savings Account

Payment type: [] Checking [] Savings
Authorized payor
2nd authorized payor
Account #
Routing #
Financial Institution
City State
Telephone #

Credit Card

Payment type: [] Debit [] Credit
Card type: [] Visa [] Mastercard [] Discover
Name as it appears on card
Sequence number Expiration date
Billing Address
City
State Zip

I authorize Lincoln Heritage Life Insurance Company (hereafter "you") to collect the initial premium and any future payments for this insurance by electronic or other means from the account identified above. I agree that the treatment of such payment, and all rights with respect to it, will be the same as if it were signed and initiated by me. I further agree that if any check, draft or debit is dishonored for any reason, you will not be under any liability, even though dishonor results in the forfeiture or lapse of insurance. This authorization is to remain in effect until you receive written notice from me of its revocation, unless you end it earlier. I understand that no insurance will go into effect until Lincoln Heritage has (a) received and approved the application for life insurance, (b) issued a policy based on the application, (c) withdrawn the first premium from the designated account. The applicant(s) must be alive at the time the payment is honored.

Please withdraw my initial premium on ___/___/___ or [] Immediately upon receipt at home office.

Authorized signature Date

Please include a void check from the account to be drafted if initial payment will be a checking account draft.

Indemnification Agreement – TO: The Financial Institution named above.

"In consideration of your compliance with the authorization of the depositor named above, we agree to indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from execution of any check, draft or order, whether or not genuine, purporting to be drawn by the Lincoln Heritage Life Insurance Company to its own order and received by you in the regular course of business, and to defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan of premium collection." Authorized by a resolution adopted by the Board of Directors of the Lincoln Heritage Life Insurance Company.

AUTH12

CONDITIONAL RECEIPT COVERAGE – LINCOLN HERITAGE LIFE INSURANCE COMPANY

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ALL CHECKS MUST BE MADE PAYABLE TO THE COMPANY – DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

Received the sum of \$ _____ from _____ as the initial premium payment for the life insurance application dated _____. This receipt is executed subject to the following conditions: Any insurance issued from the application for which this receipt is given will take effect on the date of the application as long as (1) The application has been completely filled out including all required signatures, (2) The proposed insured's health represents a risk acceptable to the Company at the rate and in the amount stated in the application, (3) The first premium is paid with the application, and (4) Any premium in excess of the equivalent of \$100,000 coverage will not be accepted.

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AUTH12

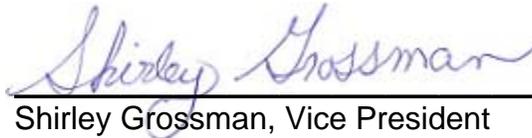
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PSEND12 – Policy Change Endorsement

LINCOLN HERITAGE LIFE INSURANCE COMPANY



Shirley Grossman, Vice President

May 7, 2012

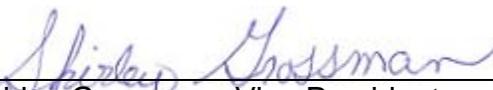
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Lincoln Heritage Life Insurance Company

As specified in the Arkansas Insurance Regulations, I do hereby certify that the Company has reviewed the contents of Arkansas Rule and Regulation 19 and to the best of its knowledge and belief this submission meets the provisions of this rule as well as all applicable requirements of the Arkansas Insurance Department.

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AGREINSAPP12-AR
REINSAPP12-AR
CHRDAPP12-AR
AUTH12
SUPAPP12-AR
END12
PSEND12



Shirley Grossman, Vice President

May 7, 2012

Date