

SERFF Tracking Number: STFL-128169578 State: Arkansas
Filing Company: State Farm Life Insurance Company State Tracking Number:
Company Tracking Number: SFL-AR-1004522 AR ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: New Life Application and New Life Application Supplement Filing
Project Name/Number: New Life Application and New Life Application Supplement Filing /SFL-AR-1004522 AR et al

Filing at a Glance

Company: State Farm Life Insurance Company

Product Name: New Life Application and New Life Application Supplement Filing SERFF Tr Num: STFL-128169578 State: Arkansas

Life Application Supplement Filing

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: SFL-AR-1004522 AR State Status: Approved-Closed
ET AL

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Rachel Lighthall, Maureen Macak Disposition Date: 05/08/2012

Date Submitted: 05/01/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: 10/07/2012

Implementation Date:

State Filing Description:

General Information

Project Name: New Life Application and New Life Application
Supplement Filing

Status of Filing in Domicile: Not Filed

Project Number: SFL-AR-1004522 AR et al
Requested Filing Mode: Review & Approval

Date Approved in Domicile:
Domicile Status Comments: Our state of
domicile, Illinois, is a member of the Interstate
Insurance Product Regulation Commission.

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Market Type: Individual
Individual Market Type:
Filing Status Changed: 05/08/2012
State Status Changed: 05/08/2012

Deemer Date:
Submitted By: Maureen Macak
Filing Description:

Created By: Maureen Macak
Corresponding Filing Tracking Number:

Enclosed for your consideration are the following new individual life insurance forms:

Form # , Form Name
1004522 AR , Application for Life Insurance

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1004563 AR , Life Application Supplement
1004567 , Binding Receipt

Form 1004522 AR, Application for Life Insurance, will be used with our Whole Life, Term, and Universal Life product lines with the exception of the \$10,000 Whole Life Insurance Policy form 11006-04. This form will replace Life Application form 1000704 AR.3, which was approved by your Department on September 2, 2011 under SERFF tracking number STFL-127348922 and state tracking number 49645.

Application form 1004522 AR can be completed through the following distribution channels:

- Customer visiting an Agent's office;
- Customer completing the online application through www.Statefarm.com; or
- Customer completing the application by telephoning a State Farm Call Center agent of licensed insurance producer.

In all cases, a copy of the completed application is included in the policy.

Completing an Application Through an Agent

Application form 1004522 AR can be completed on paper or electronically in an agent's office. The application must be completed by a licensed State Farm agent or a licensed member of the agent's staff. The electronic application is accessed through our internal State Farm system. Information included in the electronic application is identical to the questions and information requested on the paper application. Responses to those questions will be printed on the paper application.

Customer Completing Application Online

Application 1004522 AR can also be completed online by the customer. If the customer is interested in applying for coverage they may do so by applying through our company website, www.statefarm.com.

The customer will complete a Quote through our company website. Before proceeding, the customer will be asked if they agree to completing the application and transacting with the company electronically. If they do not agree, they will be instructed to visit a State Farm agent's office. If they agree to continue electronically, they can continue with the online application. If the person completing the online application is a current State Farm customer, then some demographic information will be retrieved. If the person completing the online application is not a current State Farm customer, they may complete a quote anonymously. If at any time they want to save that Quote, we will ask them to establish an account. We will ask a series of unique questions to authenticate the identity of the customer. Once customer identification has been verified, the customer will be asked if the policy being applied for will replace an

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existing policy. If a replacement is indicated, the customer will be instructed to visit an agent's office to complete the application and the required replacement forms. If the application does not involve a replacement, the customer can continue through the online submission process.

The customer will be given the option to electronically sign the application using a digital signature solution or they can print the application, physically sign it, and mail the completed application to the Company.

The following explanation addresses the electronic handling of the application when applied for through www.statefarm.com:

- Information included in the electronic application is identical to the questions and information requested on the paper application. Responses to those questions will be printed on the paper application.
- The customer will be provided with the appropriate disclosure and will be asked if they consent to electronically sign the application. If the customer agrees, they will be asked to review the application. A tab will appear in the signature area(s) of an electronic version (PDF) of the application to indicate where signatures are needed and to navigate the customer through the signature ceremony.
- When the customer indicates they are ready to sign, they will be asked to type in their name and choose a style that will convert their name to a handwritten signature or if device type allows, the customer will be able to choose to write/draw their signature instead of using a chosen stylized signature.
- The customer will then apply the signature in each required location.
- Once all signatures are applied the customer will be presented with a confirmation message. When the customer confirms, the signature is permanently associated with the application, which completes the signature ceremony.
- When the confirm signature step is completed, the signature software will capture signature data such as date signed, time signed (timestamp), and Internet Protocol (IP) address to uniquely identify the signature and the form and ensure that the application can no longer be altered.
- The completed application will then be stored electronically by State Farm and an electronic copy of the signed application will be made available to the customer that they can store electronically or print a paper copy.
- Once the electronic signature is applied, the signature is no longer accessible. The signature ceremony relies on the identity authentication and will only allow that individual to apply a signature to the application.

If the customer electronically signs the application, they will be asked if they wish to apply a payment at time of application. If they wish to pay later, the application will be submitted and payment will be collected after the application is underwritten but prior to the policy being issued. All documents will be available for viewing by the customer through their online account once the application has been submitted.

Application Completed by an Agent or Licensed Insurance Producer at a State Farm Call Center

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The customer can call a State Farm Call Center to have an agent or licensed insurance producer complete Application form 1004522 AR. The agent or licensed insurance producer will ask the customer if he or she agrees to transact with the Company electronically. The response to this question will determine if the company can electronically communicate with the customer or will need to use traditional mail. If the customer agrees to electronic transactions with the Company, then the call center application process will continue. If the customer is a current State Farm customer, then some demographic information will be retrieved. If the customer is not a current State Farm customer, then an account will be established.

As part of the application call center process, we will ask a series of unique questions to authenticate the identity of the customer. Once identification has been verified, the licensed insurance producer will provide the customer with product information by means of a quote or an illustration. The customer will then be asked underwriting and beneficiary information questions. Once the application is complete, the agent or licensed insurance producer will print and sign the application and any supporting documents and mail the application and supporting documents to the customer for their review and signatures. After signing all required documents, the customer will mail the signed documents back to the Company.

Replacement situations are identified by the replacement question found in the application. If the replacement question is answered "yes", a state mandated replacement form (Important Notice: Replacement of Life Insurance or Annuities) must be completed by the applicant and submitted with the application. A separate signed statement as to whether or not an agent knows a replacement is or may be involved in the transaction is accomplished in the Agent's Statement.

Form 1004563 AR, Life Application Supplement (LAS), will be used if the Proposed Insured is age 16 or over. The Life Application Supplement requests additional medical information and may be required on any application received through any distribution channel.

This form will replace form 1002906, approved by your Department on March 2, 2010 under SERFF tracking number STFL-126423717 and state tracking number 45046.

Life Application Supplement form 1004563 AR can be completed through the following channels:

- Recorded telephone interview by a third party vendor;
- Customer completes interview online; or
- Recorded telephone interview by a State Farm Call Center agent or licensed insurance producer

In all cases, a completed copy of the Life Application Supplement is included in the policy.

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Recorded Telephone Interview by a Third Party Vendor

When a paper application is submitted, form 1004563 AR will be completed by a recorded telephone underwriting interview. The interview is confidential and is conducted by a third party vendor. Information obtained during the interview is recorded on the Life Application Supplement form. The tele-underwriting interview is not a sales or solicitation call. There is no discussion of life insurance products and no premium is collected or requested. An oral verification and consent may be obtained and noted on the completed form. If an oral verification and consent is not obtained, a handwritten signature will be obtained when the policy is delivered. If a telephone underwriting interview is not conducted, a paramedical laboratory technician or medical examiner may complete the form and obtain the handwritten signatures. In each case, the proposed insured will have the opportunity to review the completed form.

Interview Completed Online

Individuals applying for life insurance coverage online must first complete Life Insurance Application 1004522 AR. Based on the proposed insured's age, type of policy, the amount applied for and the answers to the medical questions on the application the system will determine whether Life Application Supplement (LAS), 1004563 AR is needed. Information obtained in the online interview questions is recorded on the LAS form. Once the LAS is completed, the customer will be given the option to electronically sign it (just as they do the application) using a digital signature solution or they can print the application and LAS, physically sign them, and mail the completed documents to the Company.

Recorded Telephone Interview by a State Farm Call Center Agent or Licensed Insurance Producer

When the customer calls a State Farm Call Center to have an agent or licensed insurance producer complete Application form 1004522 AR, when required, they will be given the option to have the agent or licensed insurance producer complete the Life Application Supplement (LAS) form 1004563 AR. When selected, form 1004563 AR will be completed by the recorded telephone interview. Information obtained during the interview is recorded on the LAS. Once the LAS is completed, the agent or licensed insurance producer will print the LAS along with the application and any supporting documents and mail to the customer for their review and signatures. After signing all required documents, the customer will mail the completed documents back to the Company.

Form 1004567 is the binding receipt form to be used with Application for Individual Life Insurance form 1004522 AR. This form will be provided upon receipt of payment in connection with the application.

Form 1004567 replaces form 1002483 which was approved by your Department on March 29, 2010 under SERFF tracking number STFL-126451532.

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These forms will be marketed to the general public and will be effective December 9, 2012.

State Narrative:

Company and Contact

Filing Contact Information

Maureen Macak, Tech - Contracts & Compliance
 maureen.macak.ljrd@statefarm.com
 1 State Farm Plaza 309-763-2341 [Phone]
 Bloomington, IL 61710-0001 309-766-8483 [FAX]

Filing Company Information

State Farm Life Insurance Company CoCode: 69108 State of Domicile: Illinois
 1 State Farm Plaza Group Code: 176 Company Type:
 Bloomington, IL 61710-0001 Group Name: 69108 State ID Number:
 (309) 766-4541 ext. [Phone] FEIN Number: 37-0533090

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? Yes
 Fee Explanation: \$50.00 per form x 3 forms = \$150.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
State Farm Life Insurance Company	\$150.00	05/01/2012	58812637

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/08/2012	05/08/2012

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Disposition

Disposition Date: 05/08/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Regulation 19		No
Supporting Document	Statement of Variability		No
Form	Application for Life Insurance		No
Form	Life Application Supplement		No
Form	Binding Receipt		No

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Form Schedule

Lead Form Number: 1004522 AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	1004522 AR	Application/ Enrollment Form	Application for Life Insurance	Revised	Replaced Form #: 1000704 AR.3 Previous Filing #: STFL-127348922	50.000	Life Application_1004522 AR_Final - BRACKETED .pdf
	1004563 AR	Application/ Enrollment Form	Life Application Supplement	Revised	Replaced Form #: 1002906 Previous Filing #: STFL-126423717	56.000	Life App Supplement_1004563 AR_FINAL - BRACKETED .pdf
	1004567	Other	Binding Receipt	Revised	Replaced Form #: 1002483 Previous Filing #: STFL-126451532	54.000	Life Binding Receipt_1004567_FINAL_3 -12-12 - BRACKETED .pdf

Application for Individual Life Insurance



State Farm Life Insurance Company

[1 State Farm Plaza
Bloomington, IL
61710-0001]

Use this section to indicate whether this is a new policy or a change to an existing policy. For changes to an existing policy, please indicate the policy number(s).

1 Application Type (Choose One)

- a. New Policy
- b. Change of Existing State Farm Life Insurance Policy:
- Change of Existing Policy/Added Benefits
 - Term Conversion with Increase in Amount
 - Universal Life Increase
 - Select Term Re-Entry

Indicate the Existing Policy Number(s)

2 Your Information (Proposed Insured #1)

a. NAME AND ADDRESS

<input checked="" type="radio"/> Mr. <input type="radio"/> Ms. [Doe]	[John]	[J]
Last Name	First Name	Middle Initial
[123 Main St.]		
Street Address		
[Bloomington]	[IL]	[61701]
City	State	ZIP Code

b. PERSONAL INFORMATION

Sex: M F Marital Status: [Married] U.S. or Canadian Citizen: Yes No

[35]	[03/01/1977]	[IL]	[6' / 1"]	[195 lbs]
Age	Date of Birth (mm/dd/yyyy)	State of Birth	Height (feet/inches)	Weight (lbs)
[D000-0000-0000]	[IL]	[000-00-0000]		
Driver's License Number	State	Social Security or Tax Identification Number		

c. EMPLOYMENT

[Attorney]	[Self]
Occupation	Employer

Do you work in one of the following occupations: amusement, construction, diving, explosives, gas/oil, liquor, logging, mining, sports? Yes No

If yes, please describe your exact duties:

Doc type
01

5 Proposed Insured Under Age 16

- a. Do you want Proposed Insured to become Owner of policy at, and after, age 21? Yes No
- b. Please indicate total amount of life insurance on: Father \$ _____ Select if none
 Mother \$ _____ Select if none

Complete this section if the Proposed Insured is under age 16.

6 Coverages — Term Life and Whole Life

a. POLICY AND AMOUNT APPLIED FOR

Basic Policy Type:

- Select Term-10
- Select Term-20
- Select Term-30
- Return of Premium Term-20
- Return of Premium Term-30
- Mortgage Life (Decreasing Term)-15
- Mortgage Life (Decreasing Term)-30
- 5 Year Term
- Whole Life
- 10 Pay Whole Life
- 15 Pay Whole Life
- 20 Pay Whole Life
- Single Premium Whole Life

\$ [100,000]
 Amount applied for

b. RIDERS/BENEFITS

- Waiver of Premium (*Proposed Insured #1 only*): Yes No
- Guaranteed Insurability Option: \$ _____
- Children's Term Rider: _____ units
- Payor (*Please complete information for Proposed Insured #2*)

If you are applying for Universal Life, Joint Universal Life or Survivorship Universal Life, skip to Section 7.

CTR unit = \$1000.

A minimum of five (5) units and a maximum of 20 units may be purchased. Maximum amount of insurance in force under CTR is \$20,000.

	Proposed Insured #1:	Proposed Insured #2:
<input type="checkbox"/> Select Term-10	\$ _____	\$ _____
<input type="checkbox"/> Select Term-20	\$ _____	\$ _____
<input type="checkbox"/> Select Term-30	\$ _____	\$ _____
<input type="checkbox"/> Mortgage Life (Decreasing Term)-15	\$ _____	\$ _____
<input type="checkbox"/> Mortgage Life (Decreasing Term)-30	\$ _____	\$ _____
<input type="checkbox"/> 5 Year Term	\$ _____	\$ _____

c. PREMIUM AMOUNT AND MODE OF PAYMENT

Amount of premium submitted with application: \$ [58.46]
 Mode of premium payment: [Monthly]

d. SELECT A DIVIDEND OPTION

- Please select a dividend option from the list provided. If the selected option is unavailable, or you do not select an option, the policy provisions will determine the option.*
- Accumulate
 - Cash
 - Paid-up Additions
 - Reduce Premium

6 Coverages — Term Life and Whole Life (continued)

e. AUTOMATIC PREMIUM LOAN (APL)

Automatic Premium Loan (APL) is a policy provision, available for some policy types, that a policyowner may elect. If any premium remains unpaid at the end of the Policy's grace period, a loan against the cash value is automatically made to pay the unpaid premium.

Do you want the APL provision to apply, if available? Yes No

7 Coverages — Universal Life/Joint Universal Life/Survivorship Universal Life

a. POLICY AND INITIAL BASIC AMOUNT

- Universal Life \$ _____
- Joint Universal Life (First to Die) Initial Basic Amount
- Survivorship Universal Life (Second to Die)

b. DEATH BENEFIT (complete for new policy)

Please select one option. The policy provisions will determine the option if you do not make a selection.

- Option 1 – Basic Amount
- Option 2 – Basic Amount plus Account Value

c. RIDERS/BENEFITS

Universal Life only:

- Waiver of Monthly Deduction (Proposed Insured #1)
- Level Term (Proposed Insured #2) \$ _____
- Children's Term Rider _____ units
- Guaranteed Insurability Option \$ _____
- Flexible Care Benefit

Joint Universal Life (First to Die) only:

- Waiver of Monthly Deduction (Proposed Insured #1)
 - Waiver of Monthly Deduction (Proposed Insured #2)
 - Level Term (Proposed Insured #1) \$ _____
 - Level Term (Proposed Insured #2) \$ _____
 - Children's Term Rider _____ units
 - Guaranteed Insurability Option \$ _____
- (Both Insureds MUST have Waiver of Monthly Deduction to apply for Guaranteed Insurability Option)

Survivorship Universal Life (Second to Die) only:

- Waiver of Monthly Deduction (Proposed Insured #1)
- Level Term (Proposed Insured #1) \$ _____
- Level Term (Proposed Insured #2) \$ _____
- Estate Preservation Rider — Four Year Level Term

CTR unit = \$1000.

A minimum of five (5) units and a maximum of 20 units may be purchased. Maximum amount of insurance in force under CTR is \$20,000.

7 Coverages — Universal Life/Joint Universal Life/Survivorship Universal Life (continued)

d. SELECT A DIVIDEND OPTION

Please select a dividend option from the list at right. If the selected option is unavailable, or you do not select an option, the policy provisions will determine the option.

- Addition to Account Value
- Cash

e. IRS DEFINITION OF LIFE INSURANCE TEST (Universal Life or First to Die only)

Please select one option. The policy provisions will determine the option if you do not make a selection.

- Cash Value Accumulation
- Guideline Premium

f. PLANNED PREMIUM

Please select a payment mode.

- Annual
- State Farm Payment Plan (SFPP) _____
Existing SFPP Account Number
- Other Special Monthly (please specify) _____

Amount to be billed each payment date: \$ _____ Amount of premium submitted with application: \$ _____

g. INCREASE IN BASIC AMOUNT (Existing Universal Life or First to Die only)

Do not complete for new policies. Minimum amounts apply.

\$ _____

8 Designate Your Beneficiaries

Please provide information on your beneficiary(ies) in the space provided.

a. PROPOSED INSURED #1

- Completion of this section will replace all previous rider and policy designations for this policy. If you are requesting a Change of Existing Policy or an addition in coverage, this designation will replace previous designations for this insured.
- If the policy is First to Die, this designation will apply if Proposed Insured #1 is the first insured to die or insured under a Level Term (PI #1) rider.
- If the policy is Second to Die, this designation will apply if Proposed Insured #1 is the last insured to die or insured under a Level Term (PI #1) rider.

Primary Beneficiary

<u>[Doe, Jane A.]</u>	<u>[100%]</u>	<u>[Spouse]</u>
● Full Name (Last, First, Middle Initial)	Allocation %	Relationship to Proposed Insured #1
<u>[Bloomington, IL]</u>		<u>[02/01/1979]</u>
City and State of Residence (optional)		Date of Birth (mm/dd/yyyy - optional)
● Full Name (Last, First, Middle Initial)	Allocation %	Relationship to Proposed Insured #1
_____	_____	_____
City and State of Residence (optional)		Date of Birth (mm/dd/yyyy - optional)

About Beneficiary

Providing optional information may help State Farm locate the beneficiary in the future.

If additional beneficiary fields are needed, please include in Explanations section.

If no allocation percentage is indicated, any proceeds would be divided equally.

If an allocation percentage is indicated for each beneficiary, the total allocation must add up to 100% using whole numbers.

8 Designate Your Beneficiaries (continued)

● Full Name (Last, First, Middle Initial)	Allocation %	Relationship to Proposed Insured #1
City and State of Residence (optional)		Date of Birth (mm/dd/yyyy - optional)

If the desired beneficiary is other than an individual (for example, Children of Insured, a Trust, Charitable Organization, Estate or similar entity), provide information in the space below.

● Entity Name	Allocation %
City and State (optional)	

Secondary Beneficiary

[Doe, Jill A.]	[100%]	[Child]
● Full Name (Last, First, Middle Initial)	Allocation %	Relationship to Proposed Insured #1
[Bloomington, IL]		
City and State of Residence (optional)		Date of Birth (mm/dd/yyyy - optional)

● Full Name (Last, First, Middle Initial)	Allocation %	Relationship to Proposed Insured #1
City and State of Residence (optional)		Date of Birth (mm/dd/yyyy - optional)

● Full Name (Last, First, Middle Initial)	Allocation %	Relationship to Proposed Insured #1
City and State of Residence (optional)		Date of Birth (mm/dd/yyyy - optional)

If the desired beneficiary is other than an individual (for example, Children of Insured, a Trust, Charitable Organization, Estate or similar entity), provide information in the space below.

● Entity Name	Allocation %
City and State (optional)	

b. PROPOSED INSURED #2

- Complete for Additional Insured's rider only if the Beneficiary provision in the rider is NOT desired. If this section is completed, the Payment of Benefit provision of the policy will control rather than the Beneficiary provision of such rider. "Additional Insured" would be used in place of the "Insured." If a Change of Existing Policy or an addition in coverage, this designation will replace previous designations for this insured.
- If the policy is First to Die, this designation will apply if Proposed Insured #2 is the first insured to die or insured under a Level Term (PI #2) rider.
- If the policy is Second to Die, this designation will apply if Proposed Insured #2 is the last insured to die or insured under a Level Term (PI #2) rider.

If additional beneficiary fields are needed, please include in Explanations section.

If no allocation percentage is indicated, any proceeds would be divided equally.

If an allocation percentage is indicated for each beneficiary, the total allocation must add up to 100% using whole numbers.

8 Designate Your Beneficiaries (continued)

Primary Beneficiary

<input type="radio"/> Full Name (Last, First, Middle Initial)	<u>Allocation %</u>	<u>Relationship to Proposed Insured #2</u>
<u>City and State of Residence (optional)</u>		<u>Date of Birth (mm/dd/yyyy - optional)</u>
<input type="radio"/> Full Name (Last, First, Middle Initial)	<u>Allocation %</u>	<u>Relationship to Proposed Insured #2</u>
<u>City and State of Residence (optional)</u>		<u>Date of Birth (mm/dd/yyyy - optional)</u>
<input type="radio"/> Full Name (Last, First, Middle Initial)	<u>Allocation %</u>	<u>Relationship to Proposed Insured #2</u>
<u>City and State of Residence (optional)</u>		<u>Date of Birth (mm/dd/yyyy - optional)</u>

If the desired beneficiary is other than an individual (for example, Children of Insured, a Trust, Charitable Organization, Estate or similar entity), provide information in the space below.

<input type="radio"/> Entity Name	<u>Allocation %</u>
<u>City and State (optional)</u>	

Secondary Beneficiary

<input type="radio"/> Full Name (Last, First, Middle Initial)	<u>Allocation %</u>	<u>Relationship to Proposed Insured #2</u>
<u>City and State of Residence (optional)</u>		<u>Date of Birth (mm/dd/yyyy - optional)</u>
<input type="radio"/> Full Name (Last, First, Middle Initial)	<u>Allocation %</u>	<u>Relationship to Proposed Insured #2</u>
<u>City and State of Residence (optional)</u>		<u>Date of Birth (mm/dd/yyyy - optional)</u>
<input type="radio"/> Full Name (Last, First, Middle Initial)	<u>Allocation %</u>	<u>Relationship to Proposed Insured #2</u>
<u>City and State of Residence (optional)</u>		<u>Date of Birth (mm/dd/yyyy - optional)</u>

If the desired beneficiary is other than an individual (for example, Children of Insured, a Trust, Charitable Organization, Estate or similar entity), provide information in the space below.

<input type="radio"/> Entity Name	<u>Allocation %</u>
<u>City and State (optional)</u>	

If additional beneficiary fields are needed, please include in Explanations section.

If no allocation percentage is indicated, any proceeds would be divided equally.

If an allocation percentage is indicated for each beneficiary, the total allocation must add up to 100% using whole numbers.

9 Children's Term Rider (CTR) Applied For

List children under 18, if any. If none, select "None." For relationship to Proposed Insured (PI), please indicate Child, Stepchild, or Legally Adopted Child.

None

Full Name (Last, First, Middle Initial)	Sex	Relationship to PI #1	Relationship to PI #2 (for First to Die only)	Date of Birth (mm/dd/yyyy)	Amount Now Insured For
	<input type="radio"/> M <input type="radio"/> F				\$
	<input type="radio"/> M <input type="radio"/> F				\$
	<input type="radio"/> M <input type="radio"/> F				\$
	<input type="radio"/> M <input type="radio"/> F				\$

Please complete this section if you have applied for CTR, listing children under age 18, if any.

If additional space is needed for children's names, please include in Explanations section.

10 CTR Applied For or Proposed Insured #1 is Under Age 16

a. In the last **10 years**, has Proposed Insured #1, or any children named in Section 9, been diagnosed, treated or given advice by a member of the medical profession for any of the following? (select all that apply)

- | | | | |
|---------------------------------------|---------------------------------------|--------------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Impairment of sight,
hearing or speech | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizure | |

None of the above

If any are selected, please provide a detailed explanation in the space provided at the end of this form.

b. Has Proposed Insured #1, or any children named in Section 9, ever tested positive for or been diagnosed by a member of the medical profession for:

- Human Immunodeficiency Virus (HIV) Yes No
- Acquired Immune Deficiency Syndrome (AIDS) Yes No

If any are selected "yes," please provide a detailed explanation in the space provided at the end of this form.

c. In the last **three (3) years**, has Proposed Insured #1, or any children named in Section 9, seen a member of the medical profession for any reason not previously explained (excluding routine physical examinations with normal findings)?

Yes No

If yes, please provide a detailed explanation in the space provided at the end of this form.

Please complete this section if you have applied for CTR, or the Proposed Insured #1 is under age 16.

11 Other Life Insurance or Annuities Owned (If Proposed Insured #1 will not be the Owner, these questions should be completed by Applicant)

All applicants should complete this section.

- a.** Do you own any life insurance or annuities on yourself or others? Yes No
- b.** If yes, is the policy being applied for a replacement of any of these policies:
- Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? Yes No
 - Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? Yes No
- c.** What is the total amount of life insurance in force from all companies (excluding group insurance)?

Proposed Insured #1:

Proposed Insured #2:

\$ _____

\$ _____

12 Stranger Originated Life Insurance (If Proposed Insured #1 will not be the Owner, these questions should be completed by Applicant)

When Proposed Insured is age 16 and up, complete this section.

If you answer "yes" to any of these questions, please provide a detailed explanation in the space provided at the end of this form.

- a.** Have you entered into, or made any plans to enter into, any agreement or contract to sell or assign the ownership of, or a beneficial interest in the policy you are applying for? Yes No
- b.** Have you received or do you anticipate receiving any type of inducement, fee, or compensation as an incentive to purchase the policy you are applying for? Yes No
- c.** Have you ever sold, transferred or assigned any life insurance or annuity policy to a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity? Yes No

13 Additional Insurance Information

When Proposed Insured is age 16 and up, complete this section.

If you answer "yes" to any of these questions, please provide a detailed explanation in the space provided at the end of this form.

- | | Proposed Insured #1: | Proposed Insured #2: |
|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------|
| a. Have you ever had an application for life insurance declined or postponed? | <input type="radio"/> Yes <input checked="" type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| b. In the last three (3) years , have you claimed or received any benefits because of injury, sickness or disability? | <input type="radio"/> Yes <input checked="" type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |

14 Medical Information

If you answer "yes" to any of these questions, please provide a detailed explanation in the space provided at the end of this form.

	Proposed Insured #1:	Proposed Insured #2:
a. Have you ever tested positive for or been diagnosed by a member of the medical profession for:		
• Human Immunodeficiency Virus (HIV)	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No
• Acquired Immune Deficiency Syndrome (AIDS)	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No
b. In the last three (3) years , have you been treated, diagnosed, or advised by a member of the medical profession as follows? (if yes, select all that apply):	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No
• Hospitalized or surgically treated for chest pain or any disorder of the heart?	<input type="checkbox"/>	<input type="checkbox"/>
• Hospitalized or surgically treated for stroke or transient ischemic attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
• Diagnosed with, or are you currently being treated for, cancer (excluding basal cell and squamous cell cancer of the skin)?	<input type="checkbox"/>	<input type="checkbox"/>
• Diagnosed with any kidney disorder that requires current dialysis treatment?	<input type="checkbox"/>	<input type="checkbox"/>
• Advised to have further evaluation or testing (except for HIV) to determine a diagnosis; or had surgery recommended that has not been performed?	<input type="checkbox"/>	<input type="checkbox"/>

When Proposed Insured is age 16 and up, complete this section.

15 Criminal Charges and Convictions

If you answer "yes" to any of these questions, please provide a detailed explanation in the space provided at the end of this form.

	Proposed Insured #1:	Proposed Insured #2:
a. In the last three (3) years , have you been involved in any of the following? (if yes, select all that apply):	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No
• Convicted of or pleaded guilty to any felony?	<input type="checkbox"/>	<input type="checkbox"/>
• Charged with a crime (with charges pending at this time)?	<input type="checkbox"/>	<input type="checkbox"/>
• Placed on parole or probation?	<input type="checkbox"/>	<input type="checkbox"/>
• Incarcerated or facing incarceration?	<input type="checkbox"/>	<input type="checkbox"/>
b. In the last three (3) years , have you been convicted of or pleaded guilty to driving under the influence of alcohol or drugs?	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No

When Proposed Insured is age 16 and up, complete this section.

16 Lifestyle and Travel Information

If you answer "yes" to any of these questions, please provide a detailed explanation in the space provided at the end of this form.

	Proposed Insured #1:	Proposed Insured #2:
a. Are you currently residing or traveling in any country outside of the United States or Canada?	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No

When Proposed Insured is age 16 and up, complete this section.

16 Lifestyle and Travel Information (continued)

	Proposed Insured #1	Proposed Insured #2
b. In the last three (3) years , have you engaged in any of the following? <i>(if yes, select all that apply):</i>	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No
• Aviation (other than as a passenger or commercial airline pilot)	<input type="checkbox"/>	<input type="checkbox"/>
• BASE jumping, hang gliding, sky diving	<input type="checkbox"/>	<input type="checkbox"/>
• Mountain/rock climbing	<input type="checkbox"/>	<input type="checkbox"/>
• SCUBA diving	<input type="checkbox"/>	<input type="checkbox"/>
• Vehicle racing	<input type="checkbox"/>	<input type="checkbox"/>
c. In the next six (6) months , do you plan to leave or travel from the United States or Canada?	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No

17 Tobacco Use

If you answer "yes" to this question, please provide a detailed explanation in the space provided at the end of this form.

	Proposed Insured #1	Proposed Insured #2
a. In the last three (3) years , have you used tobacco or other nicotine products in any form?	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No
<i>If yes, please provide month/year last used:</i>	_____ / _____ mm/yyyy	_____ / _____ mm/yyyy

When Proposed Insured is age 16 and up, complete this section.

18 Additional Medical Information (If no medical exam is required)

If you answer "yes" to any of these questions, please provide a detailed explanation in the space provided at the end of this form.

	Proposed Insured #1	Proposed Insured #2
a. In the last 10 years , have you been diagnosed, treated, or been given advice by a member of the medical profession for any of the conditions listed below? <i>(if yes, select all that apply):</i>	<input type="radio"/> Yes [<input checked="" type="radio"/>]No	<input type="radio"/> Yes <input type="radio"/> No
• Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>
• Asthma	<input type="checkbox"/>	<input type="checkbox"/>
• Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
• Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>
• Chronic Obstructive Pulmonary Disease (COPD)/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
• Heart Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>
• High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
• Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>
• Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>
• Mental/Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>
• Organ Transplant (other than cornea transplant)	<input type="checkbox"/>	<input type="checkbox"/>
• Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>

When Proposed Insured is age 16 and up and no medical exam is required, complete this section.

18 Additional Medical Information (If no medical exam is required) (continued)

b. In the last five (5) years, have you for any reason not previously explained:	Proposed Insured #1	Proposed Insured #2
• Seen a doctor or any member of the medical profession, or been treated at a hospital or other medical facility (excluding seasonal illnesses such as colds, flu, bronchitis and allergies such as hay fever)?	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Had medication prescribed other than medications for cold, flu, seasonal allergies or birth control?	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
c. In the last 10 years, have you:		
• Used cocaine, marijuana, methamphetamine, or any other controlled substance or narcotic not prescribed by a member of the medical profession?	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Had medical treatment or counseling for use of alcohol or prescribed or non-prescribed drugs?	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Been advised by a member of the medical profession to discontinue use of alcohol or prescribed or non-prescribed drugs?	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

19 Explanations

If you need more space, please attach additional pages, which will become part of this application. Please note that these must be signed and dated by the Proposed Insured(s) and/or Applicant, and witnessed by Agent.

[18 b. Annual physical with Dr. William Catner, Bloomington, IL]

20 Agreements

Coverage will be effective as of the Policy Date if the following conditions are met: the first premium is paid when this policy is delivered; the Proposed Insureds are living on the delivery date; and, on that delivery date, the information given to the Company is true and complete to the best of the Proposed Insureds' and Applicant's knowledge and belief.

For changes in Basic Amount for a Universal Life Policy or First to Die Policy, the change will be effective on the Deduction Date on or next following acceptance of the change by the Company if on such Deduction Date the following conditions are met: there is enough Cash Surrender Value to make the required monthly deduction; the Proposed Insureds are all living; and the information given to the Company is true and complete to the best of the Proposed Insureds' and Applicant's knowledge and belief.

However, if a Binding Receipt has been given and is in effect, its terms apply.

All Proposed Insureds and the Applicant state that the information in this Application and any medical history is true and complete to the best of their knowledge and belief. Information is not true and complete to the best of their knowledge and belief if it misrepresents or omits a fact which a Proposed Insured or the Applicant knew or should have known, regardless whether the misrepresentation or omission was intentional. It is agreed that the Company can investigate the truth and completeness of such information while this policy is contestable.

By accepting this Policy, the Owner agrees to the beneficiaries named and corrections made. No change in plan, amount, benefits, or age at issue may be made on the Application unless the Owner agrees in writing. Only an authorized company officer may change the policy provisions. Neither the agent nor a medical examiner may pass on insurability.

Any policy issued on this Application will be owned by Proposed Insured #1 or the Applicant, if other than Proposed Insured #1.

NOTICE: Insurance laws may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. The Owner should consult with legal advisors for any questions about these matters.

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.

Signatures on
next page 

20 Agreements (continued)

Social Security or Tax Identification Number (TIN) Certification – Substitute W-9

Applicant — By signing this application, I certify under penalties of perjury that

- (1) The TIN shown above is correct, and
- (2) I am a U.S. citizen or other U.S. person (defined below), and
- (3) Select the one that applies:

- I am subject to backup withholding
- I am exempt from backup withholding, or I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding.

Definition of U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. (See instructions.)

[]

Proposed Insured #1 Signature

[December 9, 2012]

Date

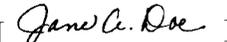
SIGNATURE

SAMPLE

Proposed Insured #2 Signature

Date

SIGNATURE

[]

Applicant Signature

[December 9, 2012]

Date

SIGNATURE

Applicant's signature is not required unless Applicant is other than Proposed Insured #1. If a firm or corporation is to be the policyowner, please provide company name and signature of an authorized officer.

[]

Agent/Licensed Insurance Producer Signature

[December 9, 2012]

Date

SIGNATURE

[At [Bloomington]
City

[IL]
State

Individual Life Insurance Application Supplement



State Farm Life Insurance Company

[1 State Farm Plaza
Bloomington, IL
61710-0001]

1 YOUR INFORMATION (PROPOSED INSURED)

[Doe] [John] [J.]
Last Name First Name Middle Initial
[1/1/1978] [LF-0000-0000]
Date of Birth (mm/dd/yyyy) Application Number(s)

2 MEDICAL INFORMATION

Please check all that apply and provide explanations in the space provided at the end of this document, including diagnoses, dates, durations, and names and addresses of all physicians and medical facilities. If needed, use additional sheets.

In the last **10 years**, have you been diagnosed, treated, or been given advice by a member of the medical profession for any of the conditions listed below?

- | | | |
|----------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Esophageal Disorder | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Headaches (frequent or severe) | <input type="checkbox"/> Mental Health Disorder (such as depression or anxiety) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Neck Disorder |
| <input type="checkbox"/> Back Disorder | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Nerve Disorder |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Organ Transplant (other than cornea transplant) |
| <input type="checkbox"/> Blood Vessel Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Brain Disorder | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Intellectual Development Disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Intestinal Disorder | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Spinal Cord Disorder |
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Stomach Disorder |
| <input type="checkbox"/> Connective Tissue Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD/Emphysema | | |
| <input type="checkbox"/> Diabetes | | |

[None of the above

3 INFORMATION ON ALCOHOL AND CONTROLLED SUBSTANCE USE

Have you in the last **10 years**:

- a. Used cocaine, marijuana, methamphetamine, or any other controlled substance or narcotic not prescribed by a member of the medical profession? Yes No
- b. Had medical treatment or counseling for use of alcohol or prescribed or non-prescribed drugs? Yes No
- c. Been advised by member of the medical profession to discontinue use of alcohol or prescribed or non-prescribed drugs? Yes No

4 ADDITIONAL MEDICAL INFORMATION

- a. Are you currently experiencing symptoms for which you plan to seek advice from a medical professional? Yes No

Signatures on next page

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4 Additional Medical Information (continued)

b. In the last **12 months**, have you experienced any unexplained changes in weight? Yes No

In the last **five (5) years**, have you **for any reason not previously explained**:

c. Seen a physician or any member of the medical profession, had surgery, or been treated at a hospital or other medical facility, including emergency treatment? Yes No

d. Had medication prescribed other than medications for cold, flu, seasonal allergies or birth control? Yes No

Please answer the following only if you are between the ages of 18 and 65:

e. Has your father, mother, or any brother or sister been diagnosed or treated by a member of the medical profession for cancer, coronary artery disease or heart attack before age 60? Yes No Unknown

Please answer the following only if you are a female between the ages of 15 and 50:

f. To the best of your knowledge and belief, are you now pregnant? Yes No

g. Have you delivered a child within the last **six (6) months**? Yes No

5 **PHYSICIAN INFORMATION**

Who is your physician for routine care or illness? (Please indicate in Explanations.)

6 **EXPLANATIONS**

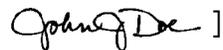
If you need more space, please attach, sign and date additional pages, which will become part of this application. Include your physician's street address, city and phone number in this section.

[5. Dr. William Catner]
[123 Main St.]
[Bloomington, IL 61701]
[309-000-0000]

I state that all information in this Life Application Supplement and any additional sheets is true and complete to the best of my knowledge and belief. This Life Application Supplement and any additional sheets will be part of the application.

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.

SAMPLE

[]

Proposed Insured Signature

[12/9/2012]

Date



Binding Receipt



State Farm Life
Insurance Company

1 State Farm Plaza
Bloomington, IL
61710-0001

Note to Agent:

Send original signed form to your State Farm Life Insurance Operation Center and provide a copy to the applicant.

State Farm Life Insurance Company (State Farm) has received payment in connection with the application for life insurance on Proposed Insured #1 and any others named in the application (*if applicable, Proposed Insured #2 and children applied for under the Children's Term Rider*). This Receipt is void if a check or other form of payment you provided is not honored or is declined by your financial institution.

If the application is for a change on a universal life policy, then payment may be in the form of collection of a deduction as of the Application Date, as applicable. "Change" includes an increase in Basic Amount or the addition of a Level Term Rider, a Children's Term Rider, a Waiver of Monthly Deduction Rider, or a Flexible Care Benefit Rider if available in your state. If the application is approved and the Application Date is a deduction date, the required deduction will be made as of that date. If the application is approved and the Application Date is not the deduction date, the required deduction will be prorated from the Application Date to the next deduction date. There must be enough policy cash surrender value to make the required deduction.

As of the Application Date, life insurance and any additional benefits will be payable according to the terms of the application and the policy applied for, subject to the requirements and limitations of this Receipt. No death benefit or benefit under a Flexible Care Benefit Rider, if applied for, is provided by this Receipt unless death or chronic illness results from an accident that occurs or an illness that first manifests itself after the Application Date. No total disability benefit, if applied for, is provided by this Receipt unless total disability results from an accident that occurs or an illness that first manifests itself after the Application Date.

Conditions for Coverage Under This Receipt

Coverage under this Receipt will become effective when the following conditions have been met:

- Proposed Insured is age 90 or younger on the date the application is signed;

- State Farm has received payment in connection with the application for life insurance;
- For Proposed Insureds age 16 and over: Questions 13a through 16a in the application are each answered "no"; and
- The application is complete and signed.

For Proposed Insureds age 16 and over: If any answer to questions 13a through 16a in the application is "yes" or any question is left blank, is incorrect, incomplete, or untrue, no Binding Receipt coverage will take effect. If premium has been paid, the total premium paid for the policy will be refunded.

Amount of Life Insurance Coverage Under This Receipt

- **Age 16 or over:** The total insurance benefit for a Proposed Insured age 16 years or over at death under this or any other in-force binding receipts and pending applications will not exceed the sum of \$1,000,000.
- **Age 15 days through 15 years:** The total insurance benefit for a Proposed Insured age 15 days through 15 years at death under this or any other in-force binding receipts and pending applications will not exceed the sum of \$100,000.
- **Age under 15 days:** The total insurance benefit for a Proposed Insured under the age of 15 days at death under this or any other in-force binding receipts and pending applications will not exceed the sum of \$3,000.

If, (1) the total insurance amount for a Proposed Insured under this or any other in-force receipts and pending applications exceeds the maximum stated above, (2) we approve the application with the policy date the same as the Application Date, and (3) you accept the policy, a credit will be provided to you based on the insurance amount in excess of the maximum stated above for the period from the Application Date to the date the application is approved.

If the application is for (a) an addition of a rider or benefit to an existing policy other than a universal life policy or (b) replacing existing life insurance with State Farm Life Insurance Company, then any

Signatures on
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benefit otherwise payable under this Receipt will be reduced by any benefit payable for the same Proposed Insured under the State Farm Life Insurance Company life insurance policies listed on the application as being replaced.

Coverage Under This Receipt Will End When the First of the Following Occurs

- The application is approved;
- Notice of disapproval of the application is given;
- Notice of termination of this Binding Receipt is given to Proposed Insured #1 or to the Applicant, if other than the Proposed Insured #1 (*underwriting may continue in some cases*); or
- 60 days have expired starting with the Application Date.

State Farm reserves the right to disapprove the application by:

- Offering to issue a policy other than as applied for, or
- Declining to issue a policy.

If the application is disapproved or the Binding Receipt is terminated, the notice will be given to Proposed Insured #1 or to the Applicant, if other than the Proposed Insured #1. The notice will be given either in person to, or by mailing to the last known address of, Proposed Insured #1 or the Applicant. If mailed, coverage will end upon mailing of that notice.

The payment will be refunded if:

- The life insurance and/or any additional benefits offered are not accepted;
- State Farm declines to approve the life insurance and any additional benefits;
- State Farm terminates the Binding Receipt; or
- The 60-day period has expired.

There is no coverage under this Receipt if the application contains any material misrepresentation.

NO AGENT OR COMPANY REPRESENTATIVE MAY WAIVE OR CHANGE THE ANSWER TO ANY QUESTION IN THE APPLICATION OR CHANGE THE TERMS OF THIS RECEIPT.

[John J. Doe]

Print Proposed Insured #1 Name

Print Proposed Insured #2 Name

SAMPLE

[Mark Smith]

Agent/Licensed Insurance Producer Signature

SIGNATURE

[December 9, 2012]

Application Date

SERFF Tracking Number: STFL-128169578 State: Arkansas
 Filing Company: State Farm Life Insurance Company State Tracking Number:
 Company Tracking Number: SFL-AR-1004522 AR ET AL
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: New Life Application and New Life Application Supplement Filing
 Project Name/Number: New Life Application and New Life Application Supplement Filing /SFL-AR-1004522 AR et al

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Please see the attached Flesch Score document for the forms included in this filing.

Attachment:

ARFLESCH 1004522 AR et al 4-30-12.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

Not applicable to this filing - this filing is actually for approval of an individual life application.

Item Status: **Status**
Date:

Satisfied - Item: Regulation 19

Comments:

Please see that attached Regulation 19 form.

Attachment:

ARREG19 1004522 AR et al 4-10-12.pdf

Item Status: **Status**
Date:

Satisfied - Item: Statement of Variability

Comments:

Please see the attached Statement of Variability documents for the required forms included in this filing.

Attachments:

1004522 AR - Life App Statement of Variability - 4-30-12.pdf

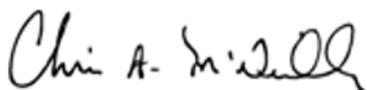
1004563 AR - LAS Statement of Variability - 4-30-12.pdf

STATE OF ARKANSAS

CERTIFICATE

This is to certify that the attached forms have achieved a Flesch Reading Ease Score indicated below and comply with the requirements of Ark. Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form #</u>	<u>Flesch Score</u>
1004522 AR	50
1004563 AR	56
1004567	54



Chris A. McNeilly

Assistant Secretary

Title

April 30, 2012

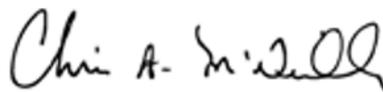
Date

STATE OF ARKANSAS

CERTIFICATION

This is to certify that the forms contained in this submission are in compliance with Arkansas Regulation No. 19:

Form # 1004522 AR, 1004563 AR, & 1004567



Chris A. McNeilly
Assistant Secretary

April 30, 2012

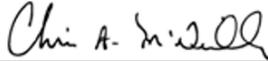
Date

State Farm Life Insurance Company

**Statement of Variability
1004522 AR**

The bracketed variable material includes the following:

- Company logo
- The company address shown on page 1 is subject to change.
- All John Doe information is hypothetical for purposes of the submission and will vary depending on the policy issued.
- Agent signature – will not appear in internet format



Signature

April 30, 2012

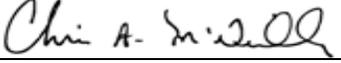
Date

State Farm Life Insurance Company

**Statement of Variability
1004563 AR**

The bracketed variable material includes the following:

- Company logo
- The company address shown on page 1 is subject to change.
- All John Doe information is hypothetical for purposes of the submission and will vary depending on the policy issued.


Signature

April 30, 2012
Date