

SERFF Tracking Number: CCGC-128386281 State: Arkansas  
Filing Company: Connecticut General Life Insurance Company State Tracking Number:  
Company Tracking Number: MIB REVISIONS  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: MIB Revisions  
Project Name/Number: MIB Revisions/MIB Revisions

## Filing at a Glance

Company: Connecticut General Life Insurance Company

Product Name: MIB Revisions

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: CCGC-128386281 State: Arkansas

SERFF Status: Closed-Accepted State Tr Num:

For Informational Purposes

Co Tr Num: MIB REVISIONS

Author: Julie Levine

Date Submitted: 06/06/2012

State Status: Closed-Accepted for  
Informational Purposes

Reviewer(s): Linda Bird

Disposition Date: 06/11/2012

Disposition Status: Accepted For  
Informational Purposes

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: MIB Revisions

Project Number: MIB Revisions

Requested Filing Mode: Informational

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 06/11/2012

State Status Changed: 06/11/2012

Created By: Julie Levine

Corresponding Filing Tracking Number:

Filing Description:

Revision of MIB language in approved applications to comply with MIB directive.

State Narrative:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Submitted to our  
domiciliary state of CT on 5/24/12.

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Julie Levine

## Company and Contact

### Filing Contact Information

Julie A. Levine, Sr. Regulatory Compliance

julie.levine@cigna.com

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 Product Name: MIB Revisions  
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**Analyst**

Wilde Building, A4COL 860-226-9019 [Phone]  
 900 Cottage Grove Road 860-226-8292 [FAX]  
 Hartford, CT 06152

**Filing Company Information**

Connecticut General Life Insurance Company	CoCode: 62308	State of Domicile: Connecticut
Wilde Building, A4COL	Group Code: 901	Company Type:
900 Cottage Grove Road	Group Name:	State ID Number:
Hartford, CT 06152	FEIN Number: 06-0303370	
(800) 225-0646 ext. [Phone]		

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$150.00  
 Retaliatory? No  
 Fee Explanation: 3 forms at \$50 each.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Connecticut General Life Insurance Company	\$150.00	06/06/2012	59860171

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Linda Bird	06/11/2012	06/11/2012

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## Disposition

Disposition Date: 06/11/2012

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Copies highlighting revised MIB language		Yes
Form	Corporate Life Insurance Application		Yes
Form	Part II of Corporate Life Insurance Application		Yes
Form	Corporate Life Insurance Supplementary Application		Yes

SERFF Tracking Number: CCGC-128386281 State: Arkansas  
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## Form Schedule

### Lead Form Number: Life App (03/03)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Life App (03/03)	Application/ Enrollment Form	Corporate Life Insurance Application	Initial		50.000	Life App (03-03)-MIB Rev.pdf
	Life App Part II (03/03)	Application/ Enrollment Form	Part II of Corporate Life Insurance Application	Initial		50.000	Life App Part II (03-03)-MIB Rev.pdf
	Sup App (03/03)	Application/ Enrollment Form	Corporate Life Insurance Supplementary Application	Initial		51.200	Supp App (03-03)-MIB Rev.pdf



MEDICAL QUESTIONS	Details of "Yes" answers to questions 8-16
8. Have you ever applied for any life or health Insurance which resulted in your being turned down, asked to pay an extra premium or issued a reduced face amount? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Have you ever had any indication of, been advised to consult, or consulted a physician, hospital or other medical facility for: any disease of the heart, including chest pain, heart murmur, heart attack or stroke; disease of the blood vessels or lungs; sleep apnea; tumor or cancer; elevated blood pressure; nervous system disorder, including seizures or paralysis; Alzheimer's disease; a mental, emotional or behavioral disorder; diabetes, kidney or urinary disorder; disease of the prostate, testicles, breast or ovaries; disease of the stomach, intestines, pancreas or liver; treatment for anemia or any other blood disorder; alcoholism, drug abuse or addiction, or use of drugs not prescribed by a physician?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Have you ever had any indication of or sought medical treatment for any physical or mental disorder not listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Have you been diagnosed by a physician, hospital or other medical facility or been treated for Acquired Immune Deficiency Syndrome or an AIDS related condition?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. a. Name and address of your personal physician. b. Physician's phone number. c. Date and reason last consulted. d. What treatment was given or medication prescribed? <i>If none, please check.</i> <input type="checkbox"/> None	
13. When and for what reason did you last consult a hospital, medical facility or physician other than your personal physician? Give details including names and addresses.	
14. Are you currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please list.</i>	
15. Have you been absent from work because of illness or injury for more than 3 of the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Have you used tobacco in any form within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", describe frequency, quantity and kind of tobacco used.</i>	
17. What is your exact height and weight?	Feet _____ Inches _____ Pounds _____
SUPPLEMENTAL INFORMATION	
18. Do you contemplate flying, or have you flown during the past 2 years as a pilot, student pilot, or crewmember? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", an Aviation Supplement is required.</i>	
19. Do you plan to participate or have you participated within the past 2 years in motor vehicle or boat racing, mountain or rock climbing, bungee jumping, hang gliding, sky diving, scuba diving or similar sports? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", an Avocation and Sports Questionnaire is required.</i>	
20. Do you contemplate residence or travel outside of the United States or Canada, other than for normal (2 weeks or less) business travel or vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", a Foreign Travel or Residence Supplement is required.</i>	

21. Have you been convicted of any moving traffic violations in the past 2 years or had your license suspended, revoked or restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please provide details.</i>	Details:		
22. What is the total amount of Life Insurance (personal and business) presently in force on your life excluding any policies being replaced? Amounts should include coverage under any term riders. Do not include Group Life or Health insurance. <i>If none, please check.</i> <input type="checkbox"/> None	<u>Company</u>	<u>When Issued</u>	<u>Amount</u>
23. ADDITIONAL INSTRUCTIONS	24. HOME OFFICE CHANGES OR CORRECTIONS		
<b>FOR VARIABLE LIFE INSURANCE ONLY</b> DOES THE APPLICANT UNDERSTAND: a) That the death benefit under a variable life insurance policy may increase or decrease depending upon the investment results of the sub-accounts? <input type="checkbox"/> Yes <input type="checkbox"/> No b) That the policy's cash surrender value may increase or decrease on any day depending upon the investment results of the sub-accounts? <input type="checkbox"/> Yes <input type="checkbox"/> No c) That no minimum cash surrender value is guaranteed? <input type="checkbox"/> Yes <input type="checkbox"/> No d) That the policy is a long-term commitment to meet insurance needs and financial goals? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**DECLARATION, AUTHORIZATION, and SIGNATURE**

I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree, a) that this Life Insurance Application, and the Insured's Enrollment Form and the Master Application, if applicable, shall form a part of the Policy issued, and b) that no Agent/Representative of Connecticut General Life Insurance Company (the Company) shall have the authority to waive or complete an answer to any question in this Application, transfer insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I further agree that no insurance shall take effect unless and until the policy has been delivered to and accepted by me and the initial premium has been paid during the lifetime, and prior to any change in the health, of the Proposed Insured.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. (MIB) or other organization, institution, or person, that has any records or knowledge of me or my health, to give to Connecticut General Life Insurance Company, or its reinsurers, any such information. I AUTHORIZE the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I AUTHORIZE the Company to have a blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorders, or the presence of medication, drugs, or nicotine. I AUTHORIZE the Company to disclose the results of these tests to MIB described in the Important Notice.

I UNDERSTAND that my medical records may be protected by certain Federal Regulations, especially as they apply to any drug or alcohol abuse data. I understand that I may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected.

This authorization shall be valid for a period of 24 months after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I will be given a copy of this authorization at my request. An investigative consumer report may be obtained and if such report is obtained, I may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained, I  do  do not request to be interviewed.

The proposed insurance  will  will not replace existing insurance.

I ACKNOWLEDGE receipt of the "Important Notice" containing Fair Credit Reporting Act and MIB, Inc. information.

**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.**

Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month / Day / Year

\_\_\_\_\_  
Witness - Licensed Agent/Representative Signature of Proposed Insured

\_\_\_\_\_  
Witness Signature of Applicant/Owner if other than Proposed Insured

**Part II of  
Corporate Life Insurance Application**

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY**  
Hartford, CT 06152



*(Proposed Insured's answers must be recorded by Medical Examiner with no one else present)*

<b>PROPOSED INSURED:</b>		<b>BIRTH DATE:</b>	_Month_	_Day_	_Year_
1. Have you ever had any indication of, been advised to consult, or consulted a physician, hospital or other medical facility for:		Yes No	Details of "Yes" answers: Identify question number, circle applicable items. Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.		
a. Chest pain, high blood pressure, heart disease, heart murmur, or other disorders of the heart or blood vessels?		<input type="checkbox"/> <input type="checkbox"/>			
b. Ulcers, colitis, jaundice, or other disease of the stomach, liver, intestines, pancreas, or gallbladder?		<input type="checkbox"/> <input type="checkbox"/>			
c. Sugar, albumin, blood or pus in the urine; venereal disease; disorder of the kidney or bladder?		<input type="checkbox"/> <input type="checkbox"/>			
d. Seizures, epilepsy, fainting, dizziness, stroke or paralysis?		<input type="checkbox"/> <input type="checkbox"/>			
e. Alzheimer's disease, nervous, mental, emotional or behavioral disorder or received counseling for anxiety, depression, nervousness, stress, mental or nervous disorder, or any other emotional problem?		<input type="checkbox"/> <input type="checkbox"/>			
f. Any tumor, cancer, cysts; any disorder of lymph glands?		<input type="checkbox"/> <input type="checkbox"/>			
g. Arthritis, gout, recurrent back pain, sciatica, neuritis, any disorder of the back, spine, nerves, muscles or joints?		<input type="checkbox"/> <input type="checkbox"/>			
h. Diabetes, thyroid or other endocrine or glandular disorder?		<input type="checkbox"/> <input type="checkbox"/>			
i. Anemia or any other blood disorder?		<input type="checkbox"/> <input type="checkbox"/>			
j. Asthma, emphysema, shortness of breath, sleep apnea, or any other disorder of the respiratory system?		<input type="checkbox"/> <input type="checkbox"/>			
k. Disorder of the eyes, ears, nose or throat?		<input type="checkbox"/> <input type="checkbox"/>			
l. Drug or alcohol abuse, been advised to limit your use of alcohol or addictive substances, or used drugs not prescribed by a physician?		<input type="checkbox"/> <input type="checkbox"/>			
m. Any physical abnormality or deformity?		<input type="checkbox"/> <input type="checkbox"/>			
n. Allergies or skin disorder?		<input type="checkbox"/> <input type="checkbox"/>			
2. Are you now under observation or treatment or taking any medications?		<input type="checkbox"/> <input type="checkbox"/>			
3. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?		<input type="checkbox"/> <input type="checkbox"/>			
4. Other than above, have you within the past 5 years:					
a. Had any mental or physical disorder not listed above?		<input type="checkbox"/> <input type="checkbox"/>			
b. Had a check-up, electrocardiogram, x-ray, blood test or diagnostic test?		<input type="checkbox"/> <input type="checkbox"/>			
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?		<input type="checkbox"/> <input type="checkbox"/>			
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?		<input type="checkbox"/> <input type="checkbox"/>			
5. Have you ever requested or received benefits or payment because of an injury, sickness or disability?		<input type="checkbox"/> <input type="checkbox"/>			
6. Have you used tobacco in any form within the last twelve months? <i>If "Yes," describe frequency and kind used.</i>		<input type="checkbox"/> <input type="checkbox"/>			
7. Family History: Diabetes, cancer, high blood pressure, mental illness, suicide or heart disease?		<input type="checkbox"/> <input type="checkbox"/>			
	Age if Living	Age at Death	Cause of Death		8. Have you ever had any disorder of the reproductive organs (testicles, prostate, breast, ovaries, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/>  9 a. Are you currently pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> b. If so, have there been any complications with this or any other pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/>
Father					
Mother					
Brothers					
Sisters					
10 a. Name and address of your personal physician: (if none, please check) <input type="checkbox"/> None					
b. Date and reason last consulted:					
c. What treatment was given or medication prescribed?					
I hereby declare that the statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that a copy of this Part II shall be attached to and form a part of any policy issued.					
DATED AT (City, State & Zip Code)		(Month, Day & Year)		SIGNATURE OF PROPOSED INSURED OR PARENT OR GUARDIAN IF A JUVENILE	
WITNESS (Medical Examiner)		on:			

**DECLARATION, AUTHORIZATION, and SIGNATURE**

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I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree, a) that this Life Insurance Application, and the Insured's Enrollment Form and the Master Application, if applicable, shall form a part of the Policy issued, and b) that no Agent/Representative of Connecticut General Life Insurance Company (the Company) shall have the authority to waive or complete an answer to any question in this Application, transfer insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I further agree that no insurance shall take effect unless and until the policy has been delivered to and accepted by me and the initial premium has been paid during the lifetime, and prior to any change in the health, of the Proposed Insured.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. (MIB) or other organization, institution, or person, that has any records or knowledge of me or my health, to give to Connecticut General Life Insurance Company, or its reinsurers, any such information. I AUTHORIZE the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I AUTHORIZE the Company to have a blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorders, or the presence of medication, drugs, or nicotine. I AUTHORIZE the Company to disclose the results of these tests to MIB described in the Important Notice previously given to me.

I UNDERSTAND that my medical records may be protected by certain Federal Regulations, especially as they apply to any drug or alcohol abuse data. I understand that I may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected.

This authorization shall be valid for a period of 24 months after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I will be given a copy of this authorization at my request. An investigative consumer report may be obtained and if such report is obtained, I may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained, I  do  do not request to be interviewed.

I ACKNOWLEDGE previous receipt of the "Important Notice" containing Fair Credit Reporting Act and MIB, Inc. information.

**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.**

Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month / Day / Year

\_\_\_\_\_  
Witness - Licensed Agent/Representative Signature of Proposed Insured

\_\_\_\_\_  
Witness Signature of Applicant/Owner if other than Proposed Insured

**Corporate Life Insurance  
Supplementary Application**

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY**  
Hartford, CT 06152



This Application is submitted to supplement my previous application for Policy No. \_\_\_\_\_. Subject to the provisions of the policy, application is hereby made for the changes indicated below, and Connecticut General Life Insurance Company is authorized to amend the above policy by endorsement to include such change or changes or to issue a new policy in place thereof incorporating such changes.

**INSURED/PROPOSED INSURED INFORMATION**

a. Name (First, M.I., Last)		b. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	c. Social Security Number
d. Date of Birth (Mo., Day, Yr.)	e. Phone Numbers: Home: _____ Work: _____		
f. Residence (Number, Street, City, State & Zip Code)			
g. Employer Name and Address (Number, Street, City, State & Zip Code)			

**Please complete all applicable sections and the Declaration, Authorization, and Signature section on page 4.**

**SECTION I**

<p><b>1. Type of Policy Change:</b>  <input type="checkbox"/> Variable   <input type="checkbox"/> Non-Variable</p> <p>a. <input type="checkbox"/> Increase Face/Specified Amount to \$ _____  <i>Complete Sections II, III, and IV</i>  <input type="checkbox"/> Add Benefits on increase (if available) specified in Question 2.</p> <p>b. <input type="checkbox"/> Decrease Face/Specified Amount to \$ _____</p> <p>c. <input type="checkbox"/> Change Death Benefit Option –</p> <p><input type="checkbox"/> To Option A/1 (increasing)  <i>Complete Sections II, III, and IV</i></p> <p><input type="checkbox"/> To Option B/2 (level)</p>	<p>3. <input type="checkbox"/> <b>Reinstatement –</b>  <i>Complete Sections II, III, and IV</i></p>
	<p>4. <input type="checkbox"/> <b>Extension of Placement –</b>  <i>Complete Sections II, III, and IV</i></p> <p>5. <b>Change of Classification</b></p> <p>a. <input type="checkbox"/> Non-smoker –  <i>Complete Sections II in full, and Section III, Question 15</i></p> <p>b. <input type="checkbox"/> Remove/Reduce Substandard –  <i>Complete Sections II and III</i></p>
<p><b>2. Additional/Cancellation of Benefits and Riders</b>  <i>Also complete Sections II and III if adding;</i></p> <p><input type="checkbox"/> Original Plan   <input type="checkbox"/> Increase in Item1   <u>ADD</u>   <u>CANCEL</u></p> <p>a. <input type="checkbox"/> Waiver of Premium (WP)   <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. <input type="checkbox"/> Waiver of Monthly Deduction (WMD)   <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. <input type="checkbox"/> Other _____   <input type="checkbox"/>   <input type="checkbox"/></p>	<p>6. <input type="checkbox"/> Correct Date of Birth to:  Mo. ____ Day ____ Yr. ____</p> <p><input type="checkbox"/> Change Date of Policy to:  Mo. ____ Day ____ Yr. ____</p>
	<p>7. <b>Special Instructions:</b></p>
	<p>8. <b>Home Office Changes or Corrections:</b>  <i>(H.O. Use Only)</i></p>



**SECTION IV**

<p>18. What is the total amount of Life Insurance (Personal and Business) in force on your life? The amount shown for each policy should also include coverage under any term riders, but Health Insurance policies should not be included. List each policy separately. Give full details in space at right. (If none, so state.)</p>	<p>COMPANY</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>DATE ISSUED</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>AMOUNT</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>AI AMOUNT</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>19. Will you discontinue or otherwise <input type="checkbox"/> Yes <input type="checkbox"/> No stop paying premiums on any Life Insurance or Annuity if this Insurance is issued? If "Yes," give full details in space at right. Forward proper replacement forms, if required.</p>	<p>COMPANY</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>POLICY NUMBER</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>AMOUNT</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

**FOR VARIABLE LIFE INSURANCE ONLY**

**DOES THE APPLICANT UNDERSTAND:**

- a) That the death benefit under a variable life insurance policy may increase or decrease depending upon the investment results of the sub-accounts?  Yes  No
- b) That the policy's cash surrender value may increase or decrease on any day depending upon the investment results of the sub-accounts?  Yes  No
- c) That no minimum cash surrender value is guaranteed?  Yes  No
- d) That the policy is a long-term commitment to meet insurance needs and financial goals?  Yes  No

**DECLARATION, AUTHORIZATION, and SIGNATURE**

I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree, a) that this Life Insurance Application, and the Insured's Enrollment Form and the Master Application, if applicable, shall form a part of the Policy issued, and b) that no Agent/Representative of Connecticut General Life Insurance Company (the Company) shall have the authority to waive or complete an answer to any question in this Application, transfer insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I further agree that no insurance shall take effect unless and until the policy has been delivered to and accepted by me and the initial premium has been paid during the lifetime, and prior to any change in the health, of the Proposed Insured.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. (MIB) or other organization, institution, or person, that has any records or knowledge of me or my health, to give to Connecticut General Life Insurance Company, or its reinsurers, any such information. I AUTHORIZE the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I AUTHORIZE the Company to have a blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorders, or the presence of medication, drugs, or nicotine. I AUTHORIZE the Company to disclose the results of these tests to MIB described in the Important Notice.

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Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month / Day / Year

\_\_\_\_\_  
Witness – Licensed Agent/Representative Signature of Proposed Insured

\_\_\_\_\_  
Witness Signature of Applicant/Owner if other than Proposed Insured

SERFF Tracking Number: CCGC-128386281 State: Arkansas  
 Filing Company: Connecticut General Life Insurance Company State Tracking Number:  
 Company Tracking Number: MIB REVISIONS  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: MIB Revisions  
 Project Name/Number: MIB Revisions/MIB Revisions

## Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

AR-Cert Rule19&49.pdf  
 AR-Readability Cert.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application

**Comments:**

The applications, which are the forms being submitted herein for approval, have been attached to the Forms Schedule as required.

**Item Status:** **Status Date:**

**Satisfied - Item:** Cover Letter

**Comments:**

**Attachment:**

AR-Cover Ltr-MIB Revision.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Copies highlighting revised MIB language

**Comments:**

**Attachments:**

Life App (03-03)-MIB Rev-Highlighted.pdf  
 Life App Part II (03-03)-MIB Rev-Highlighted.pdf  
 Supp App (03-03)-MIB Rev-Highlighted.pdf

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY**

CERTIFICATION OF COMPLIANCE WITH

ARKANSAS RULE & REGULATION 19 and 49

Re: Life App (03/03) – Corporate Life Insurance Application  
Life App Part II – Part II of Corporate Life Insurance Application  
Supp App (03/03) – Corporate Life Insurance Supplementary Application

I hereby certify that the above-captioned forms meet the requirements of Rule and Regulation 19 and 49 and all applicable requirements of the Arkansas Department of Insurance.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

June 6, 2012

Date

By:



\_\_\_\_\_  
Jeffrey J. Krauss, Director Corporate Insurance

STATE OF ARKANSAS

CERTIFICATION

Re: RID-STABILIZED INCOME (03-12)

This is to certify that the above-captioned form(s) submitted herewith have achieved the Flesch Ease Score noted below and comply with the requirements of Ark. Stat. Ann. Sections 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Description of Form</u>	<u>Score</u>
Life App (03/03)	50.0
Life App Part II (03/03)	50.0
Supp App (03/03)	51.2

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Date: June 6, 2012

By:   
Jeffrey J. Krauss, Director, Corporate Insurance



**Julie A. Levine, J.D.**  
**Connecticut General Life Insurance Company**  
900 Cottage Grove Rd, A4COL  
Bloomfield, CT 06002  
Telephone 860-226-9019  
Facsimile 860-226-8292

June 6, 2012

FILED VIA SERFF

The Honorable Jay Bradford  
Insurance Commissioner  
Arkansas Department of Insurance  
1200 W. Third Street  
Little Rock, AR 72201-1904

Attention: Linda Bird  
Life & Health Division

RE: Connecticut General Life Insurance Company  
NAIC #62308

Revised MIB Authorization Language for the following applications:  
Life App (03/03) – Corporate Life Insurance Application  
Life App Part II (03/03) – Part II of Corporate Life Insurance Application  
Supp App (03/03) – Corporate Life Insurance Supplementary Application

Dear Ms. Bird:

Pursuant to a directive by MIB, Inc., Connecticut General Life Insurance Company respectfully submits for your information the above-captioned approved life insurance applications with revised MIB authorization language. The original approval dates of the applications are as follows:

Life App (03/03) – 9/24/03  
Life App Part II (03/03) – 7/2/03  
Supp App (03/03) – 7/2/03

These applications are for use with any of our policies approved in Arkansas, both Individual and Group (even though SERFF requires a selection of one or the other.) The only change to the approved forms is the revision of the MIB language, as directed by MIB. Highlighted copies of the revised forms are included on the Supporting Documentation tab for your ease of review.

Any certification or other materials we believe you require are enclosed. Unless otherwise informed, we reserve the right to alter the layout, color, sequential order, and typeset of these forms. We certify that any such change will be in conformance with your requirements. These forms comply with your readability requirements.

These revisions were filed for domiciliary approval on May 24, 2012.

Thank you for your time and consideration. Please feel free to contact me by phone (860-226-9019), email ([Julie.Levine@CIGNA.com](mailto:Julie.Levine@CIGNA.com)), or via SERFF if you have any questions or concerns regarding this submission.

Sincerely,

A handwritten signature in black ink that reads "Julie A. Levine".

Julie A. Levine  
Sr. Compliance Analyst



MEDICAL QUESTIONS	Details of "Yes" answers to questions 8-16
8. Have you ever applied for any life or health Insurance which resulted in your being turned down, asked to pay an extra premium or issued a reduced face amount? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Have you ever had any indication of, been advised to consult, or consulted a physician, hospital or other medical facility for: any disease of the heart, including chest pain, heart murmur, heart attack or stroke; disease of the blood vessels or lungs; sleep apnea; tumor or cancer; elevated blood pressure; nervous system disorder, including seizures or paralysis; Alzheimer's disease; a mental, emotional or behavioral disorder; diabetes, kidney or urinary disorder; disease of the prostate, testicles, breast or ovaries; disease of the stomach, intestines, pancreas or liver; treatment for anemia or any other blood disorder; alcoholism, drug abuse or addiction, or use of drugs not prescribed by a physician?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Have you ever had any indication of or sought medical treatment for any physical or mental disorder not listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Have you been diagnosed by a physician, hospital or other medical facility or been treated for Acquired Immune Deficiency Syndrome or an AIDS related condition?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. a. Name and address of your personal physician. b. Physician's phone number. c. Date and reason last consulted. d. What treatment was given or medication prescribed? <i>If none, please check.</i> <input type="checkbox"/> None	
13. When and for what reason did you last consult a hospital, medical facility or physician other than your personal physician? Give details including names and addresses.	
14. Are you currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please list.</i>	
15. Have you been absent from work because of illness or injury for more than 3 of the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Have you used tobacco in any form within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", describe frequency, quantity and kind of tobacco used.</i>	
17. What is your exact height and weight?	Feet _____ Inches _____ Pounds _____
SUPPLEMENTAL INFORMATION	
18. Do you contemplate flying, or have you flown during the past 2 years as a pilot, student pilot, or crewmember? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", an Aviation Supplement is required.</i>	
19. Do you plan to participate or have you participated within the past 2 years in motor vehicle or boat racing, mountain or rock climbing, bungee jumping, hang gliding, sky diving, scuba diving or similar sports? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", an Avocation and Sports Questionnaire is required.</i>	
20. Do you contemplate residence or travel outside of the United States or Canada, other than for normal (2 weeks or less) business travel or vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", a Foreign Travel or Residence Supplement is required.</i>	

21. Have you been convicted of any moving traffic violations in the past 2 years or had your license suspended, revoked or restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please provide details.</i>	Details:		
22. What is the total amount of Life Insurance (personal and business) presently in force on your life excluding any policies being replaced? Amounts should include coverage under any term riders. Do not include Group Life or Health insurance. <i>If none, please check.</i> <input type="checkbox"/> None	<u>Company</u>	<u>When Issued</u>	<u>Amount</u>
23. ADDITIONAL INSTRUCTIONS	24. HOME OFFICE CHANGES OR CORRECTIONS		

FOR VARIABLE LIFE INSURANCE ONLY			
DOES THE APPLICANT UNDERSTAND:			
a) That the death benefit under a variable life insurance policy may increase or decrease depending upon the investment results of the sub-accounts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) That the policy's cash surrender value may increase or decrease on any day depending upon the investment results of the sub-accounts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
c) That no minimum cash surrender value is guaranteed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
d) That the policy is a long-term commitment to meet insurance needs and financial goals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**DECLARATION, AUTHORIZATION, and SIGNATURE**

I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree, a) that this Life Insurance Application, and the Insured's Enrollment Form and the Master Application, if applicable, shall form a part of the Policy issued, and b) that no Agent/Representative of Connecticut General Life Insurance Company (the Company) shall have the authority to waive or complete an answer to any question in this Application, transfer insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I further agree that no insurance shall take effect unless and until the policy has been delivered to and accepted by me and the initial premium has been paid during the lifetime, and prior to any change in the health, of the Proposed Insured.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, ~~the Medical Information Bureau MIB, Inc. (MIB)~~ or other organization, institution, or person, that has any records or knowledge of me or my health, to give to Connecticut General Life Insurance Company, or its reinsurers, any such information. **I AUTHORIZE the Company, or its reinsurers, to make a brief report of my personal health information to MIB.**

I AUTHORIZE the Company to have a blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorders, or the presence of medication, drugs, or nicotine. I AUTHORIZE the Company to disclose the results of these tests to ~~the Medical Information Bureau MIB~~ described in the Important Notice.

I UNDERSTAND that my medical records may be protected by certain Federal Regulations, especially as they apply to any drug or alcohol abuse data. I understand that I may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected.

This authorization shall be valid for a period of 24 months after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I will be given a copy of this authorization at my request. An investigative consumer report may be obtained and if such report is obtained, I may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained, I  do  do not **request to be interviewed.**

The proposed insurance  will  will not replace existing insurance.

I ACKNOWLEDGE receipt of the "Important Notice" containing Fair Credit Reporting Act and ~~Medical Information Bureau MIB, Inc.~~ information.

**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.**

Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month / Day / Year

\_\_\_\_\_  
Witness - Licensed Agent/Representative Signature of Proposed Insured

\_\_\_\_\_  
Witness Signature of Applicant/Owner if other than Proposed Insured

**Part II of  
Corporate Life Insurance Application**

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY**  
Hartford, CT 06152



*(Proposed Insured's answers must be recorded by Medical Examiner with no one else present)*

<b>PROPOSED INSURED:</b>		<b>BIRTH DATE:</b>	_Month_	_Day_	_Year_
1. Have you ever had any indication of, been advised to consult, or consulted a physician, hospital or other medical facility for:		Yes No	Details of "Yes" answers: Identify question number, circle applicable items. Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.		
a. Chest pain, high blood pressure, heart disease, heart murmur, or other disorders of the heart or blood vessels?		<input type="checkbox"/> <input type="checkbox"/>			
b. Ulcers, colitis, jaundice, or other disease of the stomach, liver, intestines, pancreas, or gallbladder?		<input type="checkbox"/> <input type="checkbox"/>			
c. Sugar, albumin, blood or pus in the urine; venereal disease; disorder of the kidney or bladder?		<input type="checkbox"/> <input type="checkbox"/>			
d. Seizures, epilepsy, fainting, dizziness, stroke or paralysis?		<input type="checkbox"/> <input type="checkbox"/>			
e. Alzheimer's disease, nervous, mental, emotional or behavioral disorder or received counseling for anxiety, depression, nervousness, stress, mental or nervous disorder, or any other emotional problem?		<input type="checkbox"/> <input type="checkbox"/>			
f. Any tumor, cancer, cysts; any disorder of lymph glands?		<input type="checkbox"/> <input type="checkbox"/>			
g. Arthritis, gout, recurrent back pain, sciatica, neuritis, any disorder of the back, spine, nerves, muscles or joints?		<input type="checkbox"/> <input type="checkbox"/>			
h. Diabetes, thyroid or other endocrine or glandular disorder?		<input type="checkbox"/> <input type="checkbox"/>			
i. Anemia or any other blood disorder?		<input type="checkbox"/> <input type="checkbox"/>			
j. Asthma, emphysema, shortness of breath, sleep apnea, or any other disorder of the respiratory system?		<input type="checkbox"/> <input type="checkbox"/>			
k. Disorder of the eyes, ears, nose or throat?		<input type="checkbox"/> <input type="checkbox"/>			
l. Drug or alcohol abuse, been advised to limit your use of alcohol or addictive substances, or used drugs not prescribed by a physician?		<input type="checkbox"/> <input type="checkbox"/>			
m. Any physical abnormality or deformity?		<input type="checkbox"/> <input type="checkbox"/>			
n. Allergies or skin disorder?		<input type="checkbox"/> <input type="checkbox"/>			
2. Are you now under observation or treatment or taking any medications?		<input type="checkbox"/> <input type="checkbox"/>			
3. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?		<input type="checkbox"/> <input type="checkbox"/>			
4. Other than above, have you within the past 5 years:					
a. Had any mental or physical disorder not listed above?		<input type="checkbox"/> <input type="checkbox"/>			
b. Had a check-up, electrocardiogram, x-ray, blood test or diagnostic test?		<input type="checkbox"/> <input type="checkbox"/>			
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?		<input type="checkbox"/> <input type="checkbox"/>			
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?		<input type="checkbox"/> <input type="checkbox"/>			
5. Have you ever requested or received benefits or payment because of an injury, sickness or disability?		<input type="checkbox"/> <input type="checkbox"/>			
6. Have you used tobacco in any form within the last twelve months? <i>If "Yes," describe frequency and kind used.</i>		<input type="checkbox"/> <input type="checkbox"/>			
7. Family History: Diabetes, cancer, high blood pressure, mental illness, suicide or heart disease?		<input type="checkbox"/> <input type="checkbox"/>			
	Age if Living	Age at Death	Cause of Death	8. Have you ever had any disorder of the reproductive organs (testicles, prostate, breast, ovaries, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/> 9 a. Are you currently pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> b. If so, have there been any complications with this or any other pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Father					
Mother					
Brothers					
Sisters					
10 a. Name and address of your personal physician: (if none, please check) <input type="checkbox"/> None					
b. Date and reason last consulted:					
c. What treatment was given or medication prescribed?					
I hereby declare that the statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that a copy of this Part II shall be attached to and form a part of any policy issued.					
DATED AT (City, State & Zip Code)		(Month, Day & Year)		SIGNATURE OF PROPOSED INSURED OR PARENT OR GUARDIAN IF A JUVENILE	
WITNESS (Medical Examiner)		on:			

**DECLARATION, AUTHORIZATION, and SIGNATURE**

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I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree, a) that this Life Insurance Application, and the Insured's Enrollment Form and the Master Application, if applicable, shall form a part of the Policy issued, and b) that no Agent/Representative of Connecticut General Life Insurance Company (the Company) shall have the authority to waive or complete an answer to any question in this Application, transfer insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I further agree that no insurance shall take effect unless and until the policy has been delivered to and accepted by me and the initial premium has been paid during the lifetime, and prior to any change in the health, of the Proposed Insured.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, ~~the Medical Information Bureau MIB, Inc. (MIB)~~ or other organization, institution, or person, that has any records or knowledge of me or my health, to give to Connecticut General Life Insurance Company, or its reinsurers, any such information. **I AUTHORIZE the Company, or its reinsurers, to make a brief report of my personal health information to MIB.**

I AUTHORIZE the Company to have a blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorders, or the presence of medication, drugs, or nicotine. I AUTHORIZE the Company to disclose the results of these tests to ~~the Medical Information Bureau MIB~~ described in the Important Notice previously given to me.

I UNDERSTAND that my medical records may be protected by certain Federal Regulations, especially as they apply to any drug or alcohol abuse data. I understand that I may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected.

This authorization shall be valid for a period of 24 months after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I will be given a copy of this authorization at my request. An investigative consumer report may be obtained and if such report is obtained, I may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained, I  do  do not request to be interviewed.

I ACKNOWLEDGE previous receipt of the "Important Notice" containing Fair Credit Reporting Act and ~~Medical Information Bureau MIB~~, Inc. information.

**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.**

Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month / Day / Year

Witness - Licensed Agent/Representative Signature of Proposed Insured

Witness Signature of Applicant/Owner if other than Proposed Insured

**Corporate Life Insurance  
Supplementary Application**

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY  
Hartford, CT 06152**



This Application is submitted to supplement my previous application for Policy No. \_\_\_\_\_. Subject to the provisions of the policy, application is hereby made for the changes indicated below, and Connecticut General Life Insurance Company is authorized to amend the above policy by endorsement to include such change or changes or to issue a new policy in place thereof incorporating such changes.

**INSURED/PROPOSED INSURED INFORMATION**

a. Name (First, M.I., Last)		b. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	c. Social Security Number
d. Date of Birth (Mo., Day, Yr.)	e. Phone Numbers: Home: _____ Work: _____		
f. Residence (Number, Street, City, State & Zip Code)			
g. Employer Name and Address (Number, Street, City, State & Zip Code)			

**Please complete all applicable sections and the Declaration, Authorization, and Signature section on page 4.**

**SECTION I**

<p><b>1. Type of Policy Change:</b>  <input type="checkbox"/> Variable   <input type="checkbox"/> Non-Variable</p> <p>a. <input type="checkbox"/> Increase Face/Specified Amount to \$ _____  <i>Complete Sections II, III, and IV</i>  <input type="checkbox"/> Add Benefits on increase (if available) specified in Question 2.</p> <p>b. <input type="checkbox"/> Decrease Face/Specified Amount to \$ _____</p> <p>c. <input type="checkbox"/> Change Death Benefit Option –</p> <p><input type="checkbox"/> To Option A/1 (increasing)  <i>Complete Sections II, III, and IV</i></p> <p><input type="checkbox"/> To Option B/2 (level)</p>	<p>3. <input type="checkbox"/> <b>Reinstatement –</b>  <i>Complete Sections II, III, and IV</i></p>
	<p>4. <input type="checkbox"/> <b>Extension of Placement –</b>  <i>Complete Sections II, III, and IV</i></p> <p>5. <b>Change of Classification</b></p> <p>a. <input type="checkbox"/> Non-smoker –  <i>Complete Sections II in full, and Section III, Question 15</i></p> <p>b. <input type="checkbox"/> Remove/Reduce Substandard –  <i>Complete Sections II and III</i></p>
<p><b>2. Additional/Cancellation of Benefits and Riders</b>  <i>Also complete Sections II and III if adding;</i></p> <p><input type="checkbox"/> Original Plan   <input type="checkbox"/> Increase in Item1   <u>ADD</u>   <u>CANCEL</u></p> <p>a. <input type="checkbox"/> Waiver of Premium (WP)   <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. <input type="checkbox"/> Waiver of Monthly Deduction (WMD)   <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. <input type="checkbox"/> Other _____   <input type="checkbox"/>   <input type="checkbox"/></p>	<p>6. <input type="checkbox"/> Correct Date of Birth to:  Mo. ____ Day ____ Yr. ____</p> <p><input type="checkbox"/> Change Date of Policy to:  Mo. ____ Day ____ Yr. ____</p>
	<p>7. <b>Special Instructions:</b></p>
	<p>8. <b>Home Office Changes or Corrections:</b>  <i>(H.O. Use Only)</i></p>



**SECTION IV**

<p>18. What is the total amount of Life Insurance (Personal and Business) in force on your life? The amount shown for each policy should also include coverage under any term riders, but Health Insurance policies should not be included. List each policy separately. Give full details in space at right. (If none, so state.)</p>	<p>COMPANY</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>DATE ISSUED</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>AMOUNT</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>AI AMOUNT</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>19. Will you discontinue or otherwise <input type="checkbox"/> Yes <input type="checkbox"/> No stop paying premiums on any Life Insurance or Annuity if this Insurance is issued? If "Yes," give full details in space at right. Forward proper replacement forms, if required.</p>	<p>COMPANY</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>POLICY NUMBER</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>AMOUNT</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

**FOR VARIABLE LIFE INSURANCE ONLY**

**DOES THE APPLICANT UNDERSTAND:**

- a) That the death benefit under a variable life insurance policy may increase or decrease depending upon the investment results of the sub-accounts?  Yes  No
- b) That the policy's cash surrender value may increase or decrease on any day depending upon the investment results of the sub-accounts?  Yes  No
- c) That no minimum cash surrender value is guaranteed?  Yes  No
- d) That the policy is a long-term commitment to meet insurance needs and financial goals?  Yes  No

**DECLARATION, AUTHORIZATION, and SIGNATURE**

I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree, a) that this Life Insurance Application, and the Insured's Enrollment Form and the Master Application, if applicable, shall form a part of the Policy issued, and b) that no Agent/Representative of Connecticut General Life Insurance Company (the Company) shall have the authority to waive or complete an answer to any question in this Application, transfer insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I further agree that no insurance shall take effect unless and until the policy has been delivered to and accepted by me and the initial premium has been paid during the lifetime, and prior to any change in the health, of the Proposed Insured.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, ~~the Medical Information Bureau~~ MIB, Inc. (MIB) or other organization, institution, or person, that has any records or knowledge of me or my health, to give to Connecticut General Life Insurance Company, or its reinsurers, any such information. I AUTHORIZE the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

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I UNDERSTAND that my medical records may be protected by certain Federal Regulations, especially as they apply to any drug or alcohol abuse data. I understand that I may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected.

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**Dated at** \_\_\_\_\_ **on** \_\_\_\_\_  
City and State Month / Day / Year

\_\_\_\_\_  
Witness – Licensed Agent/Representative Signature of Proposed Insured

\_\_\_\_\_  
Witness Signature of Applicant/Owner if other than Proposed Insured