
SERFF Tracking #:	MLLM-128574754	State Tracking #:		Company Tracking #:	0146ALM01-34
State:	Arkansas	Filing Company:	First Allmerica Financial Life Insurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	FAFLIC Reinstatement Application Material				
Project Name/Number:	Reinstatement Application Submission/0146ALM01-34				

Filing at a Glance

Company:	First Allmerica Financial Life Insurance Company
Product Name:	FAFLIC Reinstatement Application Material
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	07/19/2012
SERFF Tr Num:	MLLM-128574754
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	0146ALM01-34

Implementation	
Date Requested:	
Author(s):	Jeff Kulesus
Reviewer(s):	Linda Bird (primary)
Disposition Date:	07/24/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

SERFF Tracking #:	MLLM-128574754	State Tracking #:	Company Tracking #: 0146ALM01-34
State:	Arkansas	Filing Company:	First Allmerica Financial Life Insurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	FAFLIC Reinstatement Application Material		
Project Name/Number:	Reinstatement Application Submission/0146ALM01-34		

General Information

Project Name: Reinstatement Application Submission	Status of Filing in Domicile: Pending
Project Number: 0146ALM01-34	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: The submission is pending review in the domiciliary state.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 07/24/2012
	State Status Changed: 07/24/2012
Deemer Date:	Created By: Jeff Kulesus
Submitted By: Jeff Kulesus	Corresponding Filing Tracking Number: MLLM-128574753

Filing Description:

Milliman, Inc., is providing this submission on behalf of First Allmerica Financial Life Insurance Company ("Company", or "First Allmerica"). A letter from First Allmerica authorizing Milliman, Inc. to represent the Company in this submission is provided under the Supporting Documentation Tab.

The forms provided with this submission include a reinstatement application and supplemental questionnaires and forms used in the application process. The forms are described below:

- REIN-12, Reinstatement Application
- ADUQ-12, Alcohol and Drug Use Questionnaire
- AQ-12, Avocation Questionnaire
- AVQ-12, Aviation Questionnaire
- HIV-12, HIV Testing and Consent Form
- HIPPA-12, Authorization to Obtain and Disclose Protected Health Information

The above forms are being submitted simultaneously for review and approval in a separate submission for a sister company, Commonwealth Annuity and Life Insurance Company, SERFF Tracking Number MLLM-128574753. None of the forms provided with this submission will be used by First Allmerica until the corresponding forms for both companies in both submissions are approved.

Copies of the statement of variability, necessary certifications and filing fees, if any, are attached.

Thank you for your review and consideration of this submission.

Company and Contact

Filing Contact Information

Jeff Kulesus, Consultant	Jeff.Kulesus@Milliman.com
2 Conway Park, Ste. 180	312-499-5635 [Phone]
150 Field Drive	847-604-8671 [FAX]
Lake Forest, IL 60045	

SERFF Tracking #: MLLM-128574754 State Tracking #: Company Tracking #: 0146ALM01-34

State: Arkansas Filing Company: First Allmerica Financial Life Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: FAFLIC Reinstatement Application Material

Project Name/Number: Reinstatement Application Submission/0146ALM01-34

Filing Company Information

(This filing was made by a third party - MUSA01)

First Allmerica Financial Life Insurance Company
132 Turnpike Road
Suite 120
Southborough, MA 01772
(508) 460-2400 ext. [Phone]

CoCode: 69140
Group Code: 3891
Group Name:
FEIN Number: 04-1867050

State of Domicile: Massachusetts
Company Type: Life
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$75.00
Retaliatory? Yes
Fee Explanation: 1 submission X \$75.00@ = \$75.00.
Per Company: No

Table with 4 columns: Company, Amount, Date Processed, Transaction #. Contains two rows of fee data.

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/24/2012	07/24/2012

SERFF Tracking #:	MLLM-128574754	State Tracking #:		Company Tracking #:	0146ALM01-34
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Product Name:	FAFLIC Reinstatement Application Material				
Project Name/Number:	Reinstatement Application Submission/0146ALM01-34				

Disposition

Disposition Date: 07/24/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Third Party Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Form	Reinstatement Application		Yes
Form	Alcohol and Drug Use Questionnaire		Yes
Form	Avocation Questionnaire		Yes
Form	Aviation Questionnaire		Yes
Form	HIV Testing and Consent Form		Yes
Form	Authorization to Obtain and Disclose Protected Health Information		Yes

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Product Name:	FAFLIC Reinstatement Application Material				
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Form Schedule

Lead Form Number: REIN-12							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1		REIN-12	AEF	Reinstatement Application	Initial:	50.500	REIN-12 Reinstatement Application 07-11-2012.pdf
2		ADUQ-12	AEF	Alcohol and Drug Use Questionnaire	Initial:	68.600	ADUQ-12 Alcohol and Drug Use Questionnaire 07-19-2012.pdf
3		AQ-12	AEF	Avocation Questionnaire	Initial:	74.700	AQ-12 Avocation Questionnaire 07-11-2012.pdf
4		AVQ-12	AEF	Aviation Questionnaire	Initial:	57.000	AVQ-12 Aviation Questionnaire 07-18-2012.pdf
5		HIV-12	AEF	HIV Testing and Consent Form	Initial:	50.000	HIV-12 HIV Testing and Consent Form 07-11-2012.pdf
6		HIPPA-12	AEF	Authorization to Obtain and Disclose Protected Health Information	Initial:	50.000	HIPPA-12 Authorization to Obtain and Disclose Protected Health Information 07-11-2012.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider

SERFF Tracking #: MLLM-128574754 **State Tracking #:** **Company Tracking #:** 0146ALM01-34

State: Arkansas **Filing Company:** First Allmerica Financial Life Insurance Company
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Product Name: FAFLIC Reinstatement Application Material
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DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

Reinstatement Application

I hereby apply for Life Insurance with

- Commonwealth Annuity and Life Insurance Company** OR **First Allmerica Financial Life Insurance Company**
 Administrative Office: [PO Box 758550, Topeka, KS 66675] Administrative Office: [PO Box 758552, Topeka, KS 66675]

herein referred to as "Company"

Home Office: [132 Turnpike Road, Suite 210, Southborough, MA 01772]

Owners Name: _____ Social Security Number (SSN) _____ Birth Date: ___/___/___
 Phone _____ (mm/dd/yyyy)
 Owners Address: _____ E-Mail: _____
 Reinstatement Policy No: _____ on the life/lives of: _____
 Insured: _____ Birth Date: ___/___/___ SSN _____
 Address: _____ (mm/dd/yyyy) _____
 Phone: _____
 2nd Insured: _____ Birth Date: ___/___/___ SSN _____
 Address: _____ (mm/dd/yyyy) _____
 Phone: _____

The insured must complete the section below, and both Owner and Insured must sign.

PART 1 COMPLETE FOR ALL APPLICATIONS

1. Annual Earned Income			
Last Year	Prior Year	Unearned Income Last Year	Prior Year
\$ _____	\$ _____	\$ _____ (indicate source)	\$ _____ (indicate source)
Total Net Worth Personal		Business	
\$ _____	\$ _____		

2. List all life insurance in force			
Company	Issue Year	Life Face Amount	Accidental Death Benefit Coverage
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____

- | | Insured | | 2 nd Insured | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | Yes | No |
| 3. Do you have any other application or negotiations for Life Insurance pending or completed?
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you smoked one or more cigarettes or used a tobacco product in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you within the last 3 years had your Motor Vehicle license suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you within the last 2 years participated in or do you intend to participate in scuba diving, parachuting, any form of motor racing, hang gliding or recreational flight activity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you flown as a trainee, pilot or crewmember within two years or contemplate such flights in the future? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. If the lapsed policy was issued with an Exclusion Rider:
Have you been treated for or diagnosed by a licensed member of the medical profession for the excluded condition since the policy was issued? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Owners Name: _____

Reinstate Policy No. _____

Explain Affirmative Answers to 3 – 8:	

1. MEDICAL HISTORY (Medical history of the person(s) upon whose life insurance coverage is proposed.)

Has any person covered under this policy/certificate within the last five years, or since the effective date of coverage than five years:

1.	Been treated for or diagnosed by a licensed member of the medical profession for::		
	a) Any heart disease, heart attack, chest pain, high blood pressure, high cholesterol, murmur, palpitations, or any other disorder of the heart of blood vessels?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	b) Any circulatory disease, stroke, Transient Ischemic Attack (TIA), aneurysm, or any other disorder of the veins or arteries?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	c) Any breathing or lung disorder, Chronic Obstructive Pulmonary Disease (COPD), asthma, bronchitis, sleep apnea, or emphysema?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	d) Diabetes, disorder of the immune system, blood disorder, or disorder of the glands?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	e) Cancer, tumor, or cysts?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	f) Depression, anxiety, dementia, Alzheimer's, or any other mental or nervous disease or disorder?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	g) Hepatitis, gastritis, colitis, or any other disease or disorder of the liver, stomach, pancreas, or intestines?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	h) Any disease or disorder of the kidneys, bladder, prostate, urinary, or reproductive systems?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	i) Arthritis or any disease or disorder of the muscles (to include strains or sprains), tendons, bones, spine, back or joints?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	j) Any disease or disorder of the skin, eyes, or ears?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	k) Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC) or positive test results indicating exposure to the AIDS virus?	<input type="checkbox"/> Y	<input type="checkbox"/> N
2.	Are you currently prescribed any medication?	<input type="checkbox"/> Y	<input type="checkbox"/> N
3.	Have you been prescribed medication in the past 5 years not previously mentioned?	<input type="checkbox"/> Y	<input type="checkbox"/> N
4.	Have you:		
	a) Been hospitalized or had surgery?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	b) Had any electrocardiograms, x-rays, laboratory tests, treatment, or surgery which has not been performed?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	c) Been recommended by a licensed member of the medical profession to have any test, treatment, or surgery which has not been performed?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	d) Been treated for or diagnosed by a licensed member of the medical profession for any illness, disease, or injury that is not included in other answers?	<input type="checkbox"/> Y	<input type="checkbox"/> N
5.	Been treated or counseled by a licensed member of the medical profession for the use of alcohol?	<input type="checkbox"/> Y	<input type="checkbox"/> N
6.	Been treated or counseled by a licensed member of the medical profession for the use of any narcotic, barbituate, stimulant, amphetamine, hallucinogenic, street or prescription drugs?	<input type="checkbox"/> Y	<input type="checkbox"/> N
7.	Made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury?	<input type="checkbox"/> Y	<input type="checkbox"/> N

Owners Name: _____

Reinstate Policy No. _____

2. FAMILY HISTORY (Please complete the following Family Record.)						
Family Record	Age if Living		Present State of Health or Cause of death		Age at Death	
	1st Insured	2nd Insured	1st Insured	2nd Insured	1st Insured	2nd Insured
Father						
Mother						
Siblings						

3. PHYSICAL CONDITION. Please confirm the condition of the person(s) upon whose life insurance coverage is proposed.

INSURED

2ND INSURED

3a. Name, address and telephone number of personal physician.

Name, address and telephone number of personal physician.

Date and Reason Last Consulted: _____

Date and Reason Last Consulted: _____

3b. Please provide your current height and weight.

Please provide your current height and weight.

Height: _____ Weight: _____

Height: _____ Weight: _____

Weight change during the past 12 months,

Weight change during the past 12 months,

if any: _____

if any: _____

4. ADDITIONAL MEDICATION INFORMATION		Complete for applicable items in Section 1. Please specify 1 st or 2 nd Insured. Continue on a separate sheet of paper if necessary.				
1 st /2 nd Insured	Question #	Condition / Diagnosis	Medication / Treatment	Date	Still Being Treated?	Physician / Address

Owners Name: _____

Reinstate Policy No. _____

INSURANCE INFORMATION PRACTICES

Name of Proposed Insured _____

Information regarding your insurability will be treated as confidential. Personal information about you may be obtained from persons other than you. You have a right of access and correction with respect to personal information obtained about you. The Company may, in some cases, also disclose personal or privileged information it has about you to other third parties without your authorization. A detailed description of the Company's information practices will be furnished on your request. Any request for information should be directed to [P.O. Box 758550, Topeka, KS 66675].

Medical Information Bureau Pre-Notice

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request will supply such company with the information in its file.

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

The Company or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com].

Fair Credit Reporting Act Pre-Notice

In making this application for insurance it is understood that the Company may order an investigative consumer report. Information may be obtained through personal interviews with third parties such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This inquiry may include information as to your character, general reputation, personal characteristics and mode of living, whichever may be applicable. Upon written request, you will be told if an investigative consumer report has been ordered. If so, you may ask to be interviewed in connection with its preparation. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigative consumer report. You also have the right in inspect and obtain a copy of the investigative consumer report from the investigating consumer reporting agency.

ACKNOWLEDGEMENTS & SIGNATURES

I (We) have read the questions and answered them on the reinstatement application. The statements made in the application are: complete, true and correctly recorded to the best of my knowledge and belief. These statements are offered to the Company as an inducement to reinstate the policy.

I (We) agree that a copy of this application will form a part of any policy/certificate issued: reinstatement will not take effect unless and until this application is approved by the Company and any required payment has been made. No agent can pass on insurability or modify any policy/certificate reinstated by the Company. If this application is not approved, the Owner will accept the return of any amount paid in connection with this application without interest. Reinstatement of the policy/certificate will be contestable for 2 years from the effective date of reinstatement for fraud or misrepresentation of any material fact in this application.

I (We) acknowledge that I (We) have received, read and understand the notices required by The Medical Information Bureau, Inc (MIB) and the Federal Credit Reporting Act regarding Investigative Consumer Reports.

Signed at (City and State)

Date Signed

(First) (Middle Initial) (Last Name)
Full signature of insured (no abbreviations)

Signed at (City and State)

Date Signed

(First) (Middle Initial) (Last Name)
Full signature of 2nd insured (if applicable)

Signed at (City and State)

Date Signed

(First) (Middle Initial) (Last Name)
Full signature of Owner (if applicable)

FRAUD WARNING NOTICES AND IMPORTANT STATEMENTS

TO ALL APPLICANTS: PLEASE READ THE APPLICABLE IMPORTANT NOTICE(S) FOR YOUR STATE:

For all states not specifically shown: [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 may be guilty of a crime and may be subject to fines and confinement in prison.]

For Residents of Alaska: [A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.]

[Upon written request, We will provide You, within seven days, reasonable factual information regarding the benefits and provisions of this Contract.]

For Residents of Arizona: [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 may be guilty of a crime and may be subject to fines and confinement in prison.]

For Residents of Arizona: [Upon Written Request We will provide, within a reasonable time, reasonable factual information regarding the benefits and provisions of the annuity Contract to the Contract Owner. If for any reason the Contract Owner is not satisfied with the annuity Contract, the Contract Owner may return the Contract to Us by sending it to the Company's Administrative Office at [P.O. Box 758550, Topeka, KS 66675], Phone: [(866) 645-1594], or to one of its authorized representatives within ten days, or within 30 days if the Contract Owner is 65 years of age or older on the date of the application for this annuity Contract. After the Contract is delivered and received by Us, We will refund all monies paid with the application.]

For Residents of Arkansas, Louisiana, Rhode Island and West Virginia: [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.]

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

For Residents of California: [Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

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

For Residents of Delaware, Idaho: [Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.]

For Residents of Florida: [Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

For Residents of Indiana: [A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.]

For Residents of Kansas: [Any person who knowingly and with intent to defraud presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.]

For Residents of Kentucky: [Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

FRAUD WARNING NOTICES AND IMPORTANT STATEMENTS

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

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

For Residents of Minnesota: [Any person who knowingly or willfully makes a false statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.]

For Residents of New Hampshire: [Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. RSA § 638.20.]

For Residents of New Jersey: [Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

For Residents of New Mexico: [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 civil fines and criminal penalties.]

For Residents of New York: [Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

For Residents of Ohio: [Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

For Residents of Oklahoma: **[WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

For Residents of Oregon: [Any person who knowingly and with intent to deceive an insurer, makes a claim for the proceeds of an insurance policy containing materially false information, may be guilty of insurance fraud.]

For Residents of Pennsylvania: [Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

For Residents of Puerto Rico: [Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.]

For Residents of Texas: [Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

SECTION 2: Drug Use

1. Are you currently using any of the following or have you ever used them in the past? If so, select all that apply.

- a. Opium derivatives _____
- b. Barbiturates _____
- c. Marijuana _____
- d. Amphetamines _____
- e. Cocaine _____
- f. Hallucinogens _____
- g. IV drug use _____
- h. Other (explain) _____

2. If you selected any above, please give details:

Type(s)	Usual quantity	Frequency of use	Dates used

3. Have you ever sought medical treatment because of drug usage? Y N

If so, please list names of doctors and institutions:

4. Have you ever been arrested or charged in connection with drugs? Y N

If so, please give dates and details:

I represent that the questions above are to the best of my knowledge, true and complete. I agree that they will form a part of my application, and the policy, if issued.

Signature of Insured

Date

Witness

Commonwealth Annuity and Life Insurance Company

Administrative Office:

[PO Box 758550, Topeka, KS 66675-8551]

OR **First Allmerica Financial Life Insurance Company**

Administrative Office:

[PO Box 758552, Topeka, KS 66675-8550]

herein referred to as "Company"

Home Office: [132 Turnpike Road, Suite 210, Southborough, MA 01772]

Avocation Questionnaire

Owners Name: _____

Owners Address: _____

Phone: _____ E-Mail: _____

Reinstate Policy No. _____ on the life/lives of:

Insured: _____ D.O.B.: ____ / ____ / ____ SSN: _____

2nd Insured: _____ D.O.B.: ____ / ____ / ____ SSN: _____

SECTION 1: Underwater Diving: To be completed by the Insured (referred to as "you").

- 1. Type: Scuba Skin or Snorkel
- 2. Purpose: Recreation Wreck/Salvage Retrieval Commercial Search/Rescue Instructor
- 3. Certification (Check highest certification attained):
 Basic Open-Water Advanced Open-Water Dive Master/Instructor No Certificate
- 4. Type of diving:
 - a. Do you use the "buddy system"? Yes No
 - b. Do you do any ice diving? Yes No
 - c. Do you do any cave diving? Yes No

If you answered Yes to any of the above questions, please provide full details, including location, dates, frequency and future intentions.

5. Details of dive history and planned activities

	Last 12 Months	Intended Next 12 Months
Average Depth		
Maximum Depth		
Number of Dives		

SECTION 2: Racing

1. Purpose of racing: Amateur Professional

If both, give details:

2. Type of vehicle/races:

- Championship (Indy Cars)
- Demolition
- Motorcycle – Select all that apply: Hill Climbing Cross Country Circular Track Motocross
- Drag Racing – Select all that apply: Funny Car Top Fuel Pro Stock Pure Stock
 Modified Production Modified Super Stock
- Formula Racing – Select all that apply: Formula One Supervee Vee Ford
 Midget Car Racing
- Sports Car Racing – Select all that Apply: Canam Trans Am Production A B C
 All American GT Showroom Stock Vintage Sports
- Stock Car – Select all that apply: NASCAR Winston Cup Division Winston Division Amateur
 NASCAR Modified Division Hobby Division USAC Super Modified Division
 Street Stock NASCAR Busch Grand National Division

Racing not covered above:

Give type and details:

3. Frequency/Speed

- a. How many races did you enter in the last 12 months? _____
- b. How many in the 12 months prior to that? _____
- c. How many races do you contemplate in the next 12 months? _____
- d. What is the maximum speed attained? _____

SECTION 3: Other Avocations

1. Please give details in remarks section, including date of last activity and future plans.

- Parachuting or Skydiving Mountain or Rock Climbing Motorboat or Powerboat Racing
- Other:

I represent that the questions above are to the best of my knowledge, true and complete. I agree that they will form a part of my application, and the policy, if issued.

Date at _____ this _____ day of _____, _____
City and State Month Year

Witness Signature of Insured

HIV Testing and Consent

In this form, the "Company" refers to:

- Commonwealth Annuity and Life Insurance Company** **OR** **First Allmerica Financial Life Insurance Company**
Administrative Office: Administrative Office:
[PO Box 758550, Topeka, KS 66675-8551] [PO Box 758552, Topeka, KS 66675-8550]

Home Office: [132 Turnpike Road, Suite 210, Southborough, MA 01772]

The Company is solely responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments.

Notice and Consent for AIDS Virus (HIV) Antibody Testing

To determine your insurability, the Company has requested that you provide a sample or samples of your bodily fluids (blood, urine, and/or oral fluid) as may be allowed under state or jurisdictional law for testing and analysis. One of the tests to be performed will determine the presence or absence of antibodies to the Human Immunodeficiency Virus (HIV). The testing will be performed by a licensed laboratory in accordance with guidelines approved by the Centers for Disease Control. By signing and dating this form, you agree that this testing may be done and that underwriting decisions may be based upon the test results.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV antibody test, a person seeks counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, before being tested.

Meaning of Test Results

A positive result, which is a series of three positive tests, does not mean you have Acquired Immune Deficiency Syndrome (AIDS). A positive test indicates that you have been infected with HIV, the causative agent for AIDS, and that you are at significant risk of developing alterations of your immune system, including AIDS and AIDS-Related Complex (ARC). The test for HIV antibodies is extremely accurate and reliable. However, in rare instances, the test may be positive in individuals who are not infected with the virus (false positive). Occasionally the test may be negative in persons infected with HIV (false negative), especially when infection occurred within the 3-6 months prior to testing. Your private physician, a public health clinic or an AIDS information organization in your city can provide you with further information on the medical implications of a positive test.

Disclosure of Test Results

All test results will be treated confidentially. The laboratory will report them only to the Company. The test result may be disclosed as required by law or may be disclosed to employees of the Company who have responsibility for making underwriting decisions on behalf of the Company or to outside legal counsel who needs such information to effectively represent the Company in regard to your application. The results may be disclosed to a reinsurer if it is involved in the underwriting process. Please also be advised that the jurisdiction in which you live may require reporting of positive HIV test results or other tests results by the Company and/or the laboratory that conducts the test to a regulatory agency. Such reporting may include disclosure of personal information such as your name, address and date of birth.

If your HIV antibody test is normal (negative), no routine notification will be sent. You will be notified of an abnormal (positive or indeterminate) test result if you indicate that you desire that this result be made known to you. You may also identify another person to whom you want the abnormal results released. If you want a doctor or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that doctor or health care provider.

If your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB) as described in the notice given to you at the

time of application. The MIB is an organization of life and health insurance companies. It operates as an information exchange on behalf of its members. There will be no records with the MIB that you have had a positive HIV antibody test; however, there will be a record that you have some type of laboratory abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request and with your permission, will supply the information on you in its file to that member.

Notification of Abnormal Test Result

In the event of an abnormal result:

Send the result to me at:

Address: _____

I authorize the Company to send the result to another person:

Name: _____

Address: _____

I authorize the Company to send the result to the following physician or health care provider:

Name: _____

Address: _____

Consent

I have read and I understand this HIV Testing and Consent form. I voluntarily consent to the withdrawal of blood and/or collection of other bodily fluids from me, the testing of bodily fluids and to the disclosure of the test results as described above. I have read the information on this form about what a test result means. I understand that I should contact my physician, a public health clinic or an AIDS information organization for more information and counseling if the test result is abnormal.

I understand I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

The consent will be valid for six (6) months from the date of my signature below.

Authorization

Name of Insured Date of birth

X _____
Signature of Insured Date signed

X _____
Signature of Person Obtaining Consent Date signed

Commonwealth Annuity and Life Insurance Company
Administrative Office:
[PO Box 758550, Topeka, KS 66675-8551]

OR **First Allmerica Financial Life Insurance Company**
Administrative Office:
[PO Box 758552, Topeka, KS 66675-8550]

herein referred to as "Company"

Home Office: [132 Turnpike Road, Suite 210, Southborough, MA 01772]

Authorization to Obtain and Disclose Protected Health Information and Other Information

Insured Name: _____ Claim No/Policy ID: _____

Policy No: Old Policy # _____

I allow the release and disclosure of my **protected health information** (PHI) and other facts to the Company (checked above), and as described below.

My PHI is my personal health information. It includes facts collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearing house and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) any health care I received; or (iii) the past, present, or future payment for health care provided to me.

I allow any health care provider, including any doctor, practitioner, pharmacy, pharmacy benefits manager, hospital or medical related facility or health care facility to which this form is sent to disclose or furnish to the Company, including any person or firm legally appointed by the Company. This health information may include **medical records or other facts of a medical nature in regard to my physical or mental condition or that of my dependents. This includes prescribed drug records, records on the use of alcohol, the use of controlled or prohibited substances, driving records, financial and work records.** This extends to and includes Human Immunodeficiency Virus (HIV)-related information, Acquired Immune Deficiency Syndrome (AIDS) or AIDS related disorders or information relating to alcohol or drug abuse treatment or services for mental health care to the extent allowed by law.

I allow any employer to which this form is sent to disclose my employment, financial and wage information to the Company and to any legal representative that it might select.

I allow the Company to use or disclose this PHI, in connection with payment or health care operations, to any person or entity doing a business or legal function on behalf of the Company or as allowed or required by law. I understand that the facts disclosed to, or by, the Company as a result of this form might be re-disclosed and, therefore, may no longer be protected by the HIPAA Privacy Rule.

I allow any licensed doctor, health care practitioner, hospital, clinic or other medical or health care related facility, insurance company, Medical Information Bureau, Inc. (MIB) or other organization, institution or person, that has any records or knowledge of me or my health, to give to the 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 the MIB. A copy of this form shall be as valid as the original.

I understand that: (1) the PHI being released will be used for the purpose of evaluating a claim for insurance to include underwriting and managing coverage; (2) my refusal to sign this form may have a negative impact on the payment of claims; (3) I have the right to revoke this form at any time by writing to the Company at the address shown at the top of this form; and (4) I should sign both copies of the form provided, and keep one copy for my own records.

This form is valid for up to 12 months from the date it was signed. I may revoke this form by sending written notice to us. If I revoke this form, it will not affect the rights of any person or entity who acted in good faith based on the form before receiving my written notice to revoke the form.

Date Form Signed

Signature of Applicant or Authorized Personal Representative
(e.g., parent or guardian, if minor)

SERFF Tracking #:	MLLM-128574754	State Tracking #:		Company Tracking #:	0146ALM01-34
State:	Arkansas	Filing Company:	First Allmerica Financial Life Insurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	FAFLIC Reinstatement Application Material				
Project Name/Number:	Reinstatement Application Submission/0146ALM01-34				

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Flesch Certification		
Attachment(s):			
Readability Certification FAFLIC.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	This submission consists of the reinstatement application and questionnaires attached under the Forms Schedule Tab.		

		Item Status:	Status Date:
Satisfied - Item:	Third Party Authorization Letter		
Comments:	Third Party Authorization Letter		
Attachment(s):			
FAFLIC Authorization Letter.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:	Statement of Variability		
Attachment(s):			
Statement of Variability FAFLIC.pdf			

First Allmerica Financial Life Insurance Company

READABILITY CERTIFICATION

I hereby certify on behalf of First Allmerica Financial Life Insurance Company that the following form has been tested by an acceptable method specified in the Model Law (all forms were scored together as part of the contract with which they may be used) and obtained the Flesch Score indicated:

Form Number	Description	Flesch Score
REIN-12	Reinstatement Application	50.5
ADUQ-12	Alcohol and Drug Use Questionnaire	68.6
AQ-12	Avocation Questionnaire	74.7
AVQ-12	Aviation Questionnaire	57
HIV-12	HIV Testing and Consent Form	50
HIPPA-12	Authorization to Obtain and Disclose Protected Health Information	50

I hereby certify that the above form complies with the N.A.I.C. Model Policy Language Simplification Act. The form described above is presented in no less than ten point type, one point leaded. The style, arrangement and overall appearance of the form gives no undue prominence to any portion of the text or section of the form.

Unless we hear from you to the contrary, we will assume that this certification satisfies the certification requirements for compliance with any present or future readability law enacted by your state. We understand that this certification will not be valid to the extent that there is a material difference between the readability law of your state and the N.A.I.C. Model.



Sheila St.Hilaire
Vice President - Legal

Date: July 18, 2012

FIRST ALLMERICA

Financial Life Insurance Company
A Goldman Sachs company

January 11, 2012

Jeff Kulesus, FLMI
Consultant
Milliman, Inc.
Two Conway Park
1450 Field Drive, Suite 180
Lake Forest, Illinois 60045

RE: State Insurance Filings

Dear Mr. Kulesus:

This letter will serve as authorization from First Allmerica Financial Life Insurance Company (the "Company") for employees of Milliman, Inc. to file contract forms and other related material in states where the Company is authorized to conduct business, and to respond to inquiries from state insurance departments and jurisdictions on the Company's behalf in relation to the filing of this contract.

Sincerely,



Sheila St.Hilaire
First Allmerica Financial Life Insurance Company
Vice President, Legal
Tel: 508 460.2438
Email: sheila.stilaire@cwannuity.com

FIRST ALLMERICA FINANCIAL LIFE INSURANCE COMPANY

STATEMENT OF VARIABILITY

REIN-12, Reinstatement Application

- **Page 1 of 6**
 - Service Center Addresses – Will change the Service Center addresses to the current name or addresses if this information changes.
 - Home Office and Address – Will change the address to the current address if this information changes.
- **Page 4 of 6**
 - Service Center Address – Will change the Service Center address to the current name or address if this information changes.
 - Medical Information Bureau Telephone Number – Will change the telephone number to the current telephone number if this information changes.
 - Medical Information Center Address – Will change the Medical Information Bureau address to the current address if this information changes.
 - Medical Information Center Website Address – Will change the Medical Information Bureau website address to the current website address if this information changes.
- **Pages 5 of 6 and 6 of 6**
 - Specific state fraud statements and important notices may be revised based upon revisions in state law or regulations regarding such statements. Additional state fraud statements may be added upon newly enacted statute or newly adopted regulation in states that require such fraud statement or important notice on the Form.

ADUQ-12, Alcohol and Drug Use Questionnaire

AQ-12, Avocation Questionnaire

AVQ, Aviation Questionnaire

HIV-12, HIV Testing and Consent Form

HIPPA-12, Authorization to Obtain and Disclose Protected Health Information

- Service Center Addresses – Will change the Service Center addresses to the current addresses if this information changes.
- Home Office and Address – Will change the address to the current address if this information changes.