

State: Arkansas **Filing Company:** The Ohio State Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 1263: Policy Administration Application - Series 5135
Project Name/Number: 1263: Policy Administration Application - Series 5135/1263

Filing at a Glance

Company: The Ohio State Life Insurance Company
Product Name: 1263: Policy Administration Application - Series 5135
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 08/07/2012
SERFF Tr Num: AFLC-128619059
SERFF Status: Closed-Withdrawn
State Tr Num:
State Status: Withdrawn
Co Tr Num: 1263 - OSL

Implementation: On Approval
Date Requested:
Author(s): Ronni Jones
Reviewer(s): Linda Bird (primary)
Disposition Date: 08/07/2012
Disposition Status: Withdrawn
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** The Ohio State Life Insurance Company
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General Information

Project Name: 1263: Policy Administration Application - Series 5135 Status of Filing in Domicile: Pending
 Project Number: 1263 Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: Texas is our state of domicile.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 08/07/2012
 State Status Changed: 08/07/2012
 Deemer Date: Created By: Ronni Jones
 Submitted By: Ronni Jones Corresponding Filing Tracking Number:

Filing Description:
 Application Series 5135, an individual life policy administration application, has been submitted for your review and approval. This application will be used by insured's to choose options such as conversion, guaranteed purchase, reinstatement, and in-force policy changes.

This application will be used with previously approved Whole Life, Interest Sensitive Whole Life, Term Life, and Flexible Premium Adjustable Life policies. This form is new and does not replace any previously approved form.

To the best of our knowledge and belief, this filing is complete and complies with the regulations of your jurisdiction.

Company and Contact

Filing Contact Information
 Ronni Jones, Compliance Analyst - Filing ronni.jones@americo.com
 300 W. 11th Street 816-512-2831 [Phone]
 Kansas City, MO 64105 816-391-2083 [FAX]

Filing Company Information
 The Ohio State Life Insurance Company CoCode: 67180 State of Domicile: Texas
 300 West 11th Street Group Code: 449 Company Type:
 Kansas City, MO 64105 Group Name: State ID Number:
 (800) 231-0801 ext. [Phone] FEIN Number: 31-4271600

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Our Domicile fee for this type of filing is \$50.00 per filing.
 Per Company: No

Company	Amount	Date Processed	Transaction #
The Ohio State Life Insurance Company	\$50.00	08/07/2012	61467278

State: Arkansas Filing Company: The Ohio State Life Insurance Company
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Linda Bird	08/07/2012	08/07/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to Withdraw Filing	Note To Reviewer	Ronni Jones	08/07/2012	08/07/2012

SERFF Tracking #:

AFLC-128619059

State Tracking #:

Company Tracking #:

1263 - OSL

State:

Arkansas

Filing Company:

The Ohio State Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

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Disposition

Disposition Date: 08/07/2012

Implementation Date:

Status: Withdrawn

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Policy Administration Application		Yes

State: Arkansas

Filing Company: The Ohio State Life Insurance Company

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Note To Reviewer

Created By:

Ronni Jones on 08/07/2012 10:13 AM

Last Edited By:

Linda Bird

Submitted On:

08/07/2012 11:22 AM

Subject:

Request to Withdraw Filing

Comments:

Please withdraw this filing as a duplicate filing was submitted on 8/6/2012--our apologies.

Thank you.

Ronni Jones

Compliance Analyst

State: Arkansas

Filing Company:

The Ohio State Life Insurance Company

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

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Form Schedule

Lead Form Number: XAA5135

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		XAA5135	AEF	Policy Administration Application	Initial:	50.800	XAA5135 Policy Administration Application [Filing Form 2012-08-06].pdf

Form Type Legend:

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

Individual Life Insurance

Policy Administration Application

Conversion * Guaranteed Purchase Option * Reinstatement * In-Force Policy Change

IMPORTANT NOTE: This form must be completed by the Owner, and the Insured, if different, must answer all health or personal history questions, as applicable.

- AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
FINANCIAL ASSURANCE LIFE INSURANCE COMPANY
GREAT SOUTHERN LIFE INSURANCE COMPANY
INVESTORS LIFE INSURANCE COMPANY OF NORTH AMERICA
NATIONAL FARMERS UNION LIFE INSURANCE COMPANY
THE OHIO STATE LIFE INSURANCE COMPANY
UNITED FIDELITY LIFE INSURANCE COMPANY

Members of the Amerigo Life, Inc. family of insurance companies. Administrative Office: PO BOX 410288, Kansas City, MO 64141-0288

Please check the Company that issued or assumed Your policy. Some transactions may not be available for all policies for every company listed above. Contact Customer Service toll free [1.800.231.0801] or Your agent if You have any questions regarding available transactions.

This application is a request for: (check one) Conversion Guaranteed Purchase Option Policy Change Reinstatement

SECTION A. (Complete Section A for all requests)

1. PRIMARY INSURED INFORMATION

Form fields for Primary Insured Information including Policy Number, Plan of Insurance, Face Amount, Premium Mode, Name, Address, Phone, Social Security Number, Date of Birth, Age, Place of Birth, Employment, Occupation, Salary, Employer, and Job Duties.

2. OWNER INFORMATION (Complete only if different from the Insured.)

If change to Owner, please check here:

Form fields for Owner Information including Owner's Name, Relationship to Primary Insured, SSN or Taxpayer ID, Address, Date of Birth, Place of Birth, Email Address, and Phone.

3. PAYOR INFORMATION (Complete only if different from the Insured and Owner.)

If change to Payor, please check here:
 Submit a new bank authorization form, if applicable.

a. Payor's Name (Last, First, MI)	b. Relationship to Insured	c. SSN or Taxpayer ID
d. Address (Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)		
e. How long at current address? _____ If less than 5 years at current address, prior address is required.		
f. Email Address	g. Primary Phone <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> mobile	h. Alternate Phone <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> mobile

4. BENEFICIARY INFORMATION (Include percentage shares. If shares are not given, they will be equal.) Not Applicable:

<i>If not specified, all beneficiaries will be Primary.</i>	Name	Social Security Number or Taxpayer ID	Relationship	Date of Birth	% of Share (Must total 100%)
<input type="checkbox"/> Primary					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

SECTION B. CONVERSION (Complete only if requesting a Term Conversion or Internal Exchange)

(1) Conversion or Internal Exchange All or \$ _____ of base policy term rider

(2) If only part of any term insurance is to be converted, check one of the following statements:
 Not applicable
 Remainder of Term Insurance to be reissued and continued if permitted by Company practices, otherwise such Term Insurance to be cancelled.
 Remainder of Term Insurance to be cancelled.

(3) Plan of Insurance: [ADVANTAGE WL] or [_____] Amount: \$ _____

(4) Rider(s): _____

Unless an immediate increase in premium is required to make the requested change, no change in billable premium will be made without Your consent.

SECTION C. GUARANTEED PURCHASE OPTION (Complete only if exercising a Guaranteed Purchase Option.)

Guaranteed Purchase Option – New Policy
 Guaranteed Purchase Option – Additional Death Benefit.

Unless an immediate increase in premium is required to make the requested change, no change in billable premium will be made without Your consent.

SECTION D. POLICY CHANGE (Complete only if requesting an In force Policy Change other than for exercising a Guaranteed Purchase Option.)

(1) Change Face Amount from: \$ _____ to \$ _____

(2) Change Death Benefit Option to: A (level) B (increasing)

(3) Non-nicotine/non-smoker discount? Yes No Date discontinued nicotine use or smoking: _____

(4) Add Rider(s)/Amount: _____ /\$ _____, _____ /\$ _____, _____ /\$ _____, _____ /\$ _____

(5) Delete Rider(s)/Amount: _____ /\$ _____, _____ /\$ _____, _____ /\$ _____, _____ /\$ _____

If applying for an increase in coverage or benefits, complete Section G. Personal History and Section H. Medical History.
 If applying for an Additional Insured, Child, or Spouse rider, also complete Section F. Additional Insured.

Unless an immediate increase in premium is required to make the requested change, no change in billable premium will be made without Your consent.

SECTION E. REINSTATEMENT *(Complete only if requesting a Reinstatement)*

- (1) Change Face Amount from: \$ _____ to \$ _____
- (2) Change Death Benefit Option to: A (level) B (increasing)
- (3) Non-nicotine/non-smoker discount? Yes No Date discontinued nicotine use or smoking: _____
- (4) Add Rider(s)/Amount: _____/\$ _____, _____/\$ _____, _____/\$ _____, _____/\$ _____
- (5) Delete Rider(s)/Amount: _____/\$ _____, _____/\$ _____, _____/\$ _____, _____/\$ _____

Complete section G. Personal History and Section H. Medical History, unless Your request for reinstatement is for a policy issued on a guaranteed issue basis.

Complete Section F. Additional Insured if You are reinstating coverage for an Additional Insured, Child, or Spouse rider.

SECTION F. ADDITIONAL INSURED *(Complete only if a rider is requested for an Additional Insured, Child or Spouse.)*

Additional Insured's Name <i>(Last, First, MI)</i>	Date of Birth <i>(MM/DD/YYYY)</i>	State of Birth	Sex	Social Security Number	Occupation and job duties	Relationship to Primary Insured
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			

SECTION G. PERSONAL HISTORY *(Provide details of all "Yes" answers in the Personal History Details section below.)*

	Primary Insured		Additional Insured	
	Yes	No	Yes	No
1. Within the past two (2) years, have You:				
a. made any flights as a pilot, student pilot, or member of a flight crew?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. engaged in the following hazardous sports: bungee or base jumping, parachuting, hang gliding; competitive skiing/snowboarding (such as heli-skiing or ski jumping); diving activities (such as scuba, cave diving, or underwater photography); canyoning, kayaking, or white water rafting; organized racing (such as automobiles, drag racers, or motorcycles); rock or mountain climbing, rodeo riding, or any other hazardous sport/activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past seven (7) years, have You been convicted of, pleaded guilty to, or entered a plea of no contest to any felony?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Within the past five (5) years, have You:				
a. had a driver's license suspended or revoked, or are You currently under license suspension or revocation?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. been convicted of reckless driving or driving under the influence of alcohol or drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have You been convicted or pled guilty to:				
a. more than two moving violations in the past five (5) years; or.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. more than three (3) violations in the past three (3) years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. List any driver's license number(s) used in the past five (5) years for any Primary Insured/Additional Insured:				

Name on Driver's License	Driver's License Number	State Issued

PERSONAL HISTORY DETAILS

Question #	Date(s)	Details	Primary Insured	Additional Insured
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

SECTION H. MEDICAL HISTORY (Provide details of all "Yes" answers in the Medical History Details section below.)

1. a. Primary Insured's Height	'	"	b. Primary Insured's Weight	lbs.
2. a. Additional Insured's Height	'	"	b. Additional Insured's Weight	lbs.

	Primary Insured		Additional Insured	
	Yes	No	Yes	No
3. Within the past seven (7) years, have You been diagnosed, treated, tested positive for, or been given advice by a member of the medical profession for:				
a. High blood pressure, elevated cholesterol, chest pain, heart murmur, cardiac arrhythmia, or any disease or disorder of the blood vessels, coronary disease including coronary artery disease (CAD) or arteriosclerotic heart disease (ASHD)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Epilepsy, fainting, stroke or transient ischemic attack (TIA), depression, mental or nervous disorder, psychiatric disorder, Alzheimer's disease, dementia or memory loss, or taking medication for dementia or memory loss?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Diabetes, any complications of diabetes including but not limited to amputation, eye or kidney problems, insulin shock or diabetic coma, thyroid or other endocrine disorders?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Rheumatoid arthritis, multiple sclerosis, any disease or disorder of the bones or muscles or muscular dystrophy including Lou Gehrig's Disease (ALS)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Melanoma, internal cancer or any additional growth or tumor?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Any disease or disorder of the lungs or respiratory system (including shortness of breath and asthma), chronic obstructive pulmonary disease (COPD), emphysema or the current use of oxygen?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. A disorder of the kidneys, prostate, breasts or uterus?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. A disorder of the stomach, intestines, or liver; Crohn's disease; ulcerative colitis; gastrointestinal bleeding; unexplained weight loss; systemic lupus; or hepatitis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Any disease, condition or other physical disorder not mentioned in the previous questions?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any Proposed Insured ever been diagnosed as having, been told by a medical professional that you have, or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are You currently on any medications or treatment or been advised to have tests or surgery which have not been completed within the last 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have You ever used heroin, morphine, other narcotics, marijuana, cocaine, barbiturates, amphetamines, hallucinogenic drugs or abused prescription drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Within the past seven (7) years, have You been treated for or been advised by a member of the medical profession to have treatment for, or to reduce or discontinue the intake of alcohol or prescription drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Please provide the full name, address and phone number of any personal physician(s):				

Name of Personal Physician	Address	Phone Number	Primary Insured	Additional Insured
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY DETAILS

Please provide details of all "Yes" answers in the area below. (Attach a separate sheet if more space is needed; additional sheet MUST be signed and dated by applicable Insured/Owner to avoid amendments.)

Question #	Date of Onset/Treatment	Details/Results	Name, Address, and Telephone Number of Attending Physician	Primary Insured	Additional Insured
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance or reinsurance company, employer, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau (MIB, Inc.) that has any record of information about me/us or my/our minor children who are to be insured, to give Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs and alcoholism required by Americo to determine insurability and/or claims eligibility for the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, to MIB, Inc., to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required. Although federal regulations require that Americo inform You of the potential that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Americo pursuant to this Authorization will be protected by federal and state privacy laws and regulations.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this Authorization will be provided, upon request, to me/us or a person authorized on my/our behalf.

This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

FRAUD NOTICE: 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.

The USA PATRIOT ACT requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing Your name, address, date of birth and taxpayer identification number allows us to verify Your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed. Notwithstanding the foregoing, if this application is not solicited face to face or is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We have read this application and represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE PERSONAL HISTORY QUESTIONS AND TO MEDICAL HISTORY QUESTIONS OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

Signed at (City and State) _____ on (Month/Day/Year) _____

Signature of Primary Insured or Parent if Primary Insured is under age 18 (required)	Signature of Owner/Trustee/Parent (if applicable)	Title/Relationship
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Signature of Additional Insured (if applicable)	Signature of Additional Insured (if applicable)	Signature of Additional Insured (if applicable)
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Signature of Witnessing Agent	Print Agent's Name (if applicable)	Agent Number
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Agent Phone Number	Agent Fax Number	Agent E-mail Address
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Name of Agent(s) to whom commissions are to be paid:					
Name	Agent #	% Split	Name	Agent #	% Split

SERFF Tracking #:

AFLC-128619059

State Tracking #:

Company Tracking #:

1263 - OSL

State:

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
RDB (G) Series 5135.pdf			

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

NAIC number: 0449-61999
FEIN number: 35-0810610

Readability Certification

I, Eric H. Petersen – FSA, MAAA hereby certify that the forms listed below have the following readability scores, as calculated by the Flesch Reading Ease Test.

Form
Number
XAA5135

Form Description
Policy Administration Application

Readability
Score
50.8



Eric H. Petersen – FSA, MAAA

Assistant Vice President – Product Development
Title

August 6, 2012
Date