

State: Arkansas **Filing Company:** Auto-Owners Life Insurance Company
TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer
or association groups
Product Name: Guaranteed Insurability Rider Application
Project Name/Number: /

Filing at a Glance

Company: Auto-Owners Life Insurance Company
Product Name: Guaranteed Insurability Rider Application
State: Arkansas
TOI: H111 Individual Health - Disability Income
Sub-TOI: H111.003 Long Term - Unrelated to marketing with employer or association groups
Filing Type: Form
Date Submitted: 09/17/2012
SERFF Tr Num: AOIC-128684372
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: On Approval
Date Requested:
Author(s): Veronica Thelen, Julia Karn
Reviewer(s): Donna Lambert (primary)
Disposition Date: 09/28/2012
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Auto-Owners Life Insurance Company
TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer
 or association groups
Product Name: Guaranteed Insurability Rider Application
Project Name/Number: /

General Information

Project Name: Status of Filing in Domicile: Pending
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 09/28/2012
 State Status Changed: 09/28/2012
 Deemer Date: Created By: Julia Karn
 Submitted By: Julia Karn Corresponding Filing Tracking Number:

Filing Description:

Auto-Owners Life Insurance Company of Lansing, Michigan, is submitting a new form for review and approval. Form 62054 (8-12) Guaranteed Insurability Rider Application, will be used with the Guaranteed Insurability Rider, form 61728 (4-10), which was approved with our Individual Disability Income Protection Insurance Plan, form 61739 (5-10) et al, by your state on 05/03/2011, SERFF Tracking # AOIC-126829993.

This rider allows an insured to increase their Total Disability Benefit amount prior to their 58th birthday. Form 62054 (8-12) will be sent to the owner to inform them of the insured's eligibility to increase their Total Disability Benefit amount after the policy has been in force for 2 years. This supplemental application is required for each increase request to verify financial information and to verify that the insured is not currently disabled.

May we please have your approval?

The attached forms are submitted in final printed format and are subject only to minor modifications, such as company address, logo and phone number, typographical errors, paper stock, ink, and adaptation to computer printing.

Company and Contact

Filing Contact Information

Julia Karn, Method and Procedure Specialist
 karn.julia@aoins.com
 P.O. Box 30325 517-323-1493 [Phone]
 Lansing, MI 48909

Filing Company Information

| | | |
|------------------------------------|-----------------------------------|-----------------------------|
| Auto-Owners Life Insurance Company | CoCode: 61190 | State of Domicile: Michigan |
| P.O. Box 30325 | Group Code: 280 | Company Type: LAH |
| Lansing, MI 48917 | Group Name: Auto-Owners Ins Group | State ID Number: |
| (800) 346-0346 ext. [Phone] | FEIN Number: 38-1814333 | |

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00

State: Arkansas **Filing Company:** Auto-Owners Life Insurance Company
TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer
or association groups
Product Name: Guaranteed Insurability Rider Application
Project Name/Number: /

Retaliatory? Yes
Fee Explanation: 1 application = 50.00
Per Company: No

| Company | Amount | Date Processed | Transaction # |
|------------------------------------|---------|----------------|---------------|
| Auto-Owners Life Insurance Company | \$50.00 | 09/17/2012 | 62745899 |

SERFF Tracking #:

AOIC-128684372

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Auto-Owners Life Insurance Company

TOI/Sub-TOI:

H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name:

Guaranteed Insurability Rider Application

Project Name/Number:

/

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|----------|---------------|------------|----------------|
| Approved | Donna Lambert | 09/28/2012 | 09/28/2012 |

Objection Letters and Response Letters

Objection Letters

| Status | Created By | Created On | Date Submitted |
|---------------------------|---------------|------------|----------------|
| Pending Industry Response | Donna Lambert | 09/18/2012 | 09/18/2012 |

Response Letters

| Responded By | Created On | Date Submitted |
|--------------|------------|----------------|
| Julia Karn | 09/24/2012 | 09/24/2012 |

SERFF Tracking #:

AOIC-128684372

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Auto-Owners Life Insurance Company

TOI/Sub-TOI:

H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name:

Guaranteed Insurability Rider Application

Project Name/Number:

/

Disposition

Disposition Date: 09/28/2012

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification | Approved | Yes |
| Supporting Document | Application | Approved | Yes |
| Supporting Document | Health - Actuarial Justification | Approved | Yes |
| Supporting Document | Outline of Coverage | Approved | Yes |
| Form (revised) | Guaranteed Insurability Rider Application | Approved | Yes |
| Form | Guaranteed Insurability Rider Application | Replaced | Yes |

State: Arkansas **Filing Company:** Auto-Owners Life Insurance Company
TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer
or association groups
Product Name: Guaranteed Insurability Rider Application
Project Name/Number: /

Objection Letter

| | |
|-------------------------|---------------------------|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 09/18/2012 |
| Submitted Date | 09/18/2012 |
| Respond By Date | 10/18/2012 |

Dear Julia Karn,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Guaranteed Insurability Rider Application, 62054 (8-12) (Form)

Comments: Please use Arkansas's fraud warning:

"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."

Fraud Statement 23-66-503 Claim forms, proofs of loss, or other docs seeking payment, and applications

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking #:

AOIC-128684372

State Tracking #:

Company Tracking #:

State: Arkansas **Filing Company:** Auto-Owners Life Insurance Company
TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer or association groups
Product Name: Guaranteed Insurability Rider Application
Project Name/Number: /

Response Letter

| | |
|------------------------|--------------------|
| Response Letter Status | Submitted to State |
| Response Letter Date | 09/24/2012 |
| Submitted Date | 09/24/2012 |

Dear Donna Lambert,

Introduction:

Thank you for your response.

Response 1

Comments:

We have updated the fraud warning on page 3. Please note the new form number and edition date.

Related Objection 1

Applies To:

- Guaranteed Insurability Rider Application, 62054 (8-12) (Form)

Comments: Please use Arkansas's fraud warning:

"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."

Fraud Statement 23-66-503 Claim forms, proofs of loss, or other docs seeking payment, and applications

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

AOIC-128684372

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company: Auto-Owners Life Insurance Company

TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name: Guaranteed Insurability Rider Application

Project Name/Number: /

Form Schedule Item Changes

| Item No. | Form Number | Form Type | Form Name | Action/ Action Specific Data | Readability Score | Attachments | Submitted |
|----------|--------------|-----------|---|---------------------------------|-------------------|-----------------------------|--|
| 1 | 62062 (9-12) | AEF | Guaranteed Insurability Rider Application | Initial | 51.280 | 62062 (9-12) GIR app_AR.pdf | Date Submitted: 09/24/2012 By: Julia Karn |

Previous Version

| | | | | | | | |
|----------|---------------------|------------|--|----------------|---------------|--|--|
| <i>1</i> | <i>62054 (8-12)</i> | <i>AEF</i> | <i>Guaranteed Insurability Rider Application</i> | <i>Initial</i> | <i>51.280</i> | <i>62054 (8-12) Guaranteed Insurability Rider App_John Doe.pdf</i> | <i>Date Submitted: 09/24/2012 By: Julia Karn</i> |
|----------|---------------------|------------|--|----------------|---------------|--|--|

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review of this filing. Please do not hesitate to contact me if you have any questions.

Sincerely,

Julia Karn

SERFF Tracking #:

AOIC-128684372

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Auto-Owners Life Insurance Company

TOI/Sub-TOI:

H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name:

Guaranteed Insurability Rider Application

Project Name/Number:

/

Form Schedule

Lead Form Number:

| Item No. | Schedule Item Status | Form Number | Form Type | Form Name | Action/ Action Specific Data | Readability Score | Attachments |
|----------|------------------------|--------------|-----------|---|------------------------------|-------------------|-----------------------------|
| 1 | Approved 09/28/2012 | 62062 (9-12) | AEF | Guaranteed Insurability Rider Application | Initial: | 51.280 | 62062 (9-12) GIR app_AR.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 |

**Guaranteed Insurability
Rider Application
for Disability Income Insurance**

Auto-Owners Life Insurance Company

P.O. BOX 30325 • LANSING, MICHIGAN 48909-7825

Please note: This form needs to be completed in its entirety *and* signed before processing. If you have any questions on the completion of this form, please contact your Auto-Owners agent or our Life and Health Policyholder Services Department at (800) 346-0346 x1860.

SECTION A

Policy Number _____

For each increase, the maximum amount that you may apply for is equal to 50% of your Total Disability Monthly Benefit as of the Policy Date. The maximum amount allowed for all increases under this Rider is equal to 2 times your Total Disability Monthly Benefit as of the Policy Date. The amount of increase available to you will be determined by our underwriting guidelines in effect at the time of your election, with consideration of factors such as your earned income, occupation, age, and other disability insurance in force or applied for.

Amount of increase being requested at this time \$ _____

Proposed Insured Name (*print full name*) _____

Social Security No. _____ Birth Date _____

Telephone No. (____) _____ Email Address _____

Home Street Address _____ City _____ State _____ Zip _____

Employer's Name and Address _____

Type of Business _____ Hours Worked/Week _____

Contemplated Change in Employment? Yes No (*if yes, please explain*) _____

Occupation (*briefly describe job duties*) _____

Gross Income \$ _____ Net Income \$ _____ Net Worth \$ _____

SECTION B

1. Do you have any additional employment or income? Yes No
If yes, provide details _____
2. Do you have any other existing disability income coverage in force? Yes No
If yes, provide details: Disability Income Amount \$ _____ Benefit Years _____
Elimination Period _____
3. Is any other disability application pending with another company? Yes No
If yes, provide details: Company Name _____
Amount requested \$ _____ Benefit Years _____
Elimination Period _____
4. Are you currently collecting or have you applied for disability income benefits? Yes No
If yes, provide details _____
5. For the period of time commencing 60 days prior to the date of this application, have you been continuously at work on a full time basis (minimum 30 hours per week) performing all the duties of your occupation without limitation due to injury or sickness? Yes No
If no, provide details _____

SECTION C

Please provide a complete copy of the past 2 years' tax returns, including all schedules and W-2 forms.

SECTION D

It is agreed that: 1) All answers to the questions on **this application** are complete and true to the best of my knowledge and/or belief. 2) All answers to such questions, together with this agreement, shall form the basis and become a part of my existing Disability Income policy. 3) In consideration of the application and premium payment, insurance benefits applied for shall take effect on the first anniversary of the policy immediately following the date of this application. 4) Only the President, Vice-President or Secretary of the Company can make, modify, alter or discharge contracts, or waive any of the Company's rights or requirements.

I AUTHORIZE any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years to disclose to Auto-Owners Life Insurance Company, its reinsurer(s), and insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. It may also concern my child or my child's health. Medical, financial or personal details may be released. This will be used by underwriters, Company Officers and medical personnel so that Auto-Owners Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and other enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Auto-Owners Life Insurance Company.

I UNDERSTAND that any information disclosed pursuant to this Authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be disclosed by Auto-Owners Life Insurance Company except as authorized by me or as required by law.

I AUTHORIZE Auto-Owners Life Insurance Company, or its reinsurer(s), to make a brief report of my protected health information to MIB, to release my protected health information to the Policyowner of this policy in the event that a separate Policyowner is named for this policy and to release my protected health information to any reinsurer, employee, affiliate, independent contractor, insurance agent or agency staff who performs a business service for Auto-Owners Life Insurance Company on the insurance applied for or on existing insurance.

I UNDERSTAND that this Authorization will remain in effect for 24 months following the date it is signed. A copy of it is also valid. I ACKNOWLEDGE having received a copy. I also received a copy of the NOTICE OF INSURANCE INFORMATION PRACTICES.

I UNDERSTAND that I have the right to revoke this Authorization at any time, subject to action on the Authorization prior to the notice of revocation, by submitting a written request to Auto-Owners Life Insurance Company.

I UNDERSTAND that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Auto-Owners Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

I wish to have an interview if an investigative consumer report is made for this application.

Signed in the city and state of _____ Date ____/____/____

Signature of Proposed Insured or Personal Representative

Description of Authority of Personal Representative
(i.e. parent of minor child)

Signature of Owner (if other than Proposed Insured)

TO BE DETACHED AND RETAINED BY PROPOSED INSURED

NOTICE OF INSURANCE INFORMATION PRACTICES

This life and disability insurance form gives personal data about the persons to be covered. Sometimes, we may need to seek more personal data from other sources. If we ask for an investigative consumer report, you have the right to ask for an interview with the reporting agency. All such personal data is treated as confidential. In some cases, however, that data may be disclosed to others without an authorization. You have a right of access to this personal data. You may also correct any errors in the data we might collect. You can learn more about these rights and our practices upon request.

MIB, INC.

Information regarding your insurability will be treated as confidential. Auto-Owners Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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, Massachusetts 02184-8734.

Auto-Owners Life Insurance 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.

CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORTS

You need to know that when you apply for insurance with us, we may ask for a report from a consumer reporting agency. That report could include interviews with you, your neighbors, friends, etc. What we learn is used to determine insurability. It may cover data as to character, reputation, personal characteristics and mode of living. Data gathered for such a report may be kept by the agency preparing it and disclosed to others. If you write to us, we will tell you if such a report was made. We will also tell you the nature and scope of the report. This will be done in a reasonable time once we receive your letter. We will also tell you who made the report. You can then contact them for a copy of the report.

MEDICAL RECORD INFORMATION

We underwrite each application to help keep the price reasonable. This also helps each person to pay a fair share of the cost in line with the risk each represents. To do this, we ask about your physical or mental illness, medical history or treatment. Your application gives some of these answers. We may ask your doctor, hospital, etc., for more details. We may ask you to take an examination. You have the right to amend or correct any personal information we collect. Write to us if you want to do this: Auto-Owners Life Insurance Company, Life Underwriting, P.O. Box 30325, Lansing, MI 48909-7825.

AUTHORIZATION AND ACKNOWLEDGEMENT

I AUTHORIZE the release of information to Auto-Owners Life Insurance Company. This release will also apply to its reinsurers, insurance support organizations and their representatives. It may concern me or my health. It may also concern my child or my child's health. Medical, financial or personal details may be released. Also to be released is data about drug use, alcoholism or mental illness. This will be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider life or disability insurance and/or benefits applied for by me.

Data may be released by physicians or practitioners. It may also be released by hospitals, clinics or other medical facilities. The Veterans Administration and the MIB, Inc. may release data. My employer and any consumer reporting agencies may also release data. Insurance companies and their reinsurers who may have information of care, treatment or advice about me or my child may also release it.

I UNDERSTAND that this authorization will remain in effect for 24 months following the date it is signed. A copy of it is also valid.

I ACKNOWLEDGE having received a copy. I also received a copy of the NOTICE OF INSURANCE INFORMATION PRACTICES.

INSURANCE FRAUD

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.

AUTO-OWNERS LIFE INSURANCE COMPANY • P.O. BOX 30325 • LANSING, MICHIGAN 48909-7825

SERFF Tracking #:

AOIC-128684372

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Auto-Owners Life Insurance Company

TOI/Sub-TOI:

H111 Individual Health - Disability Income/H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name:

Guaranteed Insurability Rider Application

Project Name/Number:

/

Supporting Document Schedules

| | | Item Status: | Status Date: |
|-------------------|--------------------------|---------------------|---------------------|
| Satisfied - Item: | Flesch Certification | Approved | 09/28/2012 |
| Comments: | Please see attached. | | |
| Attachment(s): | Arkansas Readability.pdf | | |

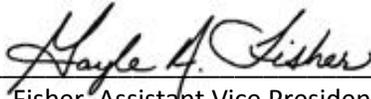
| | | Item Status: | Status Date: |
|------------------|--|---------------------|---------------------|
| Bypassed - Item: | Application | Approved | 09/28/2012 |
| Bypass Reason: | This is a new application, so it has been placed on the Form Schedule tab. | | |
| Comments: | | | |

| | | Item Status: | Status Date: |
|------------------|----------------------------------|---------------------|---------------------|
| Bypassed - Item: | Health - Actuarial Justification | Approved | 09/28/2012 |
| Bypass Reason: | Not applicable to this filing. | | |
| Comments: | | | |

| | | Item Status: | Status Date: |
|------------------|--------------------------------|---------------------|---------------------|
| Bypassed - Item: | Outline of Coverage | Approved | 09/28/2012 |
| Bypass Reason: | Not applicable to this filing. | | |
| Comments: | | | |

AUTO-OWNERS LIFE INSURANCE COMPANY
Certification of Readability

I hereby certify, to the best of my knowledge and belief, that the following forms have the respective Flesch Scores which meet the readability requirements of the Arkansas Department of Insurance.



Gayle A. Fisher, Assistant Vice President, Life Operations

Form 62054 (8-12) – Guaranteed Insurability Rider Application

Flesch Score: 51.28

*Exclusions: Section D, page 2; Notice of Insurance Information Practices, page 3

*Certain sections of this form have been excluded from readability scoring. The reasons for exclusion include 1) form language prescribed by rules and regulations of state and federal statutes; *and/or* 2) form language represented as headings and charts.

SERFF Tracking #:

AOIC-128684372

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Auto-Owners Life Insurance Company

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Product Name:

Guaranteed Insurability Rider Application

Project Name/Number:

/

Superceded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|---------------|----------|---|---------------------------|--|
| 09/17/2012 | Form | Guaranteed Insurability Rider Application | 09/24/2012 | 62054 (8-12) Guaranteed Insurability Rider App_John Doe.pdf (Superceded) |

**Guaranteed Insurability
Rider Application
for Disability Income Insurance**

Auto-Owners Life Insurance Company

P.O. BOX 30325 • LANSING, MICHIGAN 48909-7825

Please note: This form needs to be completed in its entirety *and* signed before processing. If you have any questions on the completion of this form, please contact your Auto-Owners agent or our Life and Health Policyholder Services Department at (800) 346-0346 x1860.

SECTION A

Policy Number XXX-XXXXXX-X

For each increase, the maximum amount that you may apply for is equal to 50% of your Total Disability Monthly Benefit as of the Policy Date. The maximum amount allowed for all increases under this Rider is equal to 2 times your Total Disability Monthly Benefit as of the Policy Date. The amount of increase available to you will be determined by our underwriting guidelines in effect at the time of your election, with consideration of factors such as your earned income, occupation, age, and other disability insurance in force or applied for.

Amount of increase being requested at this time \$ 400.00

Proposed Insured Name (*print full name*) John Doe

Social Security No. XXX-XX-XXXX Birth Date XX/XX/XX

Telephone No. (555) 555-5555 Email Address johndoe@johndoe.com

Home Street Address 123 Any Street City Anywhere State MI Zip 55555

Employer's Name and Address America, Inc.

Type of Business Automotive Hours Worked/Week 40

Contemplated Change in Employment? Yes No (*if yes, please explain*) _____

Occupation (*briefly describe job duties*) Manager, Marketing Dept.

Gross Income \$ 80,000 Net Income \$ 60,000 Net Worth \$ 500,000

SECTION B

1. Do you have any additional employment or income?..... Yes No
If yes, provide details _____
2. Do you have any other existing disability income coverage in force?..... Yes No
If yes, provide details: Disability Income Amount \$ _____ Benefit Years _____
Elimination Period _____
3. Is any other disability application pending with another company? Yes No
If yes, provide details: Company Name _____
Amount requested \$ _____ Benefit Years _____
Elimination Period _____
4. Are you currently collecting or have you applied for disability income benefits? Yes No
If yes, provide details _____
5. For the period of time commencing 60 days prior to the date of this application, have you been continuously at work on a full time basis (minimum 30 hours per week) performing all the duties of your occupation without limitation due to injury or sickness? Yes No
If no, provide details _____

SECTION C

Please provide a complete copy of the past 2 years' tax returns, including all schedules and W-2 forms.

SECTION D

It is agreed that: 1) All answers to the questions on this application are complete and true to the best of my knowledge and/or belief. 2) All answers to such questions, together with this agreement, shall form the basis and become a part of my existing Disability Income policy. 3) In consideration of the application and premium payment, insurance benefits applied for shall take effect on the first anniversary of the policy immediately following the date of this application. 4) Only the President, Vice-President or Secretary of the Company can make, modify, alter or discharge contracts, or waive any of the Company's rights or requirements.

I AUTHORIZE any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years to disclose to Auto-Owners Life Insurance Company, its reinsurer(s), and insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. It may also concern my child or my child's health. Medical, financial or personal details may be released. This will be used by underwriters, Company Officers and medical personnel so that Auto-Owners Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and other enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Auto-Owners Life Insurance Company.

I UNDERSTAND that any information disclosed pursuant to this Authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be disclosed by Auto-Owners Life Insurance Company except as authorized by me or as required by law.

I AUTHORIZE Auto-Owners Life Insurance Company, or its reinsurer(s), to make a brief report of my protected health information to MIB, to release my protected health information to the Policyowner of this policy in the event that a separate Policyowner is named for this policy and to release my protected health information to any reinsurer, employee, affiliate, independent contractor, insurance agent or agency staff who performs a business service for Auto-Owners Life Insurance Company on the insurance applied for or on existing insurance.

I UNDERSTAND that this Authorization will remain in effect for 24 months following the date it is signed. A copy of it is also valid. I ACKNOWLEDGE having received a copy. I also received a copy of the NOTICE OF INSURANCE INFORMATION PRACTICES.

I UNDERSTAND that I have the right to revoke this Authorization at any time, subject to action on the Authorization prior to the notice of revocation, by submitting a written request to Auto-Owners Life Insurance Company.

I UNDERSTAND that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Auto-Owners Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

I wish to have an interview if an investigative consumer report is made for this application.

Signed in the city and state of Anywhere, Michigan Date 09 / 17 / 2012

John Doe
Signature of Proposed Insured or Personal Representative

N/A
Description of Authority of Personal Representative (i.e. parent of minor child)

Signature of Owner (if other than Proposed Insured)

TO BE DETACHED AND RETAINED BY PROPOSED INSURED

NOTICE OF INSURANCE INFORMATION PRACTICES

This life and disability insurance form gives personal data about the persons to be covered. Sometimes, we may need to seek more personal data from other sources. If we ask for an investigative consumer report, you have the right to ask for an interview with the reporting agency. All such personal data is treated as confidential. In some cases, however, that data may be disclosed to others without an authorization. You have a right of access to this personal data. You may also correct any errors in the data we might collect. You can learn more about these rights and our practices upon request.

MIB, INC.

Information regarding your insurability will be treated as confidential. Auto-Owners Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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, Massachusetts 02184-8734.

Auto-Owners Life Insurance 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.

CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORTS

You need to know that when you apply for insurance with us, we may ask for a report from a consumer reporting agency. That report could include interviews with you, your neighbors, friends, etc. What we learn is used to determine insurability. It may cover data as to character, reputation, personal characteristics and mode of living. Data gathered for such a report may be kept by the agency preparing it and disclosed to others. If you write to us, we will tell you if such a report was made. We will also tell you the nature and scope of the report. This will be done in a reasonable time once we receive your letter. We will also tell you who made the report. You can then contact them for a copy of the report.

MEDICAL RECORD INFORMATION

We underwrite each application to help keep the price reasonable. This also helps each person to pay a fair share of the cost in line with the risk each represents. To do this, we ask about your physical or mental illness, medical history or treatment. Your application gives some of these answers. We may ask your doctor, hospital, etc., for more details. We may ask you to take an examination. You have the right to amend or correct any personal information we collect. Write to us if you want to do this: Auto-Owners Life Insurance Company, Life Underwriting, P.O. Box 30325, Lansing, MI 48909-7825.

AUTHORIZATION AND ACKNOWLEDGEMENT

I AUTHORIZE the release of information to Auto-Owners Life Insurance Company. This release will also apply to its reinsurers, insurance support organizations and their representatives. It may concern me or my health. It may also concern my child or my child's health. Medical, financial or personal details may be released. Also to be released is data about drug use, alcoholism or mental illness. This will be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider life or disability insurance and/or benefits applied for by me.

Data may be released by physicians or practitioners. It may also be released by hospitals, clinics or other medical facilities. The Veterans Administration and the MIB, Inc. may release data. My employer and any consumer reporting agencies may also release data. Insurance companies and their reinsurers who may have information of care, treatment or advice about me or my child may also release it.

I UNDERSTAND that this authorization will remain in effect for 24 months following the date it is signed. A copy of it is also valid.

I ACKNOWLEDGE having received a copy. I also received a copy of the NOTICE OF INSURANCE INFORMATION PRACTICES.

INSURANCE FRAUD

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

AUTO-OWNERS LIFE INSURANCE COMPANY • P.O. BOX 30325 • LANSING, MICHIGAN 48909-7825