

**State:** Arkansas **Filing Company:** First Investors Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** MIB Authorization (2012 rev)  
**Project Name/Number:** FirstInv/132/132

## Filing at a Glance

Company: First Investors Life Insurance Company  
Product Name: MIB Authorization (2012 rev)  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 09/07/2012  
SERFF Tr Num: FRCS-128671385  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 5801  
  
Implementation: On Approval  
Date Requested:  
Author(s): Marilyn Odell  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 09/12/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** MIB Authorization (2012 rev)  
**Project Name/Number:** FirstInv/132/132

**Filing Company:** First Investors Life Insurance Company

## General Information

Project Name: FirstInv/132 Status of Filing in Domicile: Pending  
Project Number: 132 Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments: Submitted to domicile state (NY) on or about this same date.  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 09/12/2012  
State Status Changed: 09/12/2012  
Deemer Date: Created By: Marilyn Odell  
Submitted By: Exselsa Cartwright Corresponding Filing Tracking Number:

### Filing Description:

We have been retained by First Investors Life Insurance Company to file the enclosed forms for approval in your state.

Our fee of \$150 has been sent by EFT on this same date.

These applications are being revised to note required MIB changes in the authorization provision. The only changes in the forms are:

1. The following sentence has been added to the Authorization section: "I authorize First Investors Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB, Inc."
2. Replaced "Medical Information Bureau" with "MIB, Inc." in the first sentence of the authorization.
3. Changed the form number.

New Form # / Form Being Replaced / Approval Date / SERFF#  
VAR-App (08/12)(AR) / VAR-App (01/07)(AR) / 03/09/2007 / FRCS-125066202  
ORD-App (08/12)(AR) / ORD-App (01/07)(AR) / 03/08/2007 / FRCS-125120288  
REIN-App (08/12)(AR) / REIN-App (12/11)(AR) / 02/09/2012 / FILI-128076650

Application form VAR-App (08/12)(AR) is exempt from the Flesch Reading Ease Test since it is a registered security.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

## Company and Contact

### Filing Contact Information

Marilyn Odell, Compliance Specialist marilyn.odell@firstconsulting.com  
1020 Central 800-927-2730 [Phone] 2835 [Ext]  
Suite 201 816-391-2755 [FAX]  
Kansas City, MO 64105

**State:** Arkansas **Filing Company:** First Investors Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** MIB Authorization (2012 rev)  
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**Filing Company Information**

(This filing was made by a third party - FC01)

First Investors Life Insurance Company	CoCode: 63495	State of Domicile: New York
110 Wall Street	Group Code:	Company Type:
New York, NY 10005	Group Name:	State ID Number:
(212) 858-8231 ext. [Phone]	FEIN Number: 13-1968606	

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$150.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form x 3 = \$150  
 Per Company: No

Company	Amount	Date Processed	Transaction #
First Investors Life Insurance Company	\$150.00	09/07/2012	62502419

State: Arkansas Filing Company: First Investors Life Insurance Company  
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
Product Name: MIB Authorization (2012 rev)  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/12/2012	09/12/2012

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** MIB Authorization (2012 rev)  
**Project Name/Number:** FirstInv/132/132

**Filing Company:** First Investors Life Insurance Company

## Disposition

Disposition Date: 09/12/2012

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		No
Supporting Document	Third Party Authorization		Yes
Supporting Document	Certificate of Compliance		Yes
Form	Individual Variable Life Application		Yes
Form	Interest Sensitive Whole Life Application		Yes
Form	Individual Life Insurance Reinstatement Application		Yes

State: Arkansas  
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Filing Company: First Investors Life Insurance Company

## Form Schedule

Lead Form Number: VAR-App (08/12)(AR)							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		VAR-App (08/12)(AR)	AEF	Individual Variable Life Application	Revised: Replaced Form #: VAR-App (01/07)(AR) Previous Filing #: FRCS-125066202	0.000	VAR-App (08-12)(AR) Final Form.pdf
2		ORD-App (08/12)(AR)	AEF	Interest Sensitive Whole Life Application	Revised: Replaced Form #: ORD-App (01/07)(AR) Previous Filing #: FRCS-125120288	52.700	ORD-App (08-12)(AR) Final Form.pdf
3		REIN-App (08/12)(AR)	AEF	Individual Life Insurance Reinstatement Application	Revised: Replaced Form #: REIN-App (12/11)(AR) Previous Filing #: FILI-128076650	67.100	REIN-App (08-12)(AR).pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate

SERFF Tracking #:

FRCS-128671385

State Tracking #:

Company Tracking #:

5801

State:

Arkansas

Filing Company:

First Investors Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MIB Authorization (2012 rev)

Project Name/Number:

FirstInv/132/132

<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages
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**20.**

a) Has the Proposed Insured lived outside the United States or Canada in the last three years?  Yes  No  
 If "Yes", please advise where, when, purpose and length of stay.

b) Does the Proposed Insured have any plans to live or travel outside the United States or Canada in the future?  Yes  No  
 If "Yes", please advise where, when, purpose and length of stay.

*(Attach additional sheet if necessary)*

**21. Suitability**

Variable life insurance is designed to achieve long-term financial objectives. It is not suitable as a vehicle for short-term savings due to the charges applicable to the Policy in the early years. You should not purchase this Policy if you believe you may need to surrender it within a short period of time.

Once your Variable Life Insurance Policy is issued and delivered to you, you have a "Free Look" period to decide if you want to keep your Policy. Your Free Look period begins when you sign and date your Policy Delivery Receipt or if your Policy is mailed to you, the Certified Return Receipt from the Post Office. The portion of the initial net premium allocated to the subaccounts will be invested in the Cash Management Fund subaccount for a period of 20 days. After 20 days, the Company will transfer the invested funds to the subaccounts you have selected. Premium allocated to the Fixed Account will be invested in the Fixed Account upon issuance of the Policy.

**22. Proposed Owner's Financial Information**

**a) Financial Resources**

Liquid Net Worth \$ \_\_\_\_\_

Net Worth \$ \_\_\_\_\_

Annual Income \$ \_\_\_\_\_

Marginal Tax Rate \_\_\_\_\_ %

**b) Investment Experience**

Stocks  Bonds

Mutual Funds  Variable Life Insurance

Other  None

**c) Risk Profile**

\_\_\_\_\_ % **Conservative** – Willing to accept some risk, but more interested in stability of principal than in larger return on investments.

\_\_\_\_\_ % **Moderate** – Willing to accept average risk of fluctuation of principal in exchange for the potential of larger long-term returns on investments.

\_\_\_\_\_ % **Aggressive** – Willing to accept significant fluctuation of principal in exchange for the potential for significant long-term returns on investment.

**d) Investment Objectives (Prioritize 1-4)**

\_\_\_\_\_ Growth \_\_\_\_\_ Income

\_\_\_\_\_ Tax Reduction \_\_\_\_\_ Other

**23. Did the Proposed Owner receive a prospectus?**  Yes  No

If "Yes" indicate the name and date of the prospectus.

a) [Variable Life Insurance Policy]  Date: \_\_\_\_\_

b) [Modified Single Premium Variable Life (SPVL)]  Date: \_\_\_\_\_

c) [Other]  Date: \_\_\_\_\_

**24. Investment Allocations**

Select the Subaccounts of the Separate Account and/or the Fixed Account and the percentage of the initial net annual premium to be allocated to each.

<u>Subaccount Options</u>	<u>% Allocated</u>
[Cash Management Fund]	_____
[Discovery Fund]	_____
[Focused Equity Fund]	_____
[Government Fund]	_____
[Growth Fund]	_____
[High Yield Fund]	_____
[International Fund]	_____
[Investment Grade Fund]	_____
[Equity Income Fund]	_____
[Target Maturity 2015 Fund]	_____
<b>Fixed Account (maximum 25%)</b>	_____
Total Allocation	100%

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**25. Does the Proposed Owner understand that in the Policy applied for:**

a) the amount of death benefit above the Guaranteed Minimum Death Benefit and the entire amount of the Surrender Value may increase or decrease depending upon the investment experience of the Subaccounts and/or the Fixed Account?  Yes  No

b) the Policy values reflect certain Deductions and Charges?  Yes  No

c) the Policy may be subject to a Surrender Charge, upon policy surrender, lapse or face amount reduction?  Yes  No

**Note: Only the Systematic Transfer Option or the Automatic Variable Subaccount Reallocation Option, but not both, may be in effect at the same time.**

**27. Automated Subaccount Reallocation Option**

Do you select the Automated Subaccount Reallocation Option feature of your policy?  Yes  No

If chosen, Automatic Reallocation will occur quarterly based on the premium investment allocations selected above for the Subaccounts.

The Fixed Account is not eligible for Automatic Reallocation.

**26. Systematic Transfer Option**

Do you select the Systematic Transfer Option?  Yes  No

If "Yes" select the frequency  Monthly or  Quarterly

Designate the Subaccounts to be used for the Transfer. The Fixed Account is not eligible for the Systematic Transfer Option.

<u>Transfer Amount</u>	<u>From Subaccount</u>	<u>To Subaccount</u>
_____	[Cash Management Fund]	_____
_____	[Discovery Fund]	_____
_____	[Focused Equity Fund]	_____
_____	[Government Fund]	_____
_____	[Growth Fund]	_____
_____	[High Yield Fund]	_____
_____	[International Fund]	_____
_____	[Investment Grade Fund]	_____
_____	[Equity Income Fund]	_____
_____	[Target Maturity 2015 Fund]	_____

**Minimum Transfer Amount is \$100  
(Whole Dollar Amounts Only)**

**28. Variable Life Disclosures**

The Policy involves a long-term commitment on your part, and you should have the intention and financial ability to make the required premium payments. It should not be used as a short-term savings vehicle. It is not like a systematic investment plan of a mutual fund.

The above subaccount selections are consistent with the investment objectives indicated above. I understand that these subaccount selections and transfer options will be relied upon by First Investors Life in regard to all Policy Transactions including Transfer Options indicated above. These options may be changed after the date of this application only by providing First Investors Life Insurance Company with a written request and instruction to change.

There shall be no contract of insurance unless a policy is issued based on this Application. The full first modal premium must be paid during the lifetime of the Insured and while his (her) health is as stated in this Application. If any premium is paid in advance to an agent of the Company at the time this Application is signed and a Conditional Receipt is given to the Proposed Owner, the terms of the Conditional Receipt shall apply. All statements and answers contained in this Application are full, complete, and true to the best of my/our knowledge and belief and I/we have not withheld any material information that may influence the assessment or acceptance of this Application. I/we agree to inform First Investors Life in writing of any material change in circumstances between the date of this Application and the issue date of the policy.

**I understand that this Application will be attached to and shall become part of any policy issued.**

No agent or medical examiner is authorized to make or discharge a contract or waive any of the conditions or provisions of any application, policy, or receipt. Only the President, Vice President, Actuary, or Secretary of the Company may make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing.

**A. ACKNOWLEDGEMENTS**

I hereby acknowledge receiving and reading the Notice, **VAR Notice (10/06)(AR)** included with this Application pertaining to the **Illustration of Benefits, Investigative Consumer Reports and the Medical Information Bureau** and authorize the Company to secure an **Investigative Consumer Report**.

I hereby acknowledge receiving a copy of the Prospectus indicated in Question #23 above.

**B. AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, the MIB, Inc., or other organization, institution or person, that has any records or knowledge of me or my health, to give First Investors Life Insurance Company or its reinsurers any such information. I authorize First Investors Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB, Inc. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for 30 months from the date below.

**C. 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.**

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_  
City & State day Month Year

Signature of Proposed Insured \_\_\_\_\_  
or of Parent/Guardian if Proposed Insured is age 0-14.

Signature of Proposed Owner \_\_\_\_\_  
(If other than the Proposed Insured)

**Agent:**  
Are you aware of existing life insurance or annuities on the life of the proposed insured, except as noted above?  Yes  No

Is the life insurance applied for on this application intended to replace an existing life insurance policy or annuity contract?  Yes  No

Licensed Agent's Name \_\_\_\_\_

Signature of Licensed Agent \_\_\_\_\_

**APPLICATION FOR VARIABLE LIFE INSURANCE  
FIRST INVESTORS LIFE INSURANCE COMPANY  
[110 Wall Street, New York, NY 10005]**

**PART II STATEMENTS MADE TO AUTHORIZED COMPANY AGENT**

<p><b>1. Name of Proposed Insured</b> (as it appears on Part I.)</p> <p>First                      Middle                      Last</p> <hr/> <p><b>2. Proposed Insured's</b>                      Month    Day    Year Date of Birth                      _____/_____/_____</p> <hr/> <p><b>3. Proposed Insured's:</b>  <b>a. Height (in shoes)</b> _____ <b>b. Weight (clothed)</b> _____  <b>c. Has your weight significantly changed in the last year?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No          If yes, Gain _____lbs. or Loss _____ lbs.  <i>(Include cause and number of months at present weight in "Details")</i></p> <hr/> <p><b>4. Has the Proposed Insured lost any time from work (school) due to illness or injury during the past five years?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>5a. Has the Proposed Insured ever been treated for alcoholism?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. Has the Proposed Insured used habit-forming drugs in the past ten (10) years or been treated for any drug habit?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>6. Has the Proposed Insured ever been under observation in a hospital, sanitarium, or other similar institution?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>7a. Has the Proposed Insured ever had any surgical operation?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. Has the Proposed Insured ever been advised to have any surgical operation which has not been performed?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>8. Has the Proposed Insured had an electrocardiogram, x-ray or other diagnostic examination within the past 10 years?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>9. Within the last past (10) ten years has the Proposed Insured had, or consulted a physician or medical practitioner for:</b>  <i>(Circle applicable items)</i></p> <p><b>a. rheumatic fever, shortness of breath, chest pain, high or low blood pressure, epilepsy, depression, fainting, sleep apnea or dizzy spells?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. duodenal or gastric ulcer, chronic indigestion, bowel disorder disorder or albumin, sugar or blood in urine?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>c. tuberculosis, asthma, allergic conditions, or blood spitting?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>d. cancer, cysts, hernia, goiter or diabetes?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>e. arthritis, back or spine disorder or impaired vision or hearing?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>f. acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or positive test results indicating the presence of the AIDS virus?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>g. any other illness, injury or impairment not mentioned above?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><b>10. Within the last ten (10) years has the Proposed Insured had or consulted a physician or practitioner for any ailment or disease of the:</b></p> <p><b>a. brain or nervous system?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. heart or blood vessels?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>c. lungs or other respiratory organs?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>d. stomach, intestines, liver or gallbladder?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>e. kidneys or other genito-urinary organs?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>f. bones, glands, or skin?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>11. Within the last ten (10) years has the Proposed Insured</b></p> <p><b>a) had any illness, disease, or injury that is not included in your other answers?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b) consulted or been examined or treated by any physician or practitioner not named in connection with your other answers?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><i>(If yes, include name doctor(s) and reason for visit in "Details")</i></p> <hr/> <p><b>12. To the best of your knowledge and belief, is the Proposed Insured pregnant? (If yes, include month of pregnancy)</b>  <input type="checkbox"/> Yes, # of months _____    <input type="checkbox"/> No</p> <hr/> <p><b>13. Name &amp; address of Proposed Insured's personal physician?</b></p> <hr/> <p><b>14. Have any of the Proposed Insured's parents, brothers or sisters, ever had heart disease, diabetes, mental illness or tuberculosis?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>15. Family Record</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Living</th> <th colspan="2">Deceased</th> </tr> <tr> <th>Age</th> <th>State of Health (if poor, explain)</th> <th>Age At Death</th> <th>Cause</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Brothers</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Sisters</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Living		Deceased		Age	State of Health (if poor, explain)	Age At Death	Cause	Father					Mother					Brothers					Sisters				
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20. a) Has the Proposed Insured lived outside the U.S. or Canada in the last three years?

Yes  No

If "Yes", please advise where, when, purpose and length of stay.

b) Does the Proposed Insured have any plans to live or travel outside the U.S. or Canada in the future?

Yes  No

If "Yes", please advise where, when, purpose and length of stay.

*(Attach additional sheet if necessary)*

There shall be no contract of insurance unless a policy is issued based on this application. The full first modal premium must be paid during the lifetime of the Proposed Insured and while his (her) health is as stated in this application. If any premium is paid in advance to an agent of the Company at the time this application is signed and the Conditional Receipt is given to the Proposed Owner, the terms of the Conditional Receipt shall apply. All statements and answers contained in this application are full, complete, and true to the best of my/our knowledge and belief and I/we have not withheld any material information that may influence the assessment or acceptance of this application. I/we agree to inform First Investors Life in writing of any material change in circumstances between the date of this application and the issue date of the policy.

**I understand that this application will be attached to and shall become part of any policy issued.**

No agent or medical examiner is authorized to make or discharge a contract or waive any of the conditions or provisions of any application, policy, or receipt. Only the President, Vice President, Actuary, or Secretary of the Company may make, modify or discharge contracts or waive any of the Company's rights or requirement and then only in writing.

**A. ACKNOWLEDGEMENTS**

I hereby acknowledge receiving and reading the Notice, **ORD Notice (07/06)(AR)**, included with this application pertaining to the **Illustration of Benefits, Investigative Consumer Reports and the Medical Information Bureau** and authorize the Company to secure an **Investigative Consumer Report**.

**For Level Term Life Insurance, Policy Form LTL-2 (09/05)(AR) including any supplemental coverage: I acknowledge, that the premium for the policy applied for is not guaranteed for the entire term of the policy and may change in accordance with the Premium Change provisions of Policy LTL-2 (09/05)(AR) and that the Company may charge the full maximum guaranteed premium.**

**B. AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, the MIB, Inc., or other organization, institution or person, that has any records or knowledge of me or my health, to give First Investors Life Insurance Company or its reinsurers any such information. I authorize First Investors Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB, Inc. A photographic copy of this Authorization shall be as valid as the original. This Authorization shall remain in effect for a period of 30 months from the date of this Application.

**C. FRAUD WARNING**

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Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_  
City & State day Month Year

Signature of Proposed Insured \_\_\_\_\_  
or of Parent/Guardian if Proposed Insured is age 0-14

Signature of Proposed Owner \_\_\_\_\_  
(If other than the Proposed Insured)

Signature of Licensed Agent \_\_\_\_\_

**APPLICATION FOR INSURANCE**  
**FIRST INVESTORS LIFE INSURANCE COMPANY**  
**[110 Wall Street, New York, NY 10005]**  
**STATEMENTS MADE TO AUTHORIZED COMPANY AGENT**

**PART II**

<p><b>1. Name of Proposed Insured (as it appears on Part I.)</b></p> <p>First                      Middle                      Last</p> <hr/> <p><b>2. Proposed Insured's</b>                      Month    Day    Year  Date of Birth                      /    /</p> <hr/> <p><b>3. Proposed Insured's:</b>  <b>a. Height (in shoes)</b> _____ <b>b. Weight (clothed)</b> _____  <b>c. Has your weight significantly changed in the last year?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No  If yes, Gain _____ lbs. or Loss _____ lbs.</p> <p><b><i>(Include cause and number of months at present weight in "Details" below)</i></b></p> <hr/> <p><b>4. Has the Proposed Insured lost any time from work (school) due to illness or injury during the past five years?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>5a. Has the Proposed Insured ever been treated for alcoholism?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. Has the Proposed Insured used habit-forming drugs in the past ten (10) years or been treated for any drug habit?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>6. Has the Proposed Insured ever been under observation in a hospital, sanitarium, or other similar institution?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>7a. Has the Proposed Insured ever had any surgical operation?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. Has the Proposed Insured ever been advised to have any surgical operation which has not been performed?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>8. Has the Proposed Insured had an electrocardiogram, x-ray or other diagnostic examination within the past 10 years?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>9. Within the last past (10) ten years has the Proposed Insured had, or consulted a physician or medical practitioner for:</b>  <b><i>(Circle applicable items)</i></b></p> <p><b>a. rheumatic fever, shortness of breath, chest pain, high or low blood pressure, epilepsy, depression, fainting, sleep apnea or dizzy spells?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. duodenal or gastric ulcer, chronic indigestion, bowel disorder or albumin, sugar or blood in urine?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>c. tuberculosis, asthma, allergic conditions, or blood spitting?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>d. cancer, cysts, hernia, goiter or diabetes?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>e. arthritis, back or spine disorder or impaired vision or hearing?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>f. acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or positive test results indicating the presence of the AIDS virus?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>g. any other illness, injury or impairment not mentioned above?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><b>10. Within the last ten (10) years has the Proposed Insured had or consulted a physician or practitioner for any ailment or disease of the</b></p> <p><b>a. brain or nervous system?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. heart or blood vessels?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>c. lungs or other respiratory organs?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>d. stomach, intestines, liver or gallbladder?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>e. kidneys or other genito-urinary organs?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>f. bones, glands, or skin?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>11. Within the last ten (10) years has the Proposed Insured</b></p> <p><b>a. had any illness, disease, or injury that is not included in your other answers?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>b. consulted or been examined or treated by any physician or practitioner not named in connection with your other answers?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b><i>(If yes, include name of each doctor and reason for visit in Details below)</i></b></p> <hr/> <p><b>12. To the best of your knowledge and belief, is the Proposed Insured pregnant? <i>(If yes, include month of pregnancy)</i></b></p> <hr/> <p><b>13. Name &amp; address of Proposed Insured's personal physician?</b></p> <hr/> <p><b>14. Have any of the Proposed Insured's parents, brothers or sisters, ever had heart disease, diabetes, mental illness or tuberculosis?</b>                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <hr/> <p><b>15. Family Record</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Living</th> <th colspan="2">Deceased</th> </tr> <tr> <th>Age</th> <th>State of Health (if poor, explain)</th> <th>Age At Death</th> <th>Cause</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Brothers</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Sisters</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Living		Deceased		Age	State of Health (if poor, explain)	Age At Death	Cause	Father					Mother					Brothers					Sisters				
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	Age	State of Health (if poor, explain)	Age At Death	Cause																										
Father																														
Mother																														
Brothers																														
Sisters																														





7a. Does the Proposed Insured contemplate flying in the next 2 years, or have they flown during the past two years, other than as a passenger on a regularly scheduled airline?  Yes  No

*(If Yes, complete Aviation Questionnaire)*

b. Has the Proposed Insured engaged in any hazardous activities such as auto, motorcycle or power boat racing, skin or scuba diving, mountain climbing, parachuting or sky diving, snowmobile racing or any other hazardous sport or hobby within the last 2 years, or plan to do so in the next 2 years?  Yes  No

*(If Yes, please complete the appropriate questionnaire or submit complete details in the Remarks section)*

8. Is the reinstatement application intended to replace any life insurance or annuity currently in force?  Yes  No

*(If Yes, furnish policy numbers and company(ies) under "Remark")*

Application is hereby made to reinstate the referenced policy which has lapsed. I have read this application and to the best of my knowledge and belief, all statements and answers in this reinstatement application are true and complete. I understand that statements and answers in this application are the basis for any reinstatement of the policy and that no information will be considered to have been given to First Investors Life unless it is stated herein. No material information that may influence the acceptance of this reinstatement application has been withheld. I agree to inform First Investors Life in writing of any changes in the information provided in this reinstatement application prior to any reinstatement of the policy.

**I understand that this reinstatement application will be attached to and shall become part of the policy if reinstated. There shall be no contract of insurance and First Investors Life will have no liability unless the policy is reinstated based on this reinstatement application, delivered to and accepted by the owner, and the full reinstatement premium is paid while the Proposed Insured is alive. If the policy is reinstated, First Investors Life will not contest the policy's validity after it has been in force for two years from the date of reinstatement.**

No agent or medical examiner is authorized to accept risk, pass on insurability or make, void, waive or change any of the conditions or provisions of any application, policy, or receipt. Only the President, Vice President, Actuary, or Secretary of the Company may make, modify or discharge contracts or waive any of the Company's rights or requirement and then only in writing.

**ACKNOWLEDGEMENTS** I hereby acknowledge receiving and reading the **NOTICE TO THE PROPOSED INSURED** included with this reinstatement application pertaining to **Investigative Consumer Reports, the MIB, Inc. and Illustrations** and authorize the Company to secure an **Investigative Consumer Report**.

**AUTHORIZATION** I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, or other medical related facility, insurance company, the MIB, Inc., or other organization, institution or person, that has any records or knowledge of me or my health, to give First Investors Life Insurance Company or its reinsurers any such information. I authorize First Investors Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB, Inc. A photographic copy of this Authorization shall be as valid as the original. This Authorization shall remain in effect for a period of 30 months from the date of this reinstatement application.

**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.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_  
City & State day Month Year

Signature of Proposed Insured \_\_\_\_\_  
or of Parent/Guardian if Proposed Insured is age 0-14

Signature of Proposed Owner \_\_\_\_\_  
(If other than the Proposed Insured)

SERFF Tracking #:

FRCS-128671385

State Tracking #:

Company Tracking #:

5801

State:

Arkansas

Filing Company:

First Investors Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MIB Authorization (2012 rev)

Project Name/Number:

FirstInv/132/132

## Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	Third Party Authorization		
Comments:			
Attachment(s):			
Auth_2012_dist.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Certificate of Compliance		
Comments:			
Attachment(s):			
AR CoC.pdf			

**STATE OF ARKANSAS  
READABILITY CERTIFICATION**

**COMPANY NAME:** First Investors Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
VAR-App (08/12)(AR)	*
ORD-App (08/12)(AR)	52.7
REIN-App (08/12)(AR)	67.1

\*This application is exempt from the Flesch Reading Ease Test since it is a registered security.

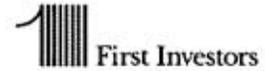


William H. Drinkwater  
Senior VP & Chief Actuary, FSA, MAAA

August 21, 2012

Date

First Investors Life Insurance Company  
95 Wall Street  
New York, NY 10005



January 3, 2012

To: The Insurance Commissioner

### Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

First Investors Life Insurance Company

By:

A handwritten signature in cursive script, appearing to read 'William H. S. [unclear]', written over a horizontal line.

Title: Senior VP & Chief Actuary, FSA,  
MAAA

**STATE OF ARKANSAS  
CERTIFICATION OF COMPLIANCE**

**Company Name:** First Investors Life Insurance Company  
**Form Title(s):** Individual Variable Life Application, Interest Sensitive Whole Life Application, Individual Life Insurance Reinstatement Application  
**Form Number(s):** VAR-App (08/12)(AR), ORD-App (08/12)(AR), REIN-App (08/12)(AR)

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



William H. Drinkwater  
Senior VP & Chief Actuary, FSA, MAAA

August 21, 2012

Date