

State: Arkansas **Filing Company:** Life Insurance Company of the Southwest
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Policy Change/Term Application
Project Name/Number: Policy Change/Term Application/1441(0712)

Filing at a Glance

Company: Life Insurance Company of the Southwest
Product Name: Policy Change/Term Application
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 09/13/2012
SERFF Tr Num: NALF-128682682
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 1441(0712)

Implementation: On Approval
Date Requested:
Author(s): Susan Carey, Michelle Goodwin, Susan Sawyer
Reviewer(s): Linda Bird (primary)
Disposition Date: 09/18/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Policy Change/Term Application
Project Name/Number: Policy Change/Term Application/1441(0712)

Filing Company: Life Insurance Company of the Southwest

General Information

Project Name: Policy Change/Term Application

Project Number: 1441(0712)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Michelle Goodwin

Filing Description:

Form Numbers:

1441(0712), Policy Change Application

20007(0712), Term Conversion Application

20114(0712), Policy Change/Term Conversion Supplement to the Application

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 09/18/2012

State Status Changed: 09/18/2012

Created By: Michelle Goodwin

Corresponding Filing Tracking Number:

Today we submit for your consideration a revised version of our Policy Change Application, as well as two new applications. We have revised the submitted Policy Change Application in order to accommodate its use not only with Life Insurance Company of the Southwest, but also with our subsidiary company, National Life Insurance Company.

The Policy Change Application, form 1441(0712) will be used for instances such as an increase or decrease to face amount, adding or removing a rider, a change in death benefit option, a change in premium class, exercise AIO, or to remove ratings. Form 1441(0712) is a new application and will not replace any previously approved form.

The Term Conversion Application, form 20007(0712) will be used when term insurance is converted to permanent insurance. This application is new and will not replace any previously approved form.

The Policy Change/Term Conversion Supplement to the Application, form 20114(0712) will be used when the policy change or term conversion requires underwriting. This application is new and will not replace any previously approved form.

These applications will be used with previously approved products in the life portfolio which include traditional whole life, term life, universal life, survivorship universal life, indexed universal life and variable life products.

This submission is to secure approval on behalf of Life Insurance Company of the Southwest. I have submitted a separate SERFF filing (NALF-128682459) of these same forms in order to secure approval on behalf of National Life Insurance Company.

Company and Contact

Filing Contact Information

Michelle Goodwin, Policy Forms Analyst MGoodwin@Nationallife.com
One National Life Drive 802-229-7441 [Phone]
Montpelier, VT 05604 802-229-3743 [FAX]

State: Arkansas **Filing Company:** Life Insurance Company of the Southwest
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Policy Change/Term Application
Project Name/Number: Policy Change/Term Application/1441(0712)

Filing Company Information

Life Insurance Company of the Southwest	CoCode: 65528	State of Domicile: Texas
15455 Dallas Parkway	Group Code: 634	Company Type:
Suite 800	Group Name: National Life Group	State ID Number: 1117
Addison, TX 75001	FEIN Number: 75-0953004	
(214) 638-9316 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? Yes
 Fee Explanation: TX charges \$100 per form
 Per Company: No

Company	Amount	Date Processed	Transaction #
Life Insurance Company of the Southwest	\$300.00	09/13/2012	62641749

State: Arkansas Filing Company: Life Insurance Company of the Southwest
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Policy Change/Term Application
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/18/2012	09/18/2012

SERFF Tracking #:

NALF-128682682

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

1441(0712)

State:

Arkansas

Filing Company:

Life Insurance Company of the Southwest

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Policy Change/Term Application

Project Name/Number:

Policy Change/Term Application/1441(0712)

Disposition

Disposition Date: 09/18/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Third Party Authorization		Yes
Form	Policy Change Application		Yes
Form	Term Conversion Application		Yes
Form	Policy Change/Term Conversion Supplement to the Application		Yes

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Policy Change/Term Application
Project Name/Number: Policy Change/Term Application/1441(0712)

Filing Company: Life Insurance Company of the Southwest

Form Schedule

Lead Form Number: 1441(0712)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1		1441AR(0712)	AEF	Policy Change Application	Initial:	69.400	1441AR.pdf
2		20007AR(0712)	AEF	Term Conversion Application	Initial:	67.200	20007AR.pdf
3		20114AR(0712)	AEF	Policy Change/Term Conversion Supplement to the Application	Initial:	51.300	20114AR.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



Policy Change Application

Instructions: Select the insurer above; hereafter known as "the Company" Policy Number: _____

Part A - Insured Information

1. Insured's Name (<i>print first, middle, last</i>)		2. Telephone Numbers H () W () C ()		
3. Email Address	4. Occupation (<i>w/specific duties</i>)		5. Annual Income	

Part B - After Issue Changes Requested

<p>1. <input type="checkbox"/> Increase Face Amount to: (<i>n/a for Traditional Insurance</i>) \$ _____ <input type="checkbox"/> Increase due to exercise of GIO/GIR <input type="checkbox"/> Increase Face Amount of Other Insured Rider to: \$ _____</p> <p>2. <input type="checkbox"/> Decrease Face Amount to: \$ _____ <input type="checkbox"/> Decrease Face Amount of Other Insured Rider to: \$ _____</p> <p>3. <input type="checkbox"/> Add Benefit/Riders: <input type="checkbox"/> Children Term Rider (<i>complete Part D</i>) \$ _____ <input type="checkbox"/> Other Insured Rider (<i>complete Part E</i>) \$ _____ <input type="checkbox"/> Other: _____ \$ _____</p> <p>4. <input type="checkbox"/> Cancel Benefit/Riders: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other Insured Rider <input type="checkbox"/> Term Rider <input type="checkbox"/> Other: _____</p>	<p>5. Universal Life Death Benefit Option Change <input type="checkbox"/> Option A (Level) <input type="checkbox"/> Option B (Increasing)</p> <p>6. Premium Information a. Premium Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Check-O-Matic b. Planned Premium Payment: _____ (<i>N/A for Traditional Life other than LifeBuilder</i>)</p> <p>7. <input type="checkbox"/> Reinstatement</p> <p>8. <input type="checkbox"/> Remove/Reduce substandard rating</p> <p>9. <input type="checkbox"/> Smoker/Tobacco status change</p>
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Part C - Exercise Additional Insurance Option (Traditional Life Only)

1. Product Name	2. Face Amount	3. Issue Age	4. Date of Issue
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5. Riders

6. Owner Information (*Owner will be the Insured unless otherwise indicated below.*)
 Present arrangement reaffirmed and continued from original policy.
 New designation as stated on form 1492 effective on the date of issue of the policy.

7. Beneficiary Information (*Beneficiary will be the Owner, unless otherwise indicated below.*)
 Present arrangement reaffirmed and continued from original policy.
 New designation as stated on form 1531 effective on the date of issue of the policy.

8. Sales Illustration
 An illustration of the policy applied for was not signed at the time the application was taken. The agent has not explained the non-guaranteed elements of the policy. An illustration and explanation of any non-guaranteed elements will be provided at policy delivery.

Part D - Children's Term Rider (CTR) (Please complete when the Proposed Insured is age 0-17.)

1. Please provide names, social security numbers and dates of birth of all children to be covered by CTR:

2. Has any child ever been diagnosed or treated for disorder of the heart, blood, respiratory system, cancer, or diabetes? Yes No

Part E - Proposed Other Insured Information

1. Name (print first, middle, last)		2. Place of Birth - State/Country		3. Date of Birth	
4. Home Address (Street, City, State & Zip. If mailing address different, provide in Remarks)			5. Issue at Age		6. Sex <input type="checkbox"/> M <input type="checkbox"/> F
7. Social Sec. #	8. Driver's License # & State		9. Telephone #'s & E-Mail H () W () C ()		
10. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country		Type of VISA		Perm. Res. Card #	
11. Employer & time employed		12. Occupation (w/specific duties)		13. Annual Income	
14. Are you actively at work at the customary workplace, doing the usual duties and functions required by the position during the normal work hours and weekly period? <input type="checkbox"/> Yes <input type="checkbox"/> No* *Reason:					
15. Face Amount		16. Riders			
17. Primary Insured Relationship		18. Beneficiary Information (Beneficiary will be the Owner, unless otherwise indicated below.) <input type="checkbox"/> Same as present arrangement on base policy <input type="checkbox"/> New designation as stated on form 1531 effective on the date of issue of this rider			

Part F - Remarks (Provide the details to questions as requested. Attach additional pages if necessary.)

Part G - Owner's Agreement

1. The Owner agrees to be bound by all statements and answers provided in this Application, including any Supplement to this Application, whether provided by the Owner or the Insured. All such statements and answers, together with this and all previous applications and supplements relating to this contract, shall be a part of the contract of insurance.

2. The agent taking this application has no authority to make, change or discharge any contract hereby applied for. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

3. The Company shall incur no liability under any change requested on this application unless and until:
a. Such change has been approved by the Company; and b. Any charge has been paid in full.

4. The changed contract shall be subject to:
a. Any assignment of the original contract filed at our Home Office or Administrative Office; and b. Any loans or liens secured by the original contract.

5. Unless set forth in the contract otherwise, it is expressly agreed that this change, if approved by the Company, shall be incontestable after the change has been in effect during the life of the Insured for two years.

6. There are no insolvency or bankruptcy proceedings now pending against the Owner.

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.

Part H - Authorized Signatures

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

By signing on behalf of a business entity owner, the undersigned individual hereby certifies that such individual has been duly appointed to transact business and execute any and all instruments on behalf of said business entity owner.

Signed at (City & State) _____ Date (mm/dd/yyyy) _____

Insured(s): (Sign in full) _____

Owner(s): (Sign in full) _____ Owner of Base Policy: (Exercise of AIO Only) _____

Irrevocable Beneficiary's / Collateral Assignee(s): (Must be notarized) _____

Signature of Licensed Agent/Representative: (Witness) _____

Name & Agent Number: (Print)



Term Conversion Application

Instructions: Select the insurer above; hereafter known as "the Company"

Current Policy No: _____ Term Rider From Policy No: _____ Effective Date of Conversion: _____

Term Conversion Application Split Policy (*Traditional Whole Life only*)

Part A - Insured Information

1. Name (<i>print first, middle, last</i>)		2. Home Address (<i>If mailing address different, provide in Remarks</i>)	
3. Social Security #	4. Date of Birth	5. Telephone #'s & E-Mail	
		H ()	W () C ()

6. After the conversion, will there be any remaining coverage on the existing policy? Yes No
 If Yes, Cancel Continue Amount to Continue _____ (*Continuance only available if \$25,000 or greater*)

Part B - Policy Information

1. Product Name _____	6. Definition of Life Insurance Test <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT)
2. Face Amount \$ _____	7. Use of Dividends: <input type="checkbox"/> Cash (<i>All Products</i>) <input type="checkbox"/> Additions (<i>Whole Life</i>) <input type="checkbox"/> Internal Paid-Up Insurance (<i>Cornerstone only</i>) <input type="checkbox"/> Flex Term Rider I - B Decreasing (<i>Whole Life only</i>) One Yr. Term + Adds = \$ _____ A premium will be charged for this rider.
3. Carry over riders from term policy? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If 'Yes', indicate rider(s) carried over in Remarks</i>)	<input type="checkbox"/> Flex Term Rider II - A Level (<i>Whole Life only</i>) One Yr. Term = \$ _____, + Adds A premium will be charged for this rider.
4. Universal Life Death Benefit Option <input type="checkbox"/> A - Level <input type="checkbox"/> B - Increasing	8. Automatic Premium Loan Payment (<i>Whole Life only</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Premium information a. Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> COM <input type="checkbox"/> Continue same Check-O-Matic Payment Plan as the Term Policy	
b. Planned Periodic Premium \$ _____	
c. Cash with Application \$ _____	

Part C - Other Insured Rider Information - Beneficiary will be the Owner, unless otherwise indicated on form 1531.

1. Name (<i>print first, middle, last</i>)	2. Social Security #	3. Date of Birth
4. Carry over riders from term policy? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If 'Yes', indicate rider(s) carried over in Remarks</i>)		5. Face Amount \$

Part D - Owner Information - Owner will be the Insured unless otherwise indicated below.

Present arrangement reaffirmed and continued from term policy.
 New designation as stated on form 1492 effective on the date of issue of the policy.

Part E - Beneficiary Information - Beneficiary will be the Owner, unless otherwise indicated below.

Present arrangement reaffirmed and continued from term policy.
 New designation as stated on form 1531 effective on the date of issue of the policy.

Part F - Inforce & Replacement Information (If 'Yes', Replacement forms must be provided; list company name & policy numbers)

	Primary Insured	Other Insured
1. Has there been or will there be a lapse, surrender, replacement, reissue, conversion, or change to reduce amount, premium, or period of coverage of any existing life, disability or annuity contract if the applied for policy or rider is issued?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part G - Remarks (Provide the details to questions as requested. Attach additional pages if necessary.)

Part H - Sales Illustration Certification (Box must be checked if an illustration has not been signed.)

An illustration of the policy applied for was not signed at the time the application was taken. The agent has not explained the non-guaranteed elements of the policy. An illustration and explanation of any non-guaranteed elements will be provided at policy delivery.

Part I - Owner's Agreement

1. The Owner agrees to be bound by all statements and answers provided in this Application, including any Supplement to this Application, whether provided by the Owner or the Insured. All such statements and answers, together with this and all previous applications and supplements relating to this contract, shall be a part of the contract of insurance.
2. The agent taking this application has no authority to make, change or discharge any contract hereby applied for. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.
3. The Company shall incur no liability under any change requested on this application unless and until:
 - a. Such change has been approved by the Company; and
 - b. Any charge has been paid in full.
4. The changed contract shall be subject to:
 - a. Any assignment of the original contract filed at our Home Office or Administrative Office; and
 - b. Any loans or liens secured by the original contract.
5. Unless set forth in the contract otherwise, it is expressly agreed that this change, if approved by the Company, shall be incontestable after the change has been in effect during the life of the Insured for two years.
6. There are no insolvency or bankruptcy proceedings now pending against the Owner.

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.

Part J - Authorized Signatures

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

By signing on behalf of a business entity owner, the undersigned individual hereby certifies that such individual has been duly appointed to transact business and execute any and all instruments on behalf of said business entity owner.

Signed at (City & State) _____ Date (mm/dd/yyyy) _____

Owner(s): (Sign in full) _____

Irrevocable Beneficiary's / Collateral Assignee(s): (Must be notarized) _____

Signature of Licensed Agent/Representative: (Witness) _____

Name & Agent Number: (Print) _____



**Policy Change/Term Conversion
Supplement To The Application**

Instructions: Select the insurer above; hereafter known as "the Company".

Insured's Name: _____

Policy Number: _____

Part A - General Information about the Proposed Insured (If yes, provide details in Remarks)

1. Have you used any type of product containing tobacco or nicotine within the last 24 months? Yes No
Product Type: _____ Frequency: _____ Date Last Used: _____
2. Have you ever applied for life, health, or disability insurance or reinstatement of same, which was declined, postponed, rated or modified in any way? Yes No
3. During the last 5 years have you plead guilty to or been convicted of any moving vehicle violations or a DUI or have you had a suspended license? Yes No
4. Have you ever been convicted of a felony or misdemeanor? Yes No
5. Have you been or are you currently involved in any bankruptcy proceedings (excluding those that have been discharged)? Yes No
6. Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation? Yes No

Part B - Health History of the Proposed Insured (Give details, dates & results for any 'Yes' questions 3-8 in Remarks).

1. Name and Address of Personal Physician (If none, so state)	Date last seen	Reason consulted & outcome
2. Height _____ Weight _____ Have you gained/lost more than 10 lbs in the last 12 months? (If yes, provide details in Remarks.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Are you taking any medications? (If yes, list type, dose and frequency in the Remarks section.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Have you ever been diagnosed, treated or taken medication for: (If yes, provide details including treating physician contact information)		
a. Any disease or abnormal condition of the heart, circulatory system, high blood pressure, high cholesterol, irregular heartbeat, murmur, rheumatic fever, coronary artery disease, chest pain, angina, transient ischemic attack, stroke or anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Any disease of the lungs or respiratory system, sleep apnea, emphysema, asthma, bronchitis, tuberculosis, shortness of breath, allergies or disorder of the nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Any digestive system disease, including ulcer, chronic indigestion, liver, stomach, intestine or pancreas disorder, hepatitis, cirrhosis, jaundice, esophagus disorder, gallbladder disorder, or colon disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No		
d. Any disorder of the nervous system, dizzy spells, epilepsy, convulsions, paralysis, unconsciousness, brain or eye disorders, or headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No		
e. Any diabetes or high blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> No		
f. Any spine, back, bones, muscles, arthritis, rheumatism, joints, skin, thyroid, gout or other gland disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No		
g. Any urinary system disease including protein, sugar or blood in urine, kidney infection or stones, disorder or disease of the breast, prostate or bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No		
h. Any depression, anxiety, bipolar, schizophrenia, attention deficient disorder (ADD), or any other developmental or psychological condition including memory loss, Alzheimer's or dementia? <input type="checkbox"/> Yes <input type="checkbox"/> No		
i. Any cancer, polyp, other tumor, hemophilia or disorders of the blood other than AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
j. HIV infection, AIDS, or have you tested positive for exposure to or been diagnosed with HIV or AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Have you ever used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, or been a member of a support group such as NA or AA? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Within the past 5 years have you:		
a. Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization or other diagnostic tests, except those related to the Human Immunodeficiency Virus (AIDS Virus)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. been admitted to a hospital, or been advised or plan to enter a hospital for observation, operation or treatment of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Do you have any pending appointments with any medical professional? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Has a parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease or polycystic kidney disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Family History		
Age if alive	Age at death	Cause of death
Father _____	_____	_____
Mother _____	_____	_____

Part C - Remarks (Provide the details to questions as requested. Attach additional pages if necessary.)

Part D - Authorization to Release Information

I understand and agree that all answers given above and in any medical exam are to the best of my knowledge and belief complete and true. I authorize any medical practitioner or facility, insurer, MIB, Inc. ("MIB") and any other organization or person that has any records or knowledge of me or my health to give such information to the Company or its reinsurers. To the extent allowed by law, I waive all rights governing disclosure of medical exams or treatment. I understand and I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization is valid for 30 months from the date signed and a photocopy shall be as valid as the original.

The Agent taking this application has no authority to make, change or discharge any contract hereby applied for. The Agent may not extend credit on behalf of the Company. No statement made to or information acquired by any representative of the Company shall bind the Company unless set out in writing in this application.

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.

Part E - Certification and Agreement

The statements and answers provided on this supplemental application are to the best knowledge and belief of the Insured, complete and true. The Insured agrees to the conditions of the Authorization to Release Information.

Part F - Signatures

Insured(s) Signature: _____ Date (mm/dd/yyyy) _____

Owner Signature: _____ Date (mm/dd/yyyy) _____

Signature of Licensed Agent/Representative: (Witness) _____

Name & Agent Number: (Print) _____

SERFF Tracking #:

NALF-128682682

State Tracking #:

Company Tracking #:

1441(0712)

State:

Arkansas

Filing Company:

Life Insurance Company of the Southwest

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Policy Change/Term Application

Project Name/Number:

Policy Change/Term Application/1441(0712)

Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Application's are attached to Form Schedule.		

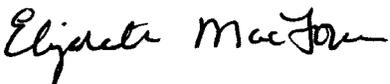
		Item Status:	Status Date:
Satisfied - Item:	Third Party Authorization		
Comments:			
Attachment(s):			
Third Party Authorization.pdf			

National Life Insurance Company
Life Insurance Company of the Southwest
Certification of Readability

We certify that, to the best of our knowledge and belief, each of the forms listed below meets the minimum reading ease score required by Arkansas Statute Annotated Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form Number</u>	<u>Flesch Score</u>
1441(0712)	69.4
20007(0712)	67.2
20114(0712)	51.3

September 12, 2012
Date



Elizabeth MacGowan,
Vice President & Chief Life Product Officer
Designated Representative



Wade H. Mayo

January 13, 2012

To Whom It May Concern:

This letter is to authorize **Michelle D. Goodwin**, Senior Policy Forms Analyst, of National Life Insurance Company, Montpelier, Vermont, as a **Designated Representative** of Life Insurance Company of the Southwest to submit product filings on their behalf.

All questions and comments regarding this filing should first be addressed to Mrs. Goodwin. I stand ready, however, to answer for Life Insurance Company of the Southwest directly should that need arise.

Mrs. Goodwin may be contacted at:

National Life Insurance Company
One National Life Drive
Montpelier, Vermont 05604
Phone: 802-229-7441
Fax: 802-229-3743

Life Insurance Company of the Southwest thanks you for your consideration in this matter.

Regards,

A handwritten signature in blue ink, appearing to read "Wade H. Mayo".

Wade H. Mayo
President & Chief Executive Officer
Life Insurance Company of the Southwest

National Life Group (NLGroup) is a trade name of National Life Insurance Company, Montpelier, VT, Life Insurance Company of the Southwest (LSW), Addison, TX and their affiliates. Each company of NLGroup is solely responsible for its own financial condition and contractual obligations. LSW is not an authorized insurer in New York and does not conduct insurance business in New York.



Wade H. Mayo

January 13, 2012

To Whom It May Concern:

This letter is to authorize **Elizabeth MacGowan**, Vice President – Protection Products, of National Life Insurance Company, Montpelier, Vermont, as a **Designated Representative** of Life Insurance Company of the Southwest to submit product filings on their behalf.

All questions and comments regarding this filing should first be addressed to Mrs. MacGowan. I stand ready, however, to answer for Life Insurance Company of the Southwest directly should that need arise.

Mrs. MacGowan may be contacted at:

National Life Insurance Company
One National Life Drive
Montpelier, Vermont 05604
Phone: 802-229-3589

Life Insurance Company of the Southwest thanks you for your consideration in this matter.

Regards,

A handwritten signature in blue ink, appearing to read "Wade H. Mayo", written over the word "Regards,".

Wade H. Mayo
President & Chief Executive Officer
Life Insurance Company of the Southwest

National Life Group (NLGroup) is a trade name of National Life Insurance Company, Montpelier, VT, Life Insurance Company of the Southwest (LSW), Addison, TX and their affiliates. Each company of NLGroup is solely responsible for its own financial condition and contractual obligations. LSW is not an authorized insurer in New York and does not conduct insurance business in New York.