

**State:** Arkansas **Filing Company:** Washington National Insurance Company  
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.500 Other  
**Product Name:** Term Life Applicaitons  
**Project Name/Number:** /

## Filing at a Glance

Company: Washington National Insurance Company  
Product Name: Term Life Applicaitons  
State: Arkansas  
TOI: L04I Individual Life - Term  
Sub-TOI: L04I.500 Other  
Filing Type: Form  
Date Submitted: 12/21/2012  
SERFF Tr Num: CNSC-128821468  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: WNIC-8000-SI-REV  
  
Implementation: On Approval  
Date Requested:  
Author(s): Janet Jones, Tammy O'Connor  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/03/2013  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

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**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.500 Other  
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## 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: 01/03/2013  
State Status Changed: 01/03/2013  
Deemer Date: Created By: Janet Jones  
Submitted By: Janet Jones Corresponding Filing Tracking Number:

### Filing Description:

RE: Washington National Insurance Company / NAIC No.: 233-70319 / FEIN #36-1933760  
Application Form numbers: WNIC-8001-EOI-REV and WNIC-8000-SI-REV

Dear Sir or Madam:

Enclosed please find the above noted new applications forms for your review and approval. These forms are being filed concurrently with our state of domicile, Indiana.

These new applications are similar to and will replace Applications WNIC-8001-EOI and WNIC-8000-SIL, which were approved by your department on 2/24/2011. A copy of the original disposition reports are attached to the Supporting Documentation tab.

The referenced application forms are submitted with revised authorization language. We have eliminated MIB authorization language in our application forms and are using a stand-alone "Authorization for Medical and Other Confidential Information" that has been approved by our Legal Department and conforms to HIPAA privacy rules. This stand-alone authorization is presented along with the application form and will be obtained prior to issuance of insurance.

In addition, we have updated the Acknowledgements Section to include documents the applicant is receiving at the time of application.

Application WNIC-8001-EOI-REV is a Life Application Supplement to be used with Policy Forms WNIC-3002-AR and WNIC-3003R-AR, and other policies that may be filed at a later date. This form will be completed by the applicant if the applicant elects a death benefit amount greater than the guaranteed issue amount. Medical questions will apply to the amount of the death benefit greater than the guaranteed issue death benefit amount. If the proposed insured is not eligible for the full death benefit elected, the proposed insured still qualifies for the guaranteed issue face amount.

Application WNIC-8000-SI-REV is a simplified issued life application to be used with Policy Forms WNIC-3000-AR and WNIC-3001R-AR, and other policies that may be filed at a later date.

Certain sections on the application are being filed as variable. Please see the Statements of Variability for the applications attached to the Supporting Documentation tab.

Also note that in the future we may offer our clients the opportunity to complete the applications electronically and will be accepting their signature in an electronic format.

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We reserve the right to make any typographical corrections, or make minor revisions to the appearance of the forms due to printing constraints.

These forms will be effective upon your approval. This filing does not contain any controversial or unusual items from normal company or industry standards.

Thank you for your time and consideration on this filing. If you have any further questions regarding this filing, please feel free to contact me.

Sincerely,

Janet Jones, HIA, AIRC, ACS  
 Product Filing Analyst  
 Policy Approval & Compliance  
 1-800-888-4918 extension 73177  
 Janet.Jones@cnoinc.com

## Company and Contact

### Filing Contact Information

Janet Jones,	Janet_Jones@conseco.com
11815 N. Pennsylvania Street	800-888-4918 [Phone] 3177 [Ext]
Carmel, IN 46032	317-817-2333 [FAX]

### Filing Company Information

Washington National Insurance Company	CoCode: 70319	State of Domicile: Indiana
11815 N. Pennsylvania St.	Group Code: 233	Company Type: Insurance
Carmel, IN 46032	Group Name:	State ID Number:
(800) 888-4918 ext. [Phone]	FEIN Number: 36-1933760	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$70.00
Retaliatory?	Yes
Fee Explanation:	Indiana domiciliary state - \$35 per form
	2 forms = \$70
	Arkansas filing fee \$50 per filing
Per Company:	No

State: Arkansas Filing Company: Washington National Insurance Company  
TOI/Sub-TOI: L04I Individual Life - Term/L04I.500 Other  
Product Name: Term Life Applicaitons  
Project Name/Number: /

Company	Amount	Date Processed	Transaction #
Washington National Insurance Company	\$70.00	12/21/2012	65981499
Washington National Insurance Company	\$30.00	01/03/2013	66220814

**State:** Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/03/2013	01/03/2013

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	01/03/2013	01/03/2013

#### Response Letters

Responded By	Created On	Date Submitted
Janet Jones	01/03/2013	01/03/2013

**State:** Arkansas  
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.500 Other  
**Product Name:** Term Life Applicaitons  
**Project Name/Number:** /

**Filing Company:** Washington National Insurance Company

## Disposition

Disposition Date: 01/03/2013

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	Life & Annuity - Acturial Memo		No
Supporting Document	Statements of Variability		Yes
Supporting Document	Disposition Reports		Yes
Form	Application for Life Insurance		Yes
Form	Life Application Supplement		Yes

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**State:** Arkansas **Filing Company:** Washington National Insurance Company  
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**Product Name:** Term Life Applicaitons  
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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/03/2013
Submitted Date	01/03/2013
Respond By Date	02/04/2013

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Dear Janet Jones,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

*Comments: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$30.00 filing fee is received.*

**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,  
Linda Bird*

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/03/2013  
Submitted Date 01/03/2013

Dear Linda Bird,

**Introduction:**

Thank you for your letter.

**Response 1**

**Comments:**

The additional \$30 filing fee has been sent.

I apologize that the correct filing fee was not originally submitted.

**Related Objection 1**

Comments: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$30.00 filing fee is received.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

**Conclusion:**

Please let me know if any additional information is needed.

Sincerely,

Janet Jones

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## Form Schedule

### Lead Form Number: WNIC-8000-SI-REV

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Life Insurance	WNIC-8000-SI-REV	AEF	Initial		51.500	WNIC-8000-SI-REV.pdf
2		Life Application Supplement	WNIC-8001-EOI-REV	AEF	Initial		50.100	WNIC-8001-EOI-REV.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
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



\*NBAP\*WNIC\*TLP\*

# APPLICATION FOR LIFE INSURANCE

Underwritten by: **Washington National Insurance Company**

Home Office: 11825 N. Pennsylvania Street, Carmel, IN 46032

Telephone: 1-800-888-4918

- Worksite Sale
- Non-Worksite Sale
- Reinstatement – Policy # \_\_\_\_\_

**SECTION 1 – EMPLOYEE / PROPOSED INSURED**

<b>A. Personal Information</b>				
First Name:		MI:	Last Name: (indicate if hyphenated name)	
Home Address: (Street/Box No.)			City, State, Zip Code:	
Social Security No.:	Home Phone:	Work Phone:	E-Mail Address:	
Place of Birth:	Date of Birth:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Occupation:		Employer's Name:		

<b>B. Beneficiary Designation</b>				
Primary Beneficiary:		Contingent Beneficiary:		
Relationship:	Date of Birth:	Relationship:	Date of Birth:	
Home Address: (Street/Box No.)		Home Address: (Street/Box No.)		
City, State, Zip Code:		City, State, Zip Code:		

**SECTION 2 – SPOUSE (as defined by State law)**  
**Complete ONLY if applying for a term life insurance policy for your Spouse (as defined by state law).**

<b>A. Personal Information</b>				
First Name:		MI:	Last Name: (indicate if hyphenated name)	
Home Address: (Street/Box No.)			City State, Zip Code	
Social Security No.:	Home Phone:	Work Phone:	E-Mail Address:	
Place of Birth:	Date of Birth:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Occupation:		Employer's Name:		

**SECTION 2 – SPOUSE (as defined by State law)**

Complete ONLY if applying for a term life insurance policy for your Spouse (as defined by state law).

**B. Beneficiary Designation**

Primary Beneficiary:	Contingent Beneficiary:
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Home Address: (Street/Box No.)	Home Address: (Street/Box No.)
City, State, Zip Code:	City, State, Zip Code:

**C. Worksite Sales – Only complete this section if Section 1, the employee information, is not completed.**

Employee Name: (First, MI, Last)	Employee's Social Security No.:	
Employer's Name:	Does the employee on average work 20 hours a week? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the employee been employed 90 days with their current employer? <input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 3 – NON-WORKSITE - OWNER OF POLICY INFORMATION**

<b>Owner of Proposed Insured's Policy If other than Proposed Insured</b>		<b>Owner of Spouse's Policy if other than Spouse (as defined by State law)</b>	
Name of Owner:		Name of Owner:	
Address: (Street/Box No.)		Address: (Street/Box No.)	
City:	State:	City:	State:
Zip Code:	Social Security No.:	Zip Code:	Social Security No.:
<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Proposed Insured:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Spouse: (as defined by State law):

**SECTION 4 – PLAN OF INSURANCE, RIDERS and BENEFIT (Riders and Benefits may vary by plan and may not be available in all states).**

	Employee / Proposed Insured	Modal Premium	Spouse (as defined by State law)	Modal Premium
<b>Plan of Insurance:</b>				
Term Life Insurance	<input type="checkbox"/>		<input type="checkbox"/>	
Term Life Insurance with Return of Premium	<input type="checkbox"/>		<input type="checkbox"/>	
<b>Level Premium Period:</b>				
15 Years (Issue Ages 18-65)	<input type="checkbox"/>		<input type="checkbox"/>	
To Age 65 (Issue Ages 18-55)	<input type="checkbox"/>		<input type="checkbox"/>	
<b>Insurance Amount:</b>				
Death Benefit	\$	\$	\$	\$

<b>SECTION 4 – PLAN OF INSURANCE, RIDERS and BENEFIT (Riders and Benefits may vary by plan and may not be available in all states).</b>				
	<b>Employee / Proposed Insured</b>	<b>Modal Premium</b>	<b>Spouse (as defined by State law)</b>	<b>Modal Premium</b>
<b>Riders:</b>				
Critical Illness Rider	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$
Total and Permanent Disability Waiver of Premium Rider	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$
* Accidental Death Benefit Rider	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$
** Child Term Insurance Rider	<input type="checkbox"/> \$10,000	\$	<input type="checkbox"/> \$10,000	\$
<b>Total Modal Premium:</b>		\$		\$

\* **Accidental Death Benefit Amount equal to the initial Death Benefit of the Policy up to \$150,000.**

\*\* **For the Children's Term Rider** -List all unmarried dependent children who are under age 19 and proposed for coverage. (Attach a separate sheet for additional persons not listed.) **(Children's Term Rider can only be attached to one policy).**

Name (First, Middle Initial, Last Name)	Gender	Relationship	Date of Birth	Height	Weight

**SECTION 5 – METHOD OF PAYMENT**

**Worksite:**

Payroll Group No.:

Current Payroll Deduction Options: Frequency:  9 pay;  10 pay;  12 pay;  13 pay;  24 pay;  26 pay;  52 pay

Employee Non-payroll:  Monthly Electronic Funds Transfer

**Non-Worksite – Non-Payroll Deduction Premium Modes (Check one box only):**

Annual;  Semi Annual;  Quarterly;  Monthly (Electronic Funds Transfer only)

**SECTION 6 – REPLACEMENT & IN FORCE INSURANCE – REGARDING ALL INDIVIDUALS TO BE INSURED**

- Will any existing life insurance or annuity with this or any other company be replaced, changed, or used as a source of premium payment for the insurance applied for? (If "Yes", list below).  Yes  No
- Does any individual applying for life insurance have any in force life insurance policies or annuity contracts? (If "Yes", list below).  Yes  No

Name of Person		Name of Company			
Type of Coverage	Insurance Amount	Accidental Death Amount	Year Issued	To Be Replaced	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Person		Name of Company			
Type of Coverage	Insurance Amount	Accidental Death Amount	Year Issued	To Be Replaced	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**SECTION 7 – MEDICAL INFORMATION – EVIDENCE OF INSURABILITY**

<b>ANSWER QUESTIONS BELOW ON ALL INDIVIDUALS TO BE INSURED.</b>	<b>Employee / Proposed Insured</b>	<b>Spouse (as defined by State Law)</b>	<b>Child / Children</b>
1. Provide height and weight for each proposed insured.	Height ____ft. ____in.  Weight ____lbs.	Height ____ft. ____in.  Weight ____lbs.	<i>Information provided in Section 4, if applicable.</i>
2. Has any proposed insured used tobacco or nicotine in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
3. Is any proposed insured actively at work? a. If yes, does the proposed insured on average work 20 hours per week? b. Has the proposed insured been employed 90 days with their current employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
4. In the past 5 years has any proposed insured, received medical treatment or counseling, or been advised to seek treatment for alcohol or illegal drug use or for Marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years, has any proposed insured been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 5 years has any proposed insured, or does any proposed insured intend to engage in piloting an aircraft, motor vehicle racing, scuba diving, sky diving, hang gliding, parachuting, mountain climbing, horse racing or any other hazardous sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any proposed insured in the past 6 months prior to application been: a. seen by a physician for anything other than a cold, flu, or routine examination? b. hospitalized? c. disabled due to accident or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any proposed insured missed more than 5 consecutive days of active work due to an illness or injury in the past 6 months prior to application?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
9. Has any proposed insured ever been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. In the past 5 years, has any proposed insured had: a. chest pain, heart attack, heart disease, high blood pressure, congestive heart failure; palpitations or other disorder of the heart or cardiovascular system? b. stroke, including transient ischemic attack (TIA), diabetes? c. lung disease, chronic obstructive pulmonary disease (COPD); asthma; emphysema? d. liver disease, hepatitis; cirrhosis? e. cancer, tumor, leukemia? f. kidney disease, blood disorder (excluding HIV)? g. memory loss, dementia, mental disorder, nervous system disorder? h. other known health impairments not included on this list?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any proposed insured taken any prescription medicine in the past 12 months? If "yes", state name of medication, reason for taking, frequency and dosage.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**REMARKS – Provide details to "yes" answers in Section 7 Questions 4-11 in space provided below. (Attach extra sheet of paper, if necessary.)**

Question Number:	Name of Person:
------------------	-----------------

Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)

Question Number:	Name of Person:
------------------	-----------------

Details: (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)

Question Number:	Name of Person:
------------------	-----------------

Details: (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)

**SECTION 8 – CONDITIONAL AMENDMENTS TO APPLICATION**

If coverage cannot be issued as initially applied for, I hereby authorize Washington National Insurance Company to amend the application under the following circumstances:

- Issue a lesser benefit amount.  Yes  No
- Issue coverage on the remaining individuals applying for coverage if any one person's coverage is declined.  Yes  No
- Increase or decrease the premium amount to cover the benefit actually issued.  Yes  No

**NOTE: NONE OF THE ABOVE CONDITIONAL AMENDMENTS CREATE ANY ADDITIONAL OBLIGATION BY WASHINGTON NATIONAL INSURANCE COMPANY TO ISSUE COVERAGE TO ANY INDIVIDUAL PROPOSED FOR COVERAGE.**

**SECTION 9 – ACKNOWLEDGMENTS**

The Employee/Proposed Insured and/or Spouse (as defined by State law) has received and acknowledges receipt of the following forms:

- Privacy Notice
- Authorization for Medical and Other Confidential Information
- Conditional Receipt (if applicable)
- Notice Regarding Replacement Form (if applicable)

**SECTION 10 – DECLARATIONS**

I represent that all statements and answers made in all parts of this application are full, complete and true. It is understood and agreed that:

1. All such statements and answers shall be the basis for and become a part of any life insurance issued as a result of this application.
2. No agent, producer, broker nor examiner has the authority to accept risks, to make or change contracts or to waive any of Washington National Insurance Company (hereinafter, the "Company") rights or requirements.
3. **The insurance coverage will become effective on the Policy Effective Date.**
4. If premium was paid with this application, I have read the conditional receipt given to me and fully understand the conditions and limitations stated in the receipt and that no agent can waive or change such conditions or limitations.
5. Acceptance of a policy by the Owner constitutes ratification of any changes made by the Company.
6. If authorizing payroll deduction, I authorize my employer to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which my employer cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my employer in writing to cancel the premium deductions.

**Fraud Warning: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.**

Signed at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month, Day, Year

**Complete for Worksite Sales**

**Sign Full Legal Name**

X \_\_\_\_\_  
Signature of Applicant/Owner

X \_\_\_\_\_  
Signature of Witness  
(Licensed Agent Must Witness Where Required by Law)

**Complete for Non-Worksite Sales**

X \_\_\_\_\_  
Signature of Proposed Insured

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

X \_\_\_\_\_  
Signature of Spouse (as defined by State law)(If applying for life insurance coverage).

X \_\_\_\_\_  
Signature of Owner (If other than Spouse – as defined by State law)

X \_\_\_\_\_  
Signature of Witness (Licensed Agent Must Witness Where Required by Law)

\_\_\_\_\_  
Print Name of Witness



## LIFE APPLICATION SUPPLEMENT

**Underwritten by: Washington National Insurance Company**

Home Office: 11825 N. Pennsylvania Street, Carmel, IN 46032

Telephone: 1-800-888-4918

- Employee – Evidence of Insurability  
 Spouse – Evidence of Insurability

- Reinstatement – Policy # \_\_\_\_\_  
 Child/Children – Evidence of Insurability

**THIS APPLICATION WILL BE USED WITH APPLICATION WNIC-8001-GI**

SECTION 1 – MEDICAL INFORMATION – EVIDENCE OF INSURABILITY					
ANSWER QUESTIONS BELOW ON ALL INDIVIDUALS TO BE INSURED.		Employee / Proposed Insured	Spouse <i>(as defined by State Law)</i>	Child / Children	
1. Provide height and weight for each proposed insured.		Height ____ft. ____in.  Weight ____lbs.	Height ____ft. ____in.  Weight ____lbs.	<i>Enter requested information in Question 12</i>	
2. Has any proposed insured used tobacco or nicotine in the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	
3. Is any proposed insured actively at work?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	
a. If yes, does the proposed insured on average work 20 hours per week?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Has the proposed insured been employed 90 days with their current employer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. In the past 5 years has any proposed insured, received medical treatment or counseling, or been advised to seek treatment for alcohol or illegal drug use or for Marijuana?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. In the past 5 years, has any proposed insured been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. In the past 5 years has any proposed insured, or does any proposed insured intend to engage in piloting an aircraft, motor vehicle racing, scuba diving, sky diving, hang gliding, parachuting, mountain climbing, horse racing or any other hazardous sports?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Has any proposed insured in the past 6 months prior to application been:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
a. seen by a physician for anything other than a cold, flu, or routine examination?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. hospitalized?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. disabled due to accident or illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Has any proposed insured missed more than 5 consecutive days of active work due to an illness or injury in the past 6 months prior to application?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	
9. Has any proposed insured ever been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. In the past 5 years, has any proposed insured had:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
a. chest pain, heart attack, heart disease, high blood pressure, congestive heart failure; palpitations or other disorder of the heart or cardiovascular system?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. stroke, including transient ischemic attack (TIA), diabetes?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. lung disease, chronic obstructive pulmonary disease (COPD); asthma; emphysema?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. liver disease, hepatitis; cirrhosis?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. cancer, tumor, leukemia?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. kidney disease, blood disorder (excluding HIV)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. memory loss, dementia, mental disorder, nervous system disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. other known health impairments not included on this list?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Has any proposed insured taken any prescription medicine in the past 12 months? If "yes", state name of medication, reason for taking, frequency and dosage.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. For the Children's Term Rider -List all unmarried dependent children who are under age 19 and proposed for coverage. (Attach a separate sheet for additional persons not listed.) <b>(Children's Term Rider can only be attached to one policy).</b>					
Name (First, Middle Initial, Last Name)	Gender	Relationship	Date of Birth	Height	Weight

12. For the Children's Term Rider -List all unmarried dependent children who are under age 19 and proposed for coverage. (Attach a separate sheet for additional persons not listed.) **(Children's Term Rider can only be attached to one policy)**. (continued)

Name (First, Middle Initial, Last Name)	Gender	Relationship	Date of Birth	Height	Weight

**REMARKS –** Provide details to “yes” answers in Section 1 Questions 4-11 in space provided below. (Attach extra sheet of paper, if necessary.)

Question Number:	Name of Person:
------------------	-----------------

*Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

Question Number:	Name of Person:
------------------	-----------------

*Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

Question Number:	Name of Person:
------------------	-----------------

*Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

Question Number:	Name of Person:
------------------	-----------------

*Details (Include duration, impairment, diagnosis, treatment, medication, date of occurrence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

**SECTION 2 – CONDITIONAL AMENDMENTS TO APPLICATION**

If coverage cannot be issued as initially applied for, I hereby authorize Washington National Insurance Company to amend the application under the following circumstances:

- Issue a lesser benefit amount.  Yes     No
- Issue coverage on the remaining individuals applying for coverage if any one person's coverage is declined.  Yes     No
- Increase or decrease the premium amount to cover the benefit actually issued.  Yes     No

**NOTE: NONE OF THE ABOVE CONDITIONAL AMENDMENTS CREATE ANY ADDITIONAL OBLIGATION BY WASHINGTON NATIONAL INSURANCE COMPANY TO ISSUE COVERAGE TO ANY INDIVIDUAL PROPOSED FOR COVERAGE.**

**SECTION 3 – ACKNOWLEDGMENTS**

The Applicant/Owner's has received and acknowledges receipt of the following forms:

- Privacy Notice
- Authorization for Medical and Other Confidential Information
- Conditional Receipt (if applicable)
- Notice Regarding Replacement Form (if applicable)

**SECTION 4 – DECLARATIONS**

I represent that all statements and answers made in all parts of this application are full, complete and true. It is understood and agreed that:

1. All such statements and answers shall be the basis for and become a part of any life insurance issued as a result of this application.
2. No agent, producer, broker nor examiner has the authority to accept risks, to make or change contracts or to waive any of Washington National Insurance Company (hereinafter, collectively "Company") rights or requirements.
3. **As a condition precedent to coverage taking effect on the Policy Effective Date, all persons to be covered under the policy must be alive and not in a hospital, nursing home or other medical facility, which provides skilled medical care on the Policy Effective Date and the full first premium must be paid. Deferred Effective Date of Coverage will apply, if any person to be covered under the policy is in a hospital, nursing home or other medical facility on the Policy Effective Date. The insurance coverage will not become effective until the date the covered person is discharged from the hospital, nursing home or other medical facility and is able to perform his/her normal activities.**
4. Acceptance of a policy by the Owner constitutes ratification of any changes made by the Company.
5. If authorizing payroll deduction, I authorize my employer to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which my employer cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my employer in writing to cancel the premium deductions.

**Fraud Warning: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.**

Signed at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month, Day, Year

Sign Full Legal Name

X \_\_\_\_\_  
Signature of Applicant/Owner

X \_\_\_\_\_  
Signature of Witness  
(Licensed Agent Must Witness Where Required by Law)

X \_\_\_\_\_  
Agent Signature

X \_\_\_\_\_  
Print Agent Name

\_\_\_\_\_  
Agent Number (Company Number)

SERFF Tracking #:

CNSC-128821468

State Tracking #:

Company Tracking #:

WNIC-8000-SI-REV

State: Arkansas

Filing Company:

Washington National Insurance Company

TOI/Sub-TOI: L04I Individual Life - Term/L04I.500 Other

Product Name: Term Life Applicaitons

Project Name/Number: /

### Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):	READABILITY CERTIFICATION.pdf WNIC-CN-AR.pdf AR Guaranty Notice.pdf Certification Rule 19.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Statements of Variability		
Comments:			
Attachment(s):	Statement of Variability for WNIC-8000-SI-REV.pdf Statement of Variability for WNIC-8001-EOI-REV.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Disposition Reports		
Comments:			
Attachment(s):	Disposition Report for WNIC-8000-SI.pdf Disposition Report for WNIC-8001-EOI.pdf		

## READABILITY CERTIFICATION

**Company Name:** WASHINGTON NATIONAL INSURANCE COMPANY

**NAIC Number:** 233-70319

As an officer of Washington National Insurance Company, I hereby certify that the below captioned forms achieve the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements in your state.

<b>Flesch Score</b>	<b>Form Number</b>	<b>Description</b>
51.5	WNIC-8000-SI-REV	Application for Life Insurance
50.1	WNIC-8001-EOI-REV	Life Supplement Application



Mathias E. Brown  
Sr. Director and Assistant Secretary, Product Approval and Compliance  
Date 12/20/2012

**IMPORTANT NOTICE**

Should you have any questions concerning this policy, you may direct your question to:

1. If to the Company,

Washington National Insurance Company  
11815 N. Pennsylvania St.  
Carmel, Indiana 46032-4555  
Telephone: 1-800-940-1843

2. If to your licensed representative:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

3. If to the Arkansas Insurance Department

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201  
Telephone: 1-501-371-2640  
1-800-852-5494

**LIMITATIONS AND EXCLUSIONS UNDER THE  
ARKANSAS LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

(Please turn to back of page)

## **COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## **EXCLUSIONS FROM COVERAGE**

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insurers who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees.)

## **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

# WASHINGTON NATIONAL INSURANCE COMPANY

## Arkansas Certification for Compliance

### With Rule and Regulation 19

WNIC-8000-SI-REV	Application for Life Insurance
WNIC-8001-EOI-REV	Life Application Supplement

I, Mathias E. Brown, an authorized officer for the company, do hereby certify that the form(s) identified above are in compliance with Arkansas Rule and Regulation 19 in regards to Unfair Sex Discrimination in the Sale of Insurance.



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**Mathias E. Brown**  
**Senior Director and Assistant Secretary**

**12/20/2012**

**DATE**

**WASHINGTON NATIONAL INSURANCE COMPANY**

Date: 12/20/2012

**STATEMENT OF VARIABILITY  
WNIC-8000-SI-REV**

This Statement of Variability is for Application for Life Insurance Form WNIC-8000-SI-REV that will be used with our Renewable Term Life Insurance Policy to Age 98, WNIC-3000-AR, and Renewable Term Life Insurance Policy to Age 98 with Return of Premium, WNIC-3001R-AR. The language that is bracketed on the attached application is intended to be illustrative and variable, and may be modified by Washington National Insurance Company on a non-discriminatory basis as described below.

Bracketed Item	Description
Page 1 – Address	Current Company Address for Home Office
Page 1 - ( 800) Telephone Number	Current 800 number
Page 3 – Section 4 - Riders	By making this area variable, in the future we will be able to delete any rider that is not being offered any longer or to add any new rider (once approved by the insurance departments) to the application.
Page 3 – Section 4 – Child Term Insurance Rider – Face Amount	By making the face amount of \$10,000 variable, in the future we will be able to change the amount of the Death Benefit to a higher or lower amount.
Page 3 – Section 5 - Current Payroll Deduction Options	By making this area variable, in the future we will be able to delete any payment method no longer being .offered or to add any new payment method..
Page 4 – Section 7 – Question 3a. ...If, yes, does the proposed insured on average work [ 20 ] hours per week?	By making [20] hours variable, in the future we will be able to change the numbers of hours, if needed.
Page 4 – Section 7 – Question 3b.... Has the proposed insured been employed [ 90 ] days with their current employer?	By making [90] days variable, in the future we will be able to change the numbers of days, if needed.

WASHINGTON NATIONAL INSURANCE COMPANY

Date: 12/20/2012

STATEMENT OF VARIABILITY  
WNIC-8001-EOI-REV

This Statement of Variability is for Application for Life Insurance Form WNIC-8001-EOI-REV that will be used with our Renewable Term Life Insurance Policy to Age 98, WNIC-3002-AR, and Renewable Term Life Insurance Policy to Age 98 with Return of Premium, WNIC-3003R-AR. The language that is bracketed on the attached application is intended to be illustrative and variable, and may be modified by Washington National Insurance Company on a non-discriminatory basis as described below.

Bracketed Item	Description
Page 1 – Address	Current Company Address for Home Office
Page 1 - ( 800) Telephone Number	Current 800 number
Page 1 – Section 1 – Question 3a. ...If, yes, does the proposed insured on average work [20] hours per week?	By making [20] hours variable, in the future we will be able to change the numbers of hours, if needed.
Page 1 – Section 1 – Question 3b.... Has the proposed insured been employed [90] days with their current employer?	By making [90] days variable, in the future we will be able to change the numbers of days, if needed.

## Disposition for CNSC-127041271

<b>SERFF Tracking Number:</b>	CNSC-127041271	<b>State:</b>	Arkansas
<b>Filing Company:</b>	Washington National Insurance Company	<b>State Tracking Number:</b>	48017
<b>Company Tracking Number:</b>	WNIC-3000		
<b>TOI:</b>	L04I Individual Life - Term	<b>Sub-TOI:</b>	L04I.500 Other
<b>Product Name:</b>	WNIC-3000 & WNIC-3001R		
<b>Project Name:</b>			

**Disposition Date:**

02/24/2011

**Implementation Date:****Status: \***

Approved-Closed

**Comments:****Schedule Items**

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statements of Variability		Yes
Form	WNIC-3000-AR, Policy/Contract/Fraternal Certificate, Renewable Term Life Insurance to Age 98		Yes
Form	WNIC-3001R-AR, Policy/Contract/Fraternal Certificate, Renewable Term Life Insurance To 98 with Return of Premium Available		Yes
Form	WNIC-8000-SI, Application/Enrollment Form, Application for Life Insurance		Yes
Form	WNIC-8000-CR, Other, Conditional Receipt		Yes
Form	WNIC-6019, Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider, Accelerated Benefit Rider For Terminal Illness		Yes
Form	WNIC-6020, Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider, Children's Term Insurance Rider		Yes
Form	WNIC-6021, Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider, Total and Permanent Disability Benefits Waiver of Premium		Yes
Form	WNIC-6022-AR, Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider, Critical Illness Rider		Yes
Form	WNIC-6026, Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider, Accidental Death Benefit Rider		Yes
Form	DISC-6019, Other, Disclosure Statement For Accelerated Benefit For Terminal Illness		Yes
Form	CLAIM-6019, Other, Benefit Payment Notice		Yes

## Disposition for CNSC-126997100

<b>SERFF Tracking Number:</b>	CNSC-126997100	<b>State:</b>	Arkansas
<b>Filing Company:</b>	Washington National Insurance Company	<b>State Tracking Number:</b>	48016
<b>Company Tracking Number:</b>	WNIC-3002		
<b>TOI:</b>	L04I Individual Life - Term	<b>Sub-TOI:</b>	L04I.500 Other
<b>Product Name:</b>	WNIC-3002 & WNIC-3003R		
<b>Project Name:</b>			

**Disposition Date:**

02/24/2011

**Implementation Date:****Status:** \*

Approved-Closed

**Comments:**

## Schedule Items

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statements of Variability		Yes
Form	WNIC-3002-AR, Policy/Contract/Fraternal Certificate, Renewable Term Life Insurance to Age 98		Yes
Form	WNIC-3003R-AR, Policy/Contract/Fraternal Certificate, Renewable Term Life Insurance To Age 98 with Return of Premium Available		Yes
Form	WNIC-8001-GI, Application/Enrollment Form, Application for Life		Yes
Form	WNIC-8001-EOI, Application/Enrollment Form, Life Application Supplement		Yes