

State: Arkansas **Filing Company:** Liberty Life Assurance Company of Boston
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Application (Whole Life and Term)
Project Name/Number: /

Filing at a Glance

Company: Liberty Life Assurance Company of Boston
Product Name: Life Application (Whole Life and Term)
State: Arkansas
TOI: L071 Individual Life - Whole
Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Filing Type: Form
Date Submitted: 12/20/2012
SERFF Tr Num: LLAC-128822297
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: APP-2012254

Implementation: On Approval
Date Requested:
Author(s): Andrew Baron, Margaret Gallagher, Lindsey Boisvert, Aimee Belliveau
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/02/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Application (Whole Life and Term)
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Filing Company: Liberty Life Assurance Company of Boston

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: 01/02/2013
State Status Changed: 01/02/2013
Deemer Date: Created By: Lindsey Boisvert
Submitted By: Lindsey Boisvert Corresponding Filing Tracking Number:

Filing Description:

Dear Reviewer,

The above referenced forms are being submitted for your review and approval. These forms are new and will not replace any forms currently on file with the Department.

Form APP-2012254 is an Application for Individual Life Insurance that will be used in the sale of the following individual life insurance products (Whole Life and Term) offered by the Company.

Form APP-2012254 will also be used in the sale of other individual life insurance products offered by the Company, as applicable.

Form APP-2012254 is intended to be used with any approved supplemental applications, as applicable. Currently, form APP-2012139-O is the only supplemental application available with form APP-2012254.

Form APP-2012139-O will be used when space is necessary for additional information.

The applicant replacement questions appear on form APP-2012254. We will obtain the agent replacement question on a separate administrative form. See certification in Supporting Documentation.

The applications can be completed in paper or using an electronic system that facilitates completion. If using the electronic completion process, there will be prompts to provide additional details where required. Signatures will be paper-based.

Variable information is described in a Statement of Variability for each form.

Company and Contact

Filing Contact Information

Lindsey Boisvert, Senior Product and Contract Analyst
100 Liberty Way
Dover, NH 03820

lindsey.boisvert@libertymutual.com
800-451-7065 [Phone] 36015 [Ext]
603-472-0796 [FAX]

State: Arkansas **Filing Company:** Liberty Life Assurance Company of Boston
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Application (Whole Life and Term)
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Filing Company Information

Liberty Life Assurance Company of Boston 100 Liberty Way Dover, NH 03820 (800) 451-7065 ext. [Phone]	CoCode: 65315 Group Code: 111 Group Name: Liberty Mutual FEIN Number: 04-6076039	State of Domicile: New Hampshire Company Type: State ID Number:
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Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: \$50.00 x 1 Form
 Per Company: No

Company	Amount	Date Processed	Transaction #
Liberty Life Assurance Company of Boston	\$50.00	12/20/2012	65946107

SERFF Tracking #:

LLAC-128822297

State Tracking #:

Company Tracking #:

APP-2012254

State:

Arkansas

Filing Company:

Liberty Life Assurance Company of Boston

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

Life Application (Whole Life and Term)

Project Name/Number:

/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/02/2013	01/02/2013

State: Arkansas **Filing Company:** Liberty Life Assurance Company of Boston
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Application (Whole Life and Term)
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Disposition

Disposition Date: 01/02/2013

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	Replacement Question Certification		Yes
Form	Application for Individual Life Insurance		Yes
Form	Statement of Variability		Yes

State: Arkansas **Filing Company:** Liberty Life Assurance Company of Boston
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Application (Whole Life and Term)
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Form Schedule

Lead Form Number: APP-2012254

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Individual Life Insurance	APP-2012254	AEF	Initial		54.600	APP-2012254 Rev 09-12 Bracketed.pdf
2		Statement of Variability	APP-2012254	OTH	Initial			Statement of Variability APP-2012254.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

Insured name _____
 (First, Last)

[Contract number _____
 (Home office use only)]

Application for Individual Life Insurance

1. PRODUCT SELECTION [Select one product.]

Term

Select one [<input type="checkbox"/> 10 year <input type="checkbox"/> 15 year <input type="checkbox"/> 20 year <input type="checkbox"/> 30 year]	Face amount \$ _____
Riders [<input type="checkbox"/> Children's Protection \$ _____ <input type="checkbox"/> Accidental Death and Dismemberment \$ _____ <input type="checkbox"/> Disability Waiver of Premium]	

Whole Life

Select one [<input type="checkbox"/> Whole Life <input type="checkbox"/> Whole Life Paid up at age 65 <input type="checkbox"/> 20 Payment Whole Life <input type="checkbox"/> Extra Value Whole Life _____%_____%]	Face amount \$ _____
Contract Credits [<input type="checkbox"/> Paid-up Additions <input type="checkbox"/> Accumulate at Interest <input type="checkbox"/> One-Year Term <input type="checkbox"/> Reduce Premiums <input type="checkbox"/> Cash]	
Riders [<input type="checkbox"/> Children's Protection \$ _____ <small>(Complete Children's Protection section if elected)</small> <input type="checkbox"/> Disability Waiver of Premium <input type="checkbox"/> Guaranteed Insurability Option \$ _____ <input type="checkbox"/> Payor Disability and Death <input type="checkbox"/> Accidental Death and Dismemberment \$ _____]	
Do you elect Automatic Premium Loan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2. INITIAL PAYMENT [Select an initial payment mode.]

Premium payment \$ _____

<input type="checkbox"/> One time Electronic Funds Transfer (EFT)	<input type="checkbox"/> Credit Card	<input type="checkbox"/> 1035 Exchange
<input type="checkbox"/> Check	<input type="checkbox"/> Other _____	

One time EFT - Complete if one time EFT was elected for initial payment.

Bank account owner name _____ Bank name _____
 Routing number _____ Bank account number _____

Credit card - Complete if credit card was elected for initial payment.

Type of credit card: [MasterCard Visa]
 Discover] Name on Credit Card _____
 Credit Card Number _____ Expiration date _____

3. SUBSEQUENT PAYMENT [Select a subsequent payment mode.]

[Annual Semiannual Quarterly Monthly EFT Other _____]

Monthly EFT - Monthly draft date (1st-28th) _____ Select if same as initial payment one time EFT information.

Bank account owner name _____ Bank name _____
 Routing number _____ Bank account number _____

Insured name _____
(First, Last)

[Contract number _____
(Home office use only)]

4. PROPOSED INSURED

Name (First, Middle, Last) _____ Male Female

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____

Birth date _____ Backdate to save age Birthplace (State, Country) _____

Social Security number _____ Driver License number _____

Are you a United States citizen? Yes No If "No," type of Visa _____

Employer name _____ Employer telephone number _____

Employer address (Street, City, State, ZIP) _____

Occupation (Include duties) _____

Annual earned income \$ _____ Other income (Include source) \$ _____ Net worth \$ _____

5. OWNER Select if same as insured.]

Name (First, Middle, Last)/Entity _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____ Birth/Trust date _____

Social Security/Tax ID number _____ Relationship to insured _____

Are you a United States citizen? Yes No If "No," type of Visa _____

6. JOINT OWNER [Complete if applicable.]

Name (First, Middle, Last)/Entity _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____ Birth date _____

Social Security/Tax ID number _____ Relationship to insured _____

Are you a United States citizen? Yes No If "No," type of Visa _____

7. ALTERNATE ADDRESSEE [You may authorize an alternate addressee to receive past due premium notices. (Optional Section)]

Name (First, Middle, Last) _____

Residence address (Street, City, State, ZIP) _____ []

Mailing address (If different) _____

8. PAYOR Select if same as owner. Select if same as insured.]

Name (First, Middle, Last)/Entity _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____

Social Security/Tax ID number _____ Relationship to insured _____

Please complete if payor rider is selected. (Payor rider is applicable for Whole Life plans only.)

Birth date _____ Birthplace (State, Country) _____ Male Female

Height (ft, in) _____ Weight (lbs) _____ Driver License number _____

Insured name _____
(First, Last)

[Contract number _____
(Home office use only)]

9. BENEFICIARIES

[All designated beneficiaries will be considered primary, sharing equally, unless otherwise indicated.]

Primary Contingent _____% Relationship to insured _____
Name (First, Middle, Last)/Entity _____ Birth/Trust date _____
Residence address (Street, City, State, ZIP) _____
Mailing address (If different) _____
Telephone number _____ Social Security/Tax ID number _____

Primary Contingent _____% Relationship to insured _____
Name (First, Middle, Last)/Entity _____ Birth/Trust date _____
Residence address (Street, City, State, ZIP) _____
Mailing address (If different) _____
Telephone number _____ Social Security/Tax ID number _____

Primary Contingent _____% Relationship to insured _____
Name (First, Middle, Last)/Entity _____ Birth/Trust date _____
Residence address (Street, City, State, ZIP) _____
Mailing address (If different) _____
Telephone number _____ Social Security/Tax ID number _____

10. CHILDREN'S PROTECTION

["Children" means all children, step-children, and legally adopted children of the Insured who have not reached their 18th birthday. Insurance will not be provided on any child until 15 days after birth.]

Name (First, Middle, Last) _____ Male Female
Birth date _____ Birthplace (State, Country) _____ Height (ft, in) _____ Weight (lbs) _____

Name (First, Middle, Last) _____ Male Female
Birth date _____ Birthplace (State, Country) _____ Height (ft, in) _____ Weight (lbs) _____

Name (First, Middle, Last) _____ Male Female
Birth date _____ Birthplace (State, Country) _____ Height (ft, in) _____ Weight (lbs) _____

Name (First, Middle, Last) _____ Male Female
Birth date _____ Birthplace (State, Country) _____ Height (ft, in) _____ Weight (lbs) _____

11. COVERAGE/REPLACEMENT

a) Is there any life insurance or annuity applied for or in force, other than group insurance, for the proposed insured? (If applicable, complete and submit replacement forms.) **Yes** **No**

Total life insurance in force \$ _____ Total Accidental Death Benefit \$ _____

b) Will this contract replace any existing life insurance or annuity in this or any other company?
If "Yes," replaced policy type Life Annuity [Select if Section 1035 exchange]
Company name _____ Contract number _____

c) Does the proposed owner intend to sell, or transfer ownership of a contract issued as a result of this application? If "Yes" provide details below.

d) Has the proposed owner entered into an agreement, or discussed any arrangement, for the sale or transfer of a contract issued as a result of this application? If "Yes" provide details below.

Coverage/Replacement Details

Question #	Details

Insured name _____
(First, Last)

Contract number _____
(Home office use only)

12. PHYSICIAN INFORMATION [Please provide physician information for proposed insured and any other insured(s).]

Physician name _____ Facility name _____
Mailing address _____ Telephone number _____
Date and reason last seen _____
Physician of (provide insured's name) _____

13. QUALIFYING INFORMATION [Provide complete details to all "Yes" answers in the Details section below.]

	Proposed Insured		Any Other Insured(s)	
	Yes	No	Yes	No
a) Proposed insured Height (ft, in) _____ Weight (lbs) _____				
b) In the last 6 months, has the proposed insured been medically advised to have any surgery, hospitalization, treatment or test that was not completed, excluding those tests related to the Human Immunodeficiency Virus (AIDS Virus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Has the proposed insured ever used any form of tobacco or nicotine products? (If "Yes," indicate date last used below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has any proposed insured been diagnosed with or treated within the past 10 years by a licensed member of the medical profession for any of the following diseases or illnesses:

	Yes	No	Yes	No
d) Chest pain, heart attack, high blood pressure, high cholesterol, heart murmur, irregular heartbeat, pacemaker, stroke, mini-stroke, heart valve disease, aneurysm, peripheral vascular disease, carotid artery disease or any other disease of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Diabetes, pre-diabetes, glucose intolerance, or metabolic syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Cancer, tumor, leukemia, lymphoma or melanoma, other than basal cell skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, asthma, pulmonary embolism or any other disease of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Ulcerative colitis, Crohn's disease, hepatitis, kidney dialysis or any other disease of the digestive or urinary systems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Seizures, paralysis, amputation, fainting, muscle weakness, Parkinson's disease, cerebral palsy, multiple sclerosis, Alzheimer's disease, dementia or any other disease of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Lupus, anemia, blood clots, infection with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) or any other disease of blood or immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Mental retardation, autism or Down syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Major depression, bipolar disorder, schizophrenia, or alcohol or drug dependency or abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has the proposed insured:

	Yes	No	Yes	No
m) collected or applied for disability or workers compensation benefits in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) within the past 3 years, engaged in, or plan to engage within the next 2 years in flying as a pilot, student pilot or crew member? (If "Yes," please complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) within the past 5 years, had license suspended or revoked or been convicted of reckless driving or driving under the influence of alcohol or drugs (DUI)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) within the past 5 years, used or been convicted of using illegal drugs, used prescription drugs other than directed, been convicted of a felony, or been on probation or parole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) ever had any application for life or health insurance declined, postponed or approved other than as applied for?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. DETAILS [Provide details here to any qualifying information questions answered "Yes."]

Question #/Insured name	Details/Diagnosis/ Condition/Dates	Medication/Treatments	Physician name

Insured name _____
(First, Last)

Contract number _____
(Home office use only)

17. DISCLOSURES AND SIGNATURES

OWNER SOCIAL SECURITY/TAX ID NUMBER (SSN/TIN) CERTIFICATION - By signing this application, I certify under penalties of perjury that: (1) the Social Security/Tax ID number shown is correct, and (2) I am not subject to backup withholding due to failure to report interest or dividend income, and (3) I am a U.S. Person (U.S. Citizen, U.S. Resident Alien or other U.S. Person as defined by the Internal Revenue Service (IRS)).

By checking this box, and signing below, I am deleting statement (2) above from this certification.

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

LIBERTY'S LIVING BENEFIT DISCLOSURE ACKNOWLEDGMENT - I acknowledge that Liberty's Living Benefit, an Accelerated Death Benefit, is available to the primary proposed insured under this contract for initial death benefits greater than or equal to \$20,000, and I have read and received the disclosure pertaining to Liberty's Living Benefit.

Check here to exclude Liberty's Living Benefit.

AUTHORIZATION TO OBTAIN INFORMATION - I AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, other medical or medically-related facility, insurance or reinsuring company, MIB, Inc. (MIB), consumer reporting agency, employer or former employer to give to Liberty Life Assurance Company of Boston (the Company), its employees and reinsurers any information about my: physical or mental condition, character, general reputation, habits, finances, insurance history, occupation, and hobbies. I also authorize the Company to obtain an investigative consumer report on me. This authorization applies to all types of information, including but not limited to information regarding HIV infection, AIDS, mental health and substance abuse. I also authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I AM AWARE that the Company will use this information to determine if I am eligible for insurance or for benefits under an in-force policy. I am aware that the Company may give this information to its reinsurers, MIB, other persons or entities that perform services related to my application or claim, or as may be authorized or required by law. I understand information obtained with my authorization may be re-disclosed as permitted or required by law and may no longer be protected by the federal privacy laws. I AGREE that this authorization shall be valid for 2 years from the date appearing below my signature and that I have the right to revoke this authorization at any time by written notification to the Company. I agree that a copy will be as valid as this original. I MAY ASK for a copy of this form. I RECEIVED the Notice of Information Practices and the notices required by the Federal Fair Credit Reporting Act and MIB.

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER - By signing this application, I authorize Liberty Life Assurance Company of Boston (the Company) to initiate a one-time or monthly withdrawal from the specified account of the financial institution indicated, for the purpose of meeting premium payment obligations. I understand: (1) No premium is considered paid until each debit is accepted by the financial institution. (2) Any debit not honored may be subject to a return fee from the financial institution. (3) For any debit not honored, the Company may attempt to debit the account again up to three days later for the amount due. (4) The Company will not incur liability as a result of a debit that is not honored by the financial institution. (5) The payor or the Company may terminate this agreement at any time by written notification from one party to the other party.

AUTHORIZATION FOR CREDIT CARD PAYMENT - By signing this application, I authorize Liberty Life Assurance Company of Boston to initiate a one-time charge to the credit card shown on the application for the purpose of meeting premium payment obligations. I agree not to contest this charge upon approval of this credit card transaction.

INSURING AGREEMENT - I(We) declare that all statements and answers given in this application are true and complete to the best of my(our) knowledge and belief. I(We) also agree that: (1) no agent/insurance producer has the authority to determine insurability, waive any rights or requirements of the Company, or make or modify any contract of insurance; (2) no information obtained by any such person will bind the Company unless set out in writing in a part of the application; (3) all statements and answers given in this application will form the basis for, and become part of, any contract of insurance issued by the Company under this application; and (4) no insurance will take effect on the basis of this application unless: (a) the full first premium has been paid; and (b) the contract has been delivered to and accepted by the applicant without a change in the insurability status of the proposed insured.

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be subject to criminal or civil penalties.

X _____
Proposed Insured/Guardian Signature

X _____
Owner Signature

X _____
Joint Owner Signature (if applicable)

X _____
Payor Signature (if applicable)

X _____
Agent/Insurance Producer Signature (as witness)

Signed in: _____

on _____

Liberty Life Assurance Company of Boston

Statement of Variability

December 11, 2012

Form No: APP-2012254 Application for Individual Life Insurance

Variable information is indicated through the use of brackets. Brackets will not appear on the owner's printed contract.

Bracketed Field Name	Description of Variability
[Contract Number _____] (Home Office Use Only) Appears on all pages	This field is an administrative field. The field is intended to display the application or contract number that would change by application. This field may be used for other administrative purposes, moved to another location on the application or may be removed.
Service Center address	This address is subject to change.
Instructional Text	Text next to section headings e.g., 1. Product Selection, are instructional in nature and may be revised to other text to facilitate the completion of the application.
Product Selection	Approved plans of insurance, product categories and instructions may be added, changed or removed.
Initial Payment [Type]	Payment options in this section may be deleted, added, or changed to other payment options.
Type of Credit card	Credit card options in this section may be deleted, added, or changed to other credit card options
Subsequent Payment [Mode]	Payment modes in this section may be deleted, added, or changed to other payment modes.
Alternate Addressee	Text in this field may be added/changed to request additional addressee information to process such request. (e.g., telephone number). The location within the section may change.
Select if Section 1035 Exchange	Text may be deleted, added, or changed for other replacement action.
Instruction Bar (Page 5 heading)	This text is instructional in nature and may be revised to other text to facilitate the completion of the application, or may be removed.
Fraud Language	This text can change in the event fraud language requirements change
Administrative Data at bottom of each page	This field is to be used for administrative data. This field may also be moved to another location on the application or may be removed.
Bar Code field at bottom of each page	A bar code or other code may be used on the application. The location, size, or type of identifier is subject to change.
Revision Date at bottom of each page	The revision date is subject to change.

The form is submitted in final print and is subject to modifications in paper size, color, stock, binding, shading, borders, font type, size, and color, and changes that occur as a result of company adaptation to computer printing/typesetting.

SERFF Tracking #:

LLAC-128822297

State Tracking #:

Company Tracking #:

APP-2012254

State:

Arkansas

Filing Company:

Liberty Life Assurance Company of Boston

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

Life Application (Whole Life and Term)

Project Name/Number:

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Flesch Certification 254.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Replacement Question Certification		
Comments:			
Attachment(s):			
Replacement Question Certification 254.pdf			

FLESCH CERTIFICATION

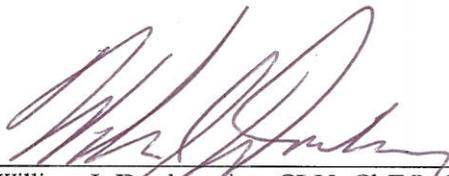
Liberty Life Assurance Company of Boston

I certify on behalf of the Company that the form referenced below is in compliance with the readability requirements of the state

The Flesch Reading Ease Test was applied to application APP-2012254 form in its entirety. In calculating this score we excluded the company name, address, form number, revision date, captions, subcaptions, required language, medical terminology, and defined terms.

Flesch Statistics

APP-2012254	
Words	1871
Characters	10227
Paragraphs	419
Sentences	82
Flesch Reading Ease	54.6



William J. Dauksewicz, CLU, ChFC, CPCU
Vice President and Manager
Individual Life Compliance
Liberty Life Assurance Company of Boston

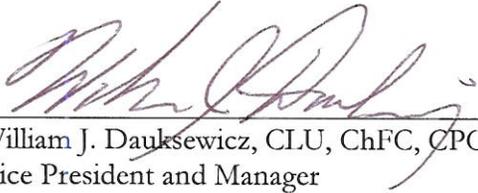
December 11, 2012

Liberty Life Assurance Company of Boston

Form No: APP-2012254 Application for Individual Life Insurance

Replacement Question Certification

On behalf of Liberty Life Assurance Company of Boston, I certify that that the agent's replacement question will be included in a separate form.



William J. Dauksewicz, CLU, ChFC, CPCU
Vice President and Manager
Individual Life Compliance
Liberty Life Assurance Company of Boston
100 Liberty Way
Dover, NH 03820

December 11, 2012

Date