

State: District of Columbia **Filing Company:** CMFG Life Insurance Company
TOI/Sub-TOI: A05I Individual Annuities- Immediate Non-Variable/A05I.000 Annuities - Immediate Non-Variable
Product Name: MEMBERS Single Premium Immediate Annuity
Project Name/Number: 2016 SPIA Application/ WM-41

Filing at a Glance

Company: CMFG Life Insurance Company
Product Name: MEMBERS Single Premium Immediate Annuity
State: District of Columbia
TOI: A05I Individual Annuities- Immediate Non-Variable
Sub-TOI: A05I.000 Annuities - Immediate Non-Variable
Filing Type: Form
Date Submitted: 11/21/2016
SERFF Tr Num: CUNA-130813948
SERFF Status: Submitted to State
State Tr Num:
State Status:
Co Tr Num: 2016 SPIA APPLICATION
Implementation: On Approval
Date Requested:
Author(s): Kari Hamrick, Kathy Strauser, Kimberly Steggall
Reviewer(s):
Disposition Date:
Disposition Status:
Implementation Date:

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General Information

Project Name: 2016 SPIA Application
 Project Number: WM-41
 Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:

Deemer Date:
 Submitted By: Kathy Strauser

Status of Filing in Domicile: Not Filed
 Date Approved in Domicile:
 Domicile Status Comments: The home state of Iowa does not require refile due to name change.
 Market Type: Individual
 Individual Market Type:
 Filing Status Changed: 11/21/2016
 State Status Changed:
 Created By: Kathy Strauser
 Corresponding Filing Tracking Number:

Filing Description:

This filing is being submitted for your review and approval. It contains no unusual or possibly controversial items from normal company or industry standards.

Form SPIAAPP-2016, Individual Single Premium Immediate Annuity Application, is a new form, in final print, with the exception of paper stock, logo, and as further described in the Explanation of Variables included with this filing. This Application will replace the following application forms, 2008-SPIA-APP(DC) and 2008-SPIAEZ-APP(DC), approved by the Department on March 25, 2008, under SERFF Tracking No# CUNA-125482422. It will be used with the Company's Single Premium Immediate Annuity product, marketed on an individual basis to ages 21 – 90 for both qualified and non-qualified plans. The product is provided for by contract forms: 2008-SPIA-I, 2008-SPIA-LO and 2008-SPIA-DB, also approved on March 25, 2008, under SERFF Tracking No# CUNA-125482422.

Upon approval, this application will be available in paper form and will be made available through a secured site on the internet where agents and home office personnel will have the option to complete fields within the application on-line. As fields are completed, sections may be expanded to accommodate information applicable to each section. The questions will be the same ones that appear on the paper form; there are no different or additional questions/sections that appear on the on-line completion of the application. The form will then be printed on paper and a wet signature obtained. When technology permits, the process may include electronic signature capabilities which will be captured in accordance with UETA and ESIGN regulations.

This form was written to be readable and easily understood by insureds; it achieved a flesch score of 50.

Thank you for your review of this submission.

Company and Contact

Filing Contact Information

Kathy Strauser, Consultant, Rate & Form Compliance kathy.strauser@cunamutual.com
 2000 Heritage Way 319-483-3510 [Phone]
 Waverly, IA 50677

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Filing Company Information

CMFG Life Insurance Company	CoCode: 62626	State of Domicile: Iowa
2000 Heritage Way	Group Code: 306	Company Type:
Waverly, IA 50677	Group Name:	State ID Number:
(319) 352-4090 ext. [Phone]	FEIN Number: 39-0230590	

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State: District of Columbia

Filing Company: CMFG Life Insurance Company

TOI/Sub-TOI: A05I Individual Annuities- Immediate Non-Variable/A05I.000 Annuities - Immediate Non-Variable

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Form Schedule

Lead Form Number: SPIAAPP-2016

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Individual Single Premium Immediate Annuity Application	SPIAAPP-2016	AEF	Initial		50.000	SPIAAPP-2016 for DC.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

Application



[MEMBERS[®] Single Premium Immediate Annuity]
Individual Single Premium Immediate Annuity

CMFG Life Insurance Company
[2000 Heritage Way • Waverly, IA 50677]

1 Who is the annuitant and owner of your contract?

REQUIRED. Minimum age on contract issue date is 21. Maximum age on contract issue date is 90.

- a. Complete to name the annuitant/owner.** The annuitant is the owner unless an irrevocable trust [or credit union] is named as owner in section 1c [or 1d].

Name _____ Gender Male Female
FIRST MI LAST
Social Security Number _____ Date of Birth _____ U.S. Citizen Yes No
Mailing Address _____
City _____ State _____ Zip _____
 Cell
Daytime Phone _____ Other Email Address _____

- b. Complete if naming a joint annuitant.** Available only if a joint life income option is checked in section 2a.

Name _____ Relationship to Annuitant _____
FIRST MI LAST
Social Security Number _____ Date of Birth _____ Gender Male Female
Mailing Address _____ U.S. Citizen Yes No
City _____ State _____ Zip _____
 Cell
Daytime Phone _____ Other Email Address _____

- c. Complete if naming an irrevocable trust as owner.** Available only if Non-qualified is checked in section 4a. It is the responsibility of the trust to determine qualification for tax deferral. Include a copy of the trust document page(s) showing trust name, trust date, trustee name(s), investment authority and signature(s), or complete form [1919(CML) Trustee Certification of Insurance/Annuity Powers].

Name of Trust _____ Tax ID Number _____
Trustee Name(s) _____ Date of Trust _____
Person Authorized to Receive Correspondence _____
Mailing Address _____
City _____ State _____ Zip _____
 Cell
Daytime Phone _____ Other Email Address _____

- d. Complete if naming a credit union as owner.** Available only if 457(b) is checked in section 4a.

Name of Credit Union _____ Employer ID Number _____
Name of Authorized Officer(s) _____ Title(s) _____
Person Authorized to Receive Correspondence _____
Mailing Address _____
City _____ State _____ Zip _____
 Cell
Daytime Phone _____ Other Email Address _____

2 Which income option do you choose?

REQUIRED. Check only one box in each section.

a. Choose single life or joint life income.

- Single Life Income (1 annuitant)
- 100% Joint Life Income (2 annuitants) - 100% paid to survivor at death
- 50% Joint Life Income (2 annuitants) - 50% paid to survivor at death

b. Choose whether to add beneficiary protection.

Life Only: Provides no beneficiary protection.

- Life Only (with no death benefit)

Life with Cash Refund: Beneficiaries receive the net purchase payment less income payments received.

- 100% Cash Refund (Not available if 50% Joint Life Income is checked in section 2a above.)

Life with Guarantee Period: Beneficiaries receive income payments for the remainder of the guarantee period.

- 5-Year Guarantee Period
- 10-Year Guarantee Period
- 15-Year Guarantee Period
- 20-Year Guarantee Period
- XX-Year Guarantee Period

Installment Payments: Beneficiaries receive income payments for the remainder of the installment period.

- Installment Payments for _____ years. (Choose your payment frequency in section 3b.)
OF YEARS

c. Choose fixed income or inflation adjusted income. Skip this section if 50% Joint Life Income was checked in section 2a above, or if Installment Income was checked in section 2b above.

- Fixed Income Inflation Adjusted Income

3 When do you want to start your income?

REQUIRED.

a. Choose the income start date.

Start income payments on _____. (Date must be no earlier than 1 month after the contract issue date and no later than 1 year following the contract issue date.)

If you specify an income payment start date that is earlier than 1 month after the contract issue date, your income payment start date will begin in the month that is at least 1 month after the issue date for the monthly day you selected. For example, if you select the 5th of the month and your contract is issued on January 10th, the income payment start date will be March 5th. (January 10th + 1 month = February 10th. The next monthly day for the 5th is March 5th.)

b. Choose payment frequency for installment payments. Complete only if you checked the Installment Payments box in Section 2b. The payment frequency for all other income options will be monthly. If no box is checked below, monthly is assumed.

Payment frequency for Installment Payments: monthly quarterly semi-annually annually

c. Provide income payment [account] information. Complete only if the owner named in section 1 is also the individual (or entity) receiving the income payments (the "payee"); otherwise complete and submit form [SPIA Payee] with the application.

[Send the income payment to the owner/payee by check.]

Send the income payment to the owner's/payee's account under an EFT agreement using the following account information. (For your convenience, we will retain your account information to automatically credit your account. Your account will be credited approximately 2 business days after the payment date.)

FINANCIAL INSTITUTION

PHONE

ADDRESS

CITY

STATE

ZIP

Account Type

- Checking/Share Draft
- Savings/Share

9 DIGIT ROUTING NUMBER

ACCOUNT NUMBER

4 What is your plan type and source of payment?

REQUIRED. Check one plan type in section 4a and complete the row for that type. Then total your payments at the bottom of section 4a. Complete one line for each payment source in section 4b.

a. Choose your plan type. [Only credit union-owned 457(b) plans are allowed.]

PLAN TYPE	PAYMENT CLASSIFICATION				
<input type="checkbox"/> Non-qualified	\$ _____ NON-1035 EXCHANGE	\$ _____ 1035 EXCHANGE			
<input type="checkbox"/> Traditional IRA	\$ _____ ROLLOVER	\$ _____ TRANSFER	\$ _____ CURRENT YEAR CONTRIBUTION Tax Year _____	\$ _____ PRIOR YEAR CONTRIBUTION Tax Year _____	
<input type="checkbox"/> Roth IRA	\$ _____ ROLLOVER	\$ _____ TRANSFER	\$ _____ CURRENT YEAR CONTRIBUTION	\$ _____ PRIOR YEAR CONTRIBUTION	\$ _____ ROTH CONVERSION
<input type="checkbox"/> 457(b)	\$ _____ ROLLOVER	\$ _____ TRANSFER			
<p>Enter total initial purchase payment. Enter the total of all amounts above at the right. Minimum is [\$25,000]. Make any checks payable to CMFG Life Insurance Company. The initial purchase payment applied will equal the actual amount received by the Company.</p>					\$ _____

b. List your source(s) of payment. For 401(k) plans, list Roth 401(k) amounts separately from Regular 401(k) amounts. Your contract will be issued only after all sources of payment are received by the Company.

Source/Company Name	Estimated Amount	Existing Plan Type
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

5 Do you have any other insurance and is this a replacement?

REQUIRED. Read and answer both questions and complete all information.

Yes No Do you have any existing life insurance policies or annuity contracts with CMFG Life Insurance Company or any other company?

If yes, a completed Important Notice: Replacement of Life Insurance or Annuities must accompany this application if required by your state.

Yes No Will this contract replace, discontinue or change any existing life insurance policies or annuity contracts with CMFG Life Insurance Company or any other company?

If yes, a completed Replacement Form must accompany this application if required by your state.

Company Name of Policy/Contract Being Replaced

Policy/Contract Number

6 Who is your beneficiary?

REQUIRED. Skip this section if Life Only was checked in section 2b. Contingent beneficiary(ies), if any, will receive proceeds only if no primary beneficiary is living when death occurs.

Name your beneficiary(ies). Even distribution of death proceeds is assumed. To list more beneficiaries or to detail uneven distribution of proceeds, use section 7 or a separate signed and dated sheet of paper. If the type (primary or contingent) is not checked, primary is assumed.

For Individual Beneficiaries:

Primary
 Contingent

NAME _____ ADDRESS _____

RELATIONSHIP _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ DAYTIME PHONE _____

Primary
 Contingent

NAME _____ ADDRESS _____

RELATIONSHIP _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ DAYTIME PHONE _____

Primary
 Contingent

NAME _____ ADDRESS _____

RELATIONSHIP _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ DAYTIME PHONE _____

Primary
 Contingent

NAME _____ ADDRESS _____

RELATIONSHIP _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ DAYTIME PHONE _____

For Trust Beneficiaries:

Primary
 Contingent

NAME OF TRUST _____ ADDRESS _____

TRUSTEE NAMES _____

DATE OF TRUST _____ DAYTIME PHONE _____

7 Do you have special instructions for the home office?

OPTIONAL. Include any special instructions for the home office to use when processing your application, or use this area to list additional beneficiaries not listed in section 6.

8 Read this agreement and sign.

REQUIRED. All parties to the contract named in section 1 must read and sign below to indicate understanding and agreement.

- I have read the application and represent that all statements and answers, as they pertain to me, are true and complete to the best of my knowledge and belief and are the basis for any contract issued by CMFG Life Insurance Company ("the Company"). I understand that no information will be considered to have been given to the Company unless it is stated in this application.
- I understand once my contract is issued, I cannot change the income option selected in section 2.
- I understand my annuity contract does not have any cash value. Therefore, I cannot make a withdrawal, request a contract loan or surrender my contract for cash.
- I understand that no interest will be credited to any funds received by the Company prior to the contract issue date, and my contract will not be issued until funds from all sources have been received.
- If Life Only was checked in section 2b, I understand that upon my death (or upon the death of the last surviving annuitant for Joint Life Options): **(a) no further payments will be made to my estate or my family if death occurs after the income payment start date; and (b) no payments will be made if death occurs before the income start date.**
- I understand that no agent is authorized to make, void, waive or change any conditions or provisions of the application or contract.
- The USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I understand that by providing my name, address, date of birth and taxpayer identification number I allow the Company to verify my identity, and this verification process may include the use of third party sources.
- I understand the Company will have no liability under this contract until it is issued, delivered and accepted by me, and while all natural persons named as parties to the contract are living.
- I understand proof of age is required and have provided proof of age for the annuitant (and joint annuitant if Joint Life was checked in section 2a) with this application. Acceptable documents are a copy of a birth certificate, baptismal record, passport or driver's license.
- I have received a quote for the income option I have selected in section 2 and understand the quote is valid only if: (a) my application, the signed quote and any other required paperwork are received by the Company in good order within [15 days] of the date of the quote; and (b) the purchase payment(s) are received by the Company within [60 days] of the date of the quote. If these requirements are not met, I understand my annuity contract will be issued at the current income rate, which may be different than the amount quoted.

District of Columbia: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[[Florida:] Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.]

All other states: 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 may be guilty of a crime and subject to fines and confinement in prison, and denial of insurance benefits, depending on state law.

[State Variations]

Signed and dated on: _____

X

SIGNATURE OF PERSON NAMED IN SECTION 1A

X

SIGNATURE OF PERSON NAMED IN SECTION 1B (IF ANY)

X

SIGNATURE OF TRUSTEE(S)/[AUTHORIZED OFFICER(S)] NAMED IN SECTION 1C [OR 1D] (IF ANY)

9 For home office use only.

FOR ADMINISTRATIVE USE ONLY. Not to be used for any change that requires the owner's agreement in writing.

10 To be completed by the agent.

REQUIRED.

a. For replacements, answer both questions and complete all information to the best of your knowledge and belief.

Yes No Does the applicant(s) have any existing life insurance policies or annuity contracts with CMFG Life Insurance Company or any other company? *If yes, a completed Important Notice: Replacement of Life Insurance or Annuities must accompany this application if required by the state.*

Yes No Will this contract replace, discontinue or change any existing life insurance policies or annuity contracts with CMFG Life Insurance Company or any other company? *If yes, a completed Replacement Form must accompany this application if required by the state.*

If yes, I confirm:

1. This replacement meets the standards for replacement sales identified in CMFG Life Insurance Company's Statement Regarding the Acceptability of Life and Annuity Replacement Sales.
2. The following sales materials were used: _____

(IF NO SALES MATERIALS WERE USED, STATE "NONE")

b. Yes No Have you reviewed the owner's identity documents in accordance with the USA Patriot Act and recorded all necessary information as follows?

1. If owner is a natural person: Driver's License Passport Green Card Other Photo ID _____
Card No. _____ Expiration Date _____ Country/State of Issue _____
2. If owner is a trust [or a credit union]: Country/State Where Formed _____ Date Formed _____

c. Yes No Is the applicant a member of the United States Armed Forces (including active duty military reserve personnel), or a dependent of such person?

d. If sales materials were used, I certify that I have used only approved sales materials in connection with this sale and that copies of all sales materials used were left with the applicant.

e. I have explained to the applicant how the annuity will meet their current financial needs and objectives.

f. I certify that I have reviewed this application and have determined that its proposed purchase is suitable as required under law based on information provided by the applicant, as applicable, including information that is reasonably appropriate to determine the suitability of my recommendation.

g. I am state-licensed for annuity contracts in all required jurisdictions.

h. I certify that I have truly and accurately recorded the information provided by the applicant(s).

i. I select the following compensation option and understand that if no box is checked, option 1 will apply: 1 (T000) 2 (T025)

I understand that when I sign this application, I am agreeing to all the terms and conditions applicable to me as an agent.

Signature _____ Date _____

SIGNATURE OF AGENT

Agent ID _____ Agent Name _____
5-DIGIT AGENT NUMBER PRINT FULL NAME [FLORIDA LICENSE ID NUMBER]

Agent Phone _____ Agent Email _____
BEST NUMBER TO CALL PRINT EMAIL

Credit Union ID _____ Credit Union Name _____
8-DIGIT CU NUMBER (IF APPLICABLE) PRINT NAME OF CU (IF APPLICABLE)

Broker/Dealer ID _____ Broker/Dealer Name _____
B/D NUMBER (IF APPLICABLE) PRINT NAME OF B/D (IF OTHER THAN CBSI)

General Agent ID _____ General Agent Name _____
GA NUMBER (IF APPLICABLE) PRINT NAME OF GA (IF APPLICABLE)

State: District of Columbia **Filing Company:** CMFG Life Insurance Company
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Supporting Document Schedules

Satisfied - Item:	Statement of Variables
Comments:	Attached.
Attachment(s):	SPIAAPP-2016-EOV(DC).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Guaranty Association Notice
Comments:	Attached.
Attachment(s):	1456DC 1014.pdf
Item Status:	
Status Date:	

MEMBERS Single Premium Immediate Annuity

**EXPLANATION OF VARIABLES
CMFG LIFE INSURANCE
COMPANY
November 15, 2016**

NOTICE REGARDING VARIABILITY:

- Red brackets around denotes variability.
- Content will not be changed except as provided in this document. However, minor reformatting may occur: spacing, lines, ink colors, shading and font style may be altered. Minimum font size will be met.

Application Form: SPIAAPP-2016

Section	Sub-Section	Item	Variable Use
Header Prior to Section 1	Logo	Logo	Allows for future changes to the logo. The logo may also be removed.
	Marketing Name	Marketing Name	Allows for future change in the marketing name. Marketing name may also be removed.
	Company Address	Company Address	The address may be revised to a new address.
Section 1 Who is the annuitant and owner of your contract?	Item a. Complete to name the annuitant/owner.	or 1d	Allows for removal of "1d" should 457(b) plans not be offered for new issues of this form (removal of item 1d. of the application, as bracketed and explained below.)
	Item c. Complete if naming an irrevocable trust as owner.	Administrative form number and name	Allows for future change in the form number and/or name of the administrative form.
	Item d. Complete if naming a credit union as owner.	Complete if naming a credit union as owner section	Allows for removal of this item in its entirety should 457(b) plan types not be available for new issues of the form.

Section 2 Which income option do you choose?	Item b. Choose whether to add beneficiary protection.	Life with Guarantee Period	The 5-Year, 10-Year, 15-Year, and 20-Year period options are those available. One or more of these options could be removed in the future for new issues of contracts. An additional “XX-Year” guarantee period option is shown on the Application for filing purposes to allow addition of another guarantee period for new issues of contracts, where “XX-Year” could be a year between 1 year and 30 years.
	Item c. Choose fixed income or inflation adjusted income.	Item c. Choose fixed income or inflation adjusted income section	Allows for removal of this item in its entirety should the Company not offer income options that are inflation adjusted for new issues of the form.
Section 3 When do you want to start your income?	Item b. Choose payment frequency for installment payments.	monthly, quarterly, semi-annual, annually	Allows for removal of one or more of these frequencies for new issues of the form.
	Item c. Provide income payment account information.	account check boxes Send the income payment to the payee by check statement administrative form name “SPIA Payee”	Allows for use or removal as follows: <ul style="list-style-type: none"> • “account” will not be included if both options appear; it will be included if only the EFT option appears. • “Send the income payment to the payee by check” will appear if offered. • check boxes will only appear if both options are included. The Company intends to make income payments available by EFT agreement. However, making income payments by check may become available for future issues of the form. Allows renaming of the administrative form.

Section 4 What is your plan type and source of payment?	Item a. Choose your plan type.	Only credit union-owned 457(b) plans are allowed statement	Allows for removal should 457(b) plan types not be available for new issues of the form.
	Plan Type and Payment Classification	Plan Type and Payment Classification section	Allows adding or removing a Plan Type and altering Payment Classification information as applicable to a plan type for future issues of the form.
	Enter total initial purchase payment	\$25,000	Allows for a change in required purchase payment for new issues of the form. Range: \$10,000 – \$25,000
Section 8 Read this agreement and sign.	Last Bullet	15 days	Allows for the number of days shown in brackets to change for future issues of the form. Range: 10 days – 25 days
		60 days	Allows for the number of days shown in brackets to change for future issues of the form. Range: 30 days - 90 days.

	<p>Fraud Statements</p>	<p>States Warnings All Other States lead-in phrase</p>	<p>The fraud warnings shown are those currently applicable. The DC warning has not been bracketed and will not change unless refiled with the Department. The state specific warning for Florida is bracketed to allow for future change in required state language as dictated by this state for any change in their state fraud regulation . Removal of the Florida warning in its entirety may also occur if this state no longer uses this version of the application form in the future.</p> <p>A field for “[State Variations]” is included in this section. Adding a field for State Variations will ONLY be used to accommodate state fraud language that may yet become required by and applicable only to a particular state. Any addition of state-dictated language will be preceded with the applicable state’s name to annotate it only applies to that state.</p>
	<p>Signature of Trustee(s) signature line</p>	<p>Authorized Officer(s) OR 1D</p>	<p>Allows for removal of “Authorized Officer(s)” and “OR 1D” should 457(b) plans not be offered for new issues of this form (removal of item 1d. of the application, as bracketed and explained above.)</p>
<p>Section 10 To be completed by the agent.</p>	<p>Item b. Have you reviewed the owner’s identity documents in accordance with the USA Patriot Act and recorded all necessary information as follows?</p>	<p>Item b. question</p>	<p>Allows for a change to information the Company may need to ask for in the future. This item may also be removed in its entirety should the Company decide to use another avenue other than the application to ask this question. If item b. is removed, the remaining items will be re-lettered accordingly.</p>

	<p>Item b. 2. If owner is a trust or credit union</p>	<p>or a credit union</p>	<p>Allows “or a credit union” to be deleted in its entirety should 457(b) plans where a credit union would be the owner not be offered for new issues of this form (removal of item 1d. of the application, as bracketed and explained above.)</p>
	<p>Item c. Is the applicant(s) a member of the United States Armed Forces (including active duty military reserve personnel), or a dependent on such person?</p>	<p>Item c. question</p>	<p>Allows for a change to how the Company may need to word this statement in the future. This item may also be removed in its entirety should the Company decide to use another avenue other than the application to obtain this information. If item c. is removed, the remaining items will be re-lettered accordingly.</p>
	<p>Items d., e., f., g., h. and i.</p>	<p>Items d., e., f., g., h. and i. labels</p>	<p>Allows for re-lettering should items b. and c. be removed in their entirety (as described above).</p>
	<p>Item i.</p>	<p>I select the following compensation option and understand that if no box is checked, option 1 will apply: 1 (T000) 2 (T025)</p>	<p>Allows for this statement to print or not print. Also allows for the options to be renamed, deleted, or added to.</p> <p>The Company does not intend to include the statement, but may decide to for future issues of the form.</p>
	<p>Agent Name</p>	<p>Florida License ID Number</p>	<p>The Florida License ID Number showing under the Agent Name line is bracketed as variable to allow removal in its entirety should FL no longer use this version of the application in the future.</p>

	Credit Union ID, Credit Union Name, Broker/Dealer ID, Broker/Dealer Name, General Agent ID, General Agent Name	Credit Union ID, Credit Union Name, Broker/Dealer ID, Broker/Dealer Name, General Agent ID, General Agent Name	Allows change or removal of all or a portion of this area depending on the information the Company needs to capture from agents.
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DISTRICT OF COLUMBIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION INSOLVENCY PROTECTION

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities should in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association (“Guaranty Association”).

The purpose of the Guaranty Association is to assure that policy or contract holders of certain types of insurance policies and contracts are covered up to the statutory levels of protection of contractual benefits in the unlikely event that a member insurer is unable to meet its financial obligations and found by a court of law to be insolvent. When a member company is found by a court to be insolvent, the Guaranty Association will assess its other member insurers to provide benefits on any outstanding covered claims of persons who reside in the District of Columbia. However, this additional protection provided through the Guaranty Association is subjected to certain statutory limits explained under “Coverage Limitations” section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep them in-force, with no change in contractual rights or benefits.

Coverage

The District of Columbia Life and Health Insurance Guaranty Association (“Guaranty Association”), established pursuant to the Life and Health Guaranty Association Act of 1992 (“Act”), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 et seq.), provides insolvency protection for certain types of insurance policies and contracts. NOTE: Certain policies and contracts may not be covered or fully covered.

The insolvency protections provided by the Guaranty Association are generally conditioned on an individual being a resident of the District and are the insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees or assignees of District insureds are also covered under the Act, even if they live in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
 - > \$300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
 - > \$300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
 - > \$300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
 - > \$300,000 for long-term insurance care benefits;
 - > \$300,000 for disability insurance;
 - > \$500,000 for basic hospital, medical, and surgical insurance, or major medical insurance;
 - > \$100,000 for coverage not defined as disability insurance or basic hospital medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than \$300,000 with respect to any one life (\$500,000 in the event of basic hospital, medical, and surgical, and major medical claims).

Additionally, the Guaranty Association is not obligated to cover more than \$5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders 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 domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to The District of Columbia Department of Insurance, Securities and Banking (DISB) will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

**District of Columbia
Department of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000**

**District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771**

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and statutory coverage protections. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any right established in any policy or contract, or under the Act.