

SERFF Tracking Number: AAMC-125816818 State: Arkansas
Filing Company: Pioneer Security Life Insurance Company State Tracking Number: 40342
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Application for Life Insurance
Project Name/Number: /

Filing at a Glance

Company: Pioneer Security Life Insurance Company

Product Name: Application for Life Insurance SERFF Tr Num: AAMC-125816818 State: ArkansasLH
TOI: L08 Life - Other SERFF Status: Closed State Tr Num: 40342
Sub-TOI: L08.000 Life - Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Linda Bird
Author: Traci Duffey Disposition Date: 10/01/2008
Date Submitted: 09/18/2008 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Filed in Texas, our
State of Domicile.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 10/01/2008
State Status Changed: 10/01/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:
See Cover Letter under Supporting Documentation.

Company and Contact

Filing Contact Information

Clara Keel, Product Filing Manager and ckeel@aatx.com
Assistant Secretary

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425 Austin Avenue (254) 297-2794 [Phone]
Waco, TX 76701 (254) 297-2138[FAX]

Filing Company Information

Pioneer Security Life Insurance Company CoCode: 67946 State of Domicile: Texas
425 Group Code: 1327 Company Type: LAH
Waco, TX 76701 Group Name: State ID Number:
(254) 297-2777 ext. [Phone] FEIN Number: 75-1083342

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Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pioneer Security Life Insurance Company	\$50.00	09/18/2008	22595689

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/01/2008	10/01/2008

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Disposition

Disposition Date: 10/01/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Form	Application for Life Insurance		Yes

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Form Schedule

Lead Form Number: 9617(Rev.6/08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	PS9617-AR(Rev.6/08)	Application/Enrollment Form	Application for Life Insurance	Initial		47	AR PS9617 Application.pdf

PIONEER SECURITY LIFE INSURANCE COMPANY
P.O. BOX 2550, WACO, TX 76702-2550 • (254) 297-2778

LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case No. _____

Proposed Insured _____ (First) _____ (Middle) _____ (Last)		Phone interview completed (Age 40-49) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address (No. & Street) _____		Phone _____ Best time to call _____	
City _____ State _____ Zip Code _____		E-mail Address _____	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Mo. / Day / Yr	Age	Occupation
SS# _____	State of Birth _____	Height ft in	Weight lbs
DL# _____	SS# _____	Sex	Birthdate

Owner: Name _____ SS# _____ Address: _____
Payor: Name _____ SS# _____ Address: _____

Relationship	Contingent Beneficiary	Relationship
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Plan: Immediate Plan (Issue Age 0-49) Automatic Prem. Loan Elected Yes No
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? Yes No **Face Amt \$**

Rider: Children's Insurance Agreement \$ _____
 ADB \$ _____
 Spouse Term Rider \$ _____
Name: _____

Mode: Bank Draft Quarterly Semi-Annual Annual **CWA:** E-Check Immediate 1st Prem
 Draft 1st premium on Requested Date Modal Premium \$ _____
 Collected \$ _____ / /

Do you have any existing life or disability insurance or annuity contract? Yes No Company _____
Will you replace an existing life or disability insurance policy or an annuity? Yes No Policy # _____
Physician: Name _____ City/State _____ Amount of Coverage \$ _____
Phone: _____

HEALTH INFORMATION - Answer Questions for all Proposed Insureds.

1. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?
2. **Within the past 24 months**, have you been convicted of any felony, or had your driver's license suspended or revoked, or been convicted of driving under the influence of alcohol or drugs, or used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug abuse?
3. **Within the past 12 months**, have you been on probation, parole, or been prohibited from actively working full time (30 hours or more per week) at your regular occupation due to any illness, injury, or health related problem, or **currently disabled**?
4. **Within the past 5 years** have you been medically diagnosed or treated, or taken medication for internal cancer, melanoma, Hodgkin's disease, or lymphoma?
5. Have you been medically diagnosed, treated, or taken medication for diabetes prior to age 21, or do you currently take insulin shots, or been medically diagnosed with diabetes combined with a medical history of any of the following: retinopathy, nephropathy, neuropathy, insulin shock, or diabetic coma?
6. Have you been medically diagnosed, treated, or taken medication for:
 - a. heart or circulatory disease or disorder, stroke, congestive heart failure, cardiomyopathy, heart valve disease, sickle cell anemia, leukemia, hemophilia, Marfan's syndrome, cystic fibrosis, muscular dystrophy, Huntington's disease, motor neuron disease, systemic lupus (SLE), connective tissue disease?
 - b. mental retardation, bi-polar or schizophrenia, Down's syndrome, liver or kidney failure or renal insufficiency (including dialysis), had an amputation caused by disease or had or been advised to have an organ transplant?
7. Have you been medically diagnosed, treated, or taken medication for:
 - a. high blood pressure prior to age 30, diabetes prior to age 39 or taking 3 or more medications for high blood pressure?
 - b. rheumatoid arthritis, paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, or Parkinson's disease), liver disease, Hepatitis C, chronic hepatitis or chronic pancreatitis, Crohn's disease or ulcerative colitis?
8. **Within the past 12 months** have you had surgical treatment for morbid obesity, or been declined for life insurance coverage or had any diagnostic testing, surgery or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received?
9. **Within the past 3 years** have you been medically diagnosed or treated, or taken medication for chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), irregular heart beat, seizures, blood clot, aneurysm?

	PROPOSED INSURED		PROPOSED SPOUSE	
	YES	NO	YES	NO
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If all questions 1 through 9 are answered "No" the Proposed Insured and Spouse, if applicable, are eligible for Immediate Coverage.

Form No. PS9617-AR(Rev.6/08)

NOTICE

Printed in compliance with Public Law 91-508

Thank you for considering Pioneer Security Life Insurance Company for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Pioneer Security Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Pioneer Security Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

CHILDREN COVERAGE ONLY Children Proposed for Insurance (any additional children should be listed on a separate sheet):

Proposed Insured Name	Ht.	Wt.	Sex	Birthdate	Proposed Insured Name	Ht.	Wt.	Sex	Birthdate

CHILDREN HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months.

List the names of the children that are exceptions to the CHILDREN HEALTH STATEMENT. **Children listed as an exception are excluded from the Children's Insurance Agreement Rider. Exceptions are:**

AGREEMENT—I agree with Pioneer Security Life Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the Medical Information Bureau or other organizations that has knowledge or records of me and my health to give such information to: (a) Pioneer Security Life Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the Medical Information Bureau, are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Pioneer Security Life Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the Medical Information Bureau; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, MIB Pre-Notice, Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Proposed Insured Signature: _____ Date Signed: _____ / _____ / _____

Signed at _____ CITY _____ STATE _____ SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED) _____ SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE) _____

AGENT'S REPORT

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms has been presented to the applicant, if applicable.

Does the proposed insured have any existing life or disability insurance or annuity contract? Yes No
 Is the proposed insurance intended to replace or change any existing life or disability insurance or annuity? Yes No

Mail Policy To: Insured Agent Owner

Agent's remarks: _____

Agent (SIGNATURE) _____ No: _____ % Agent (SIGNATURE) _____ No: _____ %

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured _____ Account Holder _____

Financial Institution (name/address) _____

Transit / ABA Number _____ Account Number _____ Checking Savings Requested Draft Day (1st-28th) _____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of Pioneer Security Life Insurance Company, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (As on Financial Institution Records) _____ DATE _____

Form No. PS9617-AR(Rev.6/08)

PIONEER SECURITY LIFE INSURANCE COMPANY
 P.O. BOX 2550, WACO, TX 76702-2550

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
 DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of _____ the sum of \$ _____ as first payment on this application.

Date _____ Agent _____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED \$150,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.

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Filing Company: *Pioneer Security Life Insurance Company* *State Tracking Number:* *40342*
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TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *Application for Life Insurance*
Project Name/Number: */*

Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 09/15/2008
Comments:
Attachment:
AR PS9617 Readability Certification.pdf

Review Status:
Satisfied -Name: Cover Letter 09/17/2008
Comments:
Attachment:
AR PS9617_Rev.6_08 Letter.pdf

ARKANSAS

PIONEER SECURITY LIFE INSURANCE COMPANY

CERTIFICATION

This is to certify that the attached Application for Life Insurance, Form Number PS9617-AR(Rev.6/08), has achieved a Flesch Reading Ease Score of 47.3 and complies with the requirements of Arkansas Statue 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Simplification Act.



Signature

Clara Keel, FLMI
Product Filing Manager & Assistant Secretary

September 18, 2008

Pioneer Security Life Insurance Company

P.O. Box 2550 • Waco, Texas 76702-2550 • 254-297-2778

September 18, 2008

NAIC No. 67946

Mr. Joe Musgrove
Policy and Other Form Filings
State of Arkansas
Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-1904
Attention: Compliance - Life and Health

Re: Form No. PS9617-AR(Rev.6/08) – Application for Life Insurance

Dear Mr. Musgrove:

The above referenced application is being submitted for your consideration and approval. This application is new and will replace application Form No. PS9617-AR previously approved by your department on July 8, 2005.

Application, Form No. PS9617-AR(Rev.6/08), will be used when applying for the whole life insurance product, Form No. PS02-9464, approved by your department on December 18, 2002. The Flesch readability score is 47.3.

The above referenced submission meets the provisions of Arkansas Rule and Regulation 19 (Unfair Sex Discrimination in the Sale of Insurance) as well as all applicable requirements of the department.

If I may be of assistance in your review, please contact me at 1-800-736-7311, extension 3216, or ckeel@aatx.com.

Sincerely,



Clara Keel, FLMI
Product Filing Manager & Assistant Secretary

CJK:tad
Enc.

