

SERFF Tracking Number: PRES-125854905 State: Arkansas
Filing Company: Presidential Life Insurance Company State Tracking Number: 40546
Company Tracking Number: MIB
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Applications
Project Name/Number: MIB/MIB

Filing at a Glance

Company: Presidential Life Insurance Company

Product Name: Life Applications

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: PRES-125854905 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 40546

Co Tr Num: MIB

State Status: Approved-Closed

Co Status:

Reviewer(s): Linda Bird

Authors: Diana Barbas, Reidlynn
Newton, Geralyn Farm

Disposition Date: 10/20/2008

Date Submitted: 10/13/2008

Disposition Status: Approved

Implementation Date Requested: 01/01/2009

Implementation Date:

State Filing Description:

General Information

Project Name: MIB

Project Number: MIB

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/20/2008

State Status Changed: 10/20/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

We are writing to inform you that the MIB Disclosure Notice portion, of our two previously approved life application forms in your state, has been revised to include the new MIB mailing address and website address. The MIB disclosure information in the applications is the only information revised. There were no changes made to any other part of the two applications and the form numbers have not changed.

Please see attached cover letter for more details.

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Company and Contact

Filing Contact Information

Geralyn Farm, gfarm@presidentallife.com
 69 Lydecker Street (845) 358-2300 [Phone]
 Nyack, NY 10960 (845) 358-0945[FAX]

Filing Company Information

Presidential Life Insurance Company CoCode: 68039 State of Domicile: New York
 69 Lydecker Street Group Code: Company Type:
 Nyack, NY 10960 Group Name: State ID Number:
 (845) 358-2300 ext. 224[Phone] FEIN Number: 13-2570714

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Presidential Life Insurance Company	\$40.00	10/13/2008	23142961

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/20/2008	10/20/2008

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Disposition

Disposition Date: 10/20/2008

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	MIB LETTER		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Fee Schedule Form		Yes
Form	Life Insurance Application		Yes
Form	Reinstatement Application		Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	1-2000 (8/00)(FW)	Application/Life Insurance Enrollment Application Form	Other	Other Explanation: Informational Filing		1-2000 8-00 (FW).pdf
	421 (Rev. 9/93)	Application/ Reinstatement Enrollment Application Form	Other	Other Explanation: Informational Filing		421 9-93.pdf

PRESIDENTIAL LIFE INSURANCE COMPANY

NYACK, NEW YORK

INSTRUCTIONS FOR AGENTS/BROKERS

BE SURE TO ASK ALL QUESTIONS AND RECORD THE ANSWERS IN DARK INK. DO NOT USE PENCIL. If, for some reason, a question is not applicable, please indicate that on the application. If an answer needs to be changed, DO NOT USE WHITE OUT. Put ONE line through the incorrect answer and insert the correct information.

All corrections MUST be initialed by the Proposed Insured. Make sure the application is properly dated, the city and state where it was completed are recorded, and that ALL of the necessary signatures are in place before the application is submitted. We will not accept an application that is completed on a photocopy or facsimile. **CONDITIONAL RECEIPT.** Give the Conditional Receipt to the applicant in exchange for premium payment. Do not take any money unless you give the applicant the Conditional Receipt. You do not have any authority to alter or waive the conditions set forth in the Receipt.

If the Conditional Receipt is given, the first modal premium (2 months premium for check-o-matic) for the plan and amount of insurance which may become effective prior to policy delivery must be collected. However, no deposit may be taken: (1) if the amount of coverage being applied for in this application **plus** the amount of any insurance and ADB previously issued or applied for with the Company exceeds \$500,000, (2) if the preliminary quote is other than Preferred or Standard, or (3) if the insurance age of the Proposed Insured exceeds 70.

Be sure the applicant understands the terms of the Conditional Receipt, in particular, the "CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY."

With the premium must be paid by check or money order. With the check or money order must be made payable to Presidential Life Insurance Company ONLY. Full amount collected must be entered in Question 9 of the Part I application.

IMPORTANT: If money is not received with the application, the Conditional Receipt must not be detached from the application.

APPLICATION FOR INSURANCE

PRESIDENTIAL LIFE INSURANCE COMPANY
69 Lydecker Street, Nyack, New York 10960

CONDITIONAL RECEIPT

This receipt is to be issued only if payment is made at the time the application is signed; otherwise, it must not be detached.

Unless the conditions specified in Paragraph "FIRST" are fulfilled exactly, no insurance will become effective prior to policy delivery. Neither the agent/broker nor the medical examiner is authorized to alter or waive these conditions.

Received from _____ the sum of \$ _____ in connection with this application for life insurance to Presidential Life Insurance Company of New York. This receipt bears the same date as the application. **FIRST. CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY.** If the following conditions are fulfilled exactly:

- (a) All medical examinations and tests, including X-rays and EKG's, initially required by published Company rules must be completed within 45 days after the date of this receipt and received at the home office within 60 days after such date.
- (b) An amount equal to the first modal premium for the amount of insurance which may become effective prior to policy delivery must be received with the application.
- (c) On the date that insurance becomes effective in accordance with the provisions of this receipt, each person to be covered must be insurable on a preferred or standard basis for the plan and the amount of insurance applied for without modification and at the rate of premium paid.

then insurance as provided by the terms and conditions of the policy applied for and for an amount not exceeding that specified in Paragraph "SECOND" will become effective on the latest of the following dates: (a) the date of Part I of this application; (b) the date that the last of the medical examinations and tests that were initially required by published Company rules is completed; and (c) the Date of Issue, if any, requested in the application. Any insurance applied for as alternate or additional to the plan and amounts of insurance applied for in the application will not become effective under this conditional receipt.

SECOND. LIMITS PROVISION: MAXIMUM AMOUNT OF INSURANCE THAT MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY. The total amount of life insurance and accidental death benefits which may become effective prior to policy delivery will not exceed \$500,000. This amount includes any insurance and ADB currently being applied for in the Company.

THIRD. RETURN OF AMOUNT REMITTED. The sum paid in exchange for this receipt will be returned upon demand and surrender of this receipt and no insurance will become effective if: (a) all of the conditions specified in Paragraph "FIRST" are not fulfilled exactly; (b) the Company declines the application; (c) the Proposed Insured dies by suicide before the policy is delivered; or (d) the application contains any material misrepresentation(s). This sum will also be returned upon written request received at the home office before the policy is delivered.

This receipt is not valid unless signed by the Proposed Insured and the owner; if different, and the agent/broker who receives payment. **MAKE CHECK OR MONEY ORDER PAYABLE TO PRESIDENTIAL LIFE INSURANCE COMPANY. DO NOT MAKE CHECK OR MONEY ORDER PAYABLE TO THE AGENT/BROKER OR LEAVE THE PAYEE BLANK.** Any check or money order given in payment must be honored on the first presentation for payment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its home office in Nyack, New York. Give the name of the agent/broker; date and amount paid.

I (We) have read this receipt and understand the **CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY** (Paragraph "FIRST").

Signed at _____ this _____ day of _____, 20_____

Proposed Insured

Signature of Agent/Broker

Owner (if other than Proposed Insured)

PRESIDENTIAL LIFE INSURANCE COMPANY

Nyack, NY 10960

**APPLICATION - PART I
(PLEASE PRINT OR TYPE)**

<p>1. FULL NAME OF PROPOSED INSURED <input type="checkbox"/> M <input type="checkbox"/> F (Women, give maiden name.)</p>		<p>13. PURPOSE OF INSURANCE</p>									
<p>2. RESIDENCE ADDRESS: Give No., Street, City, State, Zip Code</p> <p>Phone Nos.: Home () Work () How long at this address? _____ Previous addresses, within past 5 years.</p>		<p>14. a. OWNER (If other than Proposed Insured, give the following information.) Full Name: Address: Relationship to Proposed Insured: Soc. Sec. or Tax ID No.: Owner is <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Trustee (Give name of trust and date of trust agreement)</p> <p>b. CONTINGENT OWNER Full Name: Soc. Sec. or Tax ID No:</p>									
<p>3. OCCUPATION: Describe Duties: Name of Employer: Business Address:</p>		<p>15. BENEFICIARY: Give full name, address, date of birth, and relationship to Proposed Insured. Right to change Beneficiary is reserved to the Owner unless otherwise indicated</p> <p>PRIMARY: _____ _____ _____</p> <p>CONTINGENT: _____ _____</p>									
<p>4a. DATE OF BIRTH Month Day Year</p>	<p>4b. AGE NEAREST BIRTHDAY</p>										
<p>5. STATE/COUNTRY OF BIRTH</p>	<p>6. SOC. SEC. NO.</p>										
<p>7.a. PLAN AND AMOUNT (Indicate Option 1 or 2, if applicable)</p>		<p>16. a. ALL INSURANCE IN FORCE ON LIFE OF PROPOSED INSURED (If NONE, so state.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">COMPANY</th> <th style="width: 25%;">AMOUNT</th> <th style="width: 25%;">ACC. DEATH</th> <th style="width: 25%;">ISSUE YR.</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		COMPANY	AMOUNT	ACC. DEATH	ISSUE YR.				
COMPANY	AMOUNT			ACC. DEATH	ISSUE YR.						
<p>7.b. Complete only if applicable for plan applied for: Planned Periodic Premium: \$ _____ Lump Sum Deposit: \$ _____ RIDERS: <input type="checkbox"/> WAIVER <input type="checkbox"/> OTHER:</p>											
<p>8. MODE OF PREMIUM PAYMENT: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Check-o-matic <input type="checkbox"/> Single</p>		<p>b. Which policies have a Business as Owner and/or Beneficiary? (If NONE, so state.)</p>									
<p>9. AMOUNT REMITTED WITH THIS APPLICATION (In exchange for Conditional Receipt: \$ _____)</p>		<p>17. SEND PREMIUM NOTICES TO: <input type="checkbox"/> Residence <input type="checkbox"/> Business <input type="checkbox"/> Owner (If other than Proposed Insured) If more than One Owner, give name and address of the one Owner who should receive the original notice: _____ _____ Other: _____</p>									
<p>10. AUTOMATIC PREMIUM LOAN: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>18. SPECIAL REQUESTS</p>									
<p>11. RATED CLASS: Issue Rated Class, if applicable. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>											
<p>12.a. Do you currently use tobacco in any form? <input type="checkbox"/> YES <input type="checkbox"/> NO (Please answer b. or c. below, whichever is appropriate.) b. If YES, indicate form(s) used; check all that apply. <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other (describe): _____ Give frequency of use for all forms checked above. For cigarettes and cigars, give number per day. c. If NO, check whichever is appropriate. <input type="checkbox"/> Never used <input type="checkbox"/> Quit: give mo. _____ yr. _____</p>											

(CONTINUED ON NEXT PAGE)

	YES	NO		YES	NO
19. Has any company or society declined to issue, reinstate, or renew a policy; offered a rated or modified policy; or postponed or canceled any insurance on your life?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have you in the past 2 years engaged in, or do you expect to engage in, hang gliding, flying ultra lights, racing (automobile, go-karts, midgets, cycle, boat, snowmobile), or diving (skin, scuba, sky)? If YES, complete Avocation Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>
20. Is any application or informal inquiry on your life or health pending in any other company or society, or have you ever withdrawn such an application or informal inquiry?	<input type="checkbox"/>	<input type="checkbox"/>	24. In the past 3 years, have you been convicted of, pleaded guilty or no contest to: a. two or more moving violations and/or accidents? b. driving under the influence of alcohol and/or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
21. Is this insurance intended to replace or change any existing insurance, including annuities, in any company or society?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have you ever been convicted of a felony or misdemeanor?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you intend to fly other than as a passenger on a commercial airline or have you flown other than as a passenger on a commercial airline in the past 2 years? (If YES, complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	26. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	<input type="checkbox"/>	<input type="checkbox"/>
			27. Have you any intention of traveling and/or residing outside the United States?	<input type="checkbox"/>	<input type="checkbox"/>

28. REMARKS: If answer to questions 19, 20, 21, 22, 23, 24, 25, 26, and/or 27 is YES, please explain.

I represent that the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief. I agree that: (1) the entire contract will consist of this application and the policy issued in response to it; (2) no agent of the Company is authorized to: (a) make or modify contracts; (b) waive any rights or requirements of the Company; or (c) waive any information requested by the Company; and (3) except as provided in the Conditional Receipt, if issued, no insurance will take effect unless: (a) the policy is delivered to the Owner; (b) the first modal premium is paid; and (c) there has been no change since the date of this application in the insurability of all persons proposed for insurance or in any of the answers to the questions on this application. I acknowledge receipt of the Notice to Proposed Insured.

If I am applying for an indeterminate premium plan, I understand that: (a) the premium for such plan is guaranteed for the initial guarantee period, and, after such period, the current annual premium is not guaranteed and may change; and (b) the premium will never exceed the specified maximum.

Any person who, knowingly and with intent to defraud, submits an application containing false, incomplete or misleading information is guilty of the crime of insurance fraud.

Signed at _____ this _____ day of _____, 20_____

City and State

Proposed Insured _____ Applicant/Owner _____

Sign name in full

If other than the Proposed Insured-Sign name in full

Licensed Agent _____

Sign name in full

AGENT'S CERTIFICATE

Is this insurance intended to replace other insurance?

Yes No

I HEREBY CERTIFY that I personally solicited and secured this application and except as indicated above, no one else is to have any share in the agent's commission thereon.

This application was solicited and written within my territory by a duly licensed agent of my agency.

Agent's Signature _____

GA's Signature _____

Code No. _____

Code No. _____

PRESIDENTIAL LIFE INSURANCE COMPANY

69 Lydecker Street, Nyack, New York 10960

**APPLICATION - PART II MEDICAL HISTORY (COMPLETE IF INSURANCE MAY BE CONSIDERED WITHOUT A MEDICAL EXAMINATION.)
PLEASE PRINT**

AGENT/BROKER'S INSTRUCTIONS

ALL QUESTIONS MUST BE ANSWERED. If, for any reason, a question is not applicable, please indicate that on the application. If an answer needs to be changed, DO NOT USE WHITE OUT. Put ONE line through the incorrect answer and insert the correct information. ALL corrections MUST be initiated by the Proposed Insured.

FULL NAME OF PROPOSED INSURED	DATE OF BIRTH Month Day Year	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER ____-____-____
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1.a. List names and addresses of all health care professionals and professional health care treatment facilities providing care, treatment, advice, or consultations during the past five (5) years and give date(s) and reason(s). If NONE, state None. _____

b. What advice, treatment, and/or medication was given? If NONE, so state. _____

c. Are you currently under observation or treatment or are you taking any medication? YES NO If YES, explain. _____

d. Have X-rays, electrocardiograms, blood studies, or other diagnostic tests, excluding any study or test for exposure to the AIDS virus (HIV), been done during the past FIVE years? _ YES NO _ If YES, when, why, by whom, and results? _____

e. Have you been advised to have any diagnostic test (excluding any test for exposure to the AIDS virus (HIV)), medication, treatment, hospitalization, or surgery which was not completed? YES NO If YES, explain. _____

2. Have you ever had or do you now have any of the following?

Please check the appropriate box.

- | | YES | NO |
|--|--------------------------|--------------------------|
| a. Disorder of eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, head injury, headaches, speech defect, paralysis, stroke, tremors, muscle weakness, depression, other mental or nervous disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, tuberculosis, pneumonia, emphysema, asthma, or chronic respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, angina, palpitations, high blood pressure, rheumatic fever, or other severe infection, heart murmur, heart attack, varicose veins, phlebitis, or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, liver, intestines, pancreas, gallbladder, or spleen? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine, stone, or any other disorder of the kidney, bladder, prostate, or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes, goiter, thyroid, or other endocrine disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Lupus erythematosus, Multiple Sclerosis, neuritis, arthritis, gout, or disorder of the muscles or connective tissue? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Any disorder of the bones, including the spine, back and joints, deformity, lameness, or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, breast or lymph glands, cyst, tumor or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Anemia, hemophilia, bleeding tendency, or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Chronic or unexplained fatigue, malaise, loss of appetite, weight loss, diarrhea, fever of unknown origin, severe night sweats, unexplained or unusual infections or skin lesions, unexplained swelling of the lymph glands, Kaposi's Sarcoma, or Pneumocystis Carinii Pneumonia? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Any sexually transmitted or venereal disease? | <input type="checkbox"/> | <input type="checkbox"/> |

DETAILS of YES answers. (Identify question number. Circle applicable items: include dates, diagnosis, duration, treatment, and names and addresses of ALL health care professionals and treatment facilities consulted.) Attach an additional sheet if more space is required for information.

(CONTINUED ON NEXT PAGE)

Page 3

	YES	NO
3. a. Height _____ ft. _____ in. Weight _____ lbs.		
b. Have you had any change in weight in the past 12 months? If YES, how much? Gain _____ lbs., Loss _____ lbs. Reason for change _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been diagnosed by a member of the medical profession as having, or received treatment from such member for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
5. a. Do you currently take or use any narcotic, stimulant, sedative, hallucinogenic, marijuana, crack, cocaine, heroin, LSD, or any illegal, restricted or controlled substance, or any other drugs, except as prescribed by a physician? If YES, give name(s), form(s), amount, frequency and length of use and age first used, for each drug and/or substance used.	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever taken or used any of the drugs/substances listed in 5.a. or any other drug, except as prescribed by a physician? If YES, give name(s), form(s), amount, frequency and length of use, and date use was discontinued, for each drug and/or substance used.	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever:		
a. Used alcoholic beverages? If YES, how often, how many ounces, and for how many years?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been advised to reduce or discontinue the use of alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been counseled, sought help or treatment, or been advised to go for treatment or counseling for alcoholism or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
d. Attended or joined any organization such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) for alcohol and/or drug related problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
8. To the best of your knowledge are you now pregnant? If YES, how many months? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Family History: Is there a history of diabetes, heart disease, high blood pressure, cancer, kidney disease, tuberculosis, alcoholism, mental illness, suicide, or any inherited disease?	<input type="checkbox"/>	<input type="checkbox"/>
	Age if Living	Age at Death
Father		Cause of Death
Mother		
Brothers and Sisters	No. Living	
	No. Dead	

DETAILS of YES answers. (Identify question number. Circle applicable items: include dates, diagnosis, duration, treatment, and names and addresses of ALL health care professionals and treatment facilities consulted.) Attach an additional sheet if more space is required for information.

I represent that the statements and answers given above are true, complete, and correctly recorded to the best of my knowledge and belief.

Signed at _____ this _____ day of _____, 20 _____

Agent/Broker Proposed Insured

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The terms that follow have the respective meanings when used in this Authorization.

COMPANY: Presidential Life Insurance Company
INSURANCE SUPPORT ORGANIZATIONS: MIB, Inc. and/or Consumer Reporting Agency
BUREAU: MIB, Inc.
AUTHORIZATION: Authorization to Obtain and Disclose Information

I understand that the Company, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage. Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) reinsurer; (6) insurance support organizations; (7) financial source; and (8) employer, to give the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid as the original.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; and (9) other personal traits. These facts may include details of alcohol and/or drug use, abuse, and/or treatment. The Company and its reinsurers will use the information in order to determine whether I am insurable.

Those parties named in the first paragraph of this Authorization, excluding insurance support organizations, may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) the Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. Insurance support organizations may disclose information according to any contract with a member company or organization. Information may also be disclosed as allowed by law.

This Authorization will be valid for two years after the date of signing. I understand that I or my authorized representative may request to receive a copy of this Authorization. I authorize the Company to procure an investigative consumer report, if required.

If a minor child is proposed for coverage, these statements are made by the person authorized (parent or legal guardian) to act on behalf of the minor child named in the application.

Signed at _____ this _____ day of , _____ 20_____

Signature of Proposed Insured

Signature of Parent or Legal Guardian, if applicable.

.....
(Please detach and give to Proposed Insured)
NOTICE TO PROPOSED INSURED - PART I

Federal Fair Credit Reporting Act Notice

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the Company within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and, if so, you will be advised of the name and address and telephone number of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely primarily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report by contacting the consumer reporting agency as explained in the Federal Fair Credit Reporting Act Notice.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of Presidential Life's and your agent/broker's information practices. If you would like to receive a more detailed explanation of those practices, please send your request to the Director of Underwriting, Presidential Life Insurance Company, 69 Lydecker Street, Nyack, NY 10960.

**PERSONAL STATEMENT SUPPLEMENT TO APPLICATION TO
PRESIDENTIAL LIFE INSURANCE COMPANY
TO BE COMPLETED AND SIGNED IN ALL CASES**

Name of Proposed Insured _____ Date of Birth _____

1. Personal Finances:

Total Assets \$ _____
Total Liabilities \$ _____
Net Worth \$ _____

Income:
Earned \$ _____
Unearned \$ _____

2. What is the purpose of this insurance? _____

3. Have you or your company ever filed for bankruptcy? YES NO
If yes, provide full details _____

4. Except for traffic violations, have you ever been arrested? YES NO
If yes, provide full details as to nature and final disposition. _____

5. Complete this section only if business insurance is applied for.

a) Business Finances:

Total Assets \$ _____
Total Liabilities \$ _____
Net Worth \$ _____

Net Profit after Taxes:
Last Year \$ _____
Previous Year \$ _____

b) Is the business a Corporation, Partnership or Proprietorship? (Circle One)

c) How long has the business been established? _____

d) What is the nature of the business? _____

e) What is your percentage ownership of this firm? _____

f) Is there business insurance applied for or in force on other key members of this firm? YES NO
Provide details: _____

Signed at _____ this _____ day of _____, 20_____

Signature of Proposed Insured

Signature of Applicant/Owner

NOTICE TO PROPOSED INSURED - PART II

MIB Disclosure Notice

Information regarding your insurability will be treated as confidential. Presidential Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-profit membership organization of 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 the 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.

Presidential 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. 9/08

General Notice

In the course of evaluating and handling each application for insurance, the Company relies primarily on the information provided by you; therefore, you must provide true, complete, and accurate information on the application. Although the Company does not always do so, it may also seek information from other sources. Any information that it obtains from these sources may not be current or complete or accurate however. Consequently, you **must** inform the Company, prior to delivery of any policy, of any change to any answer on your application. Please review your application for accuracy after all parts have been completed. Any policy that is delivered to you may be contested for a period of two years after the date of issue; this period is referred to as the contestable period. A contest may result if your application is incomplete or if it contains false statements or misrepresentations. Any policy that is delivered to you may be voided and coverage or benefits may be lost as the result of a successful contest within the contestable period. Also, be sure to inform the Company of any changes to any answers on your application that occur before any policy is delivered. In so doing, you can facilitate the issue of your policy and the commencement of coverage.

Presidential Life Insurance Company

69 Lydecker Street • Nyack, New York 10960

APPLICATION FOR REINSTATEMENT

**THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND PROPERLY SIGNED
(PLEASE PRINT)**

Policy No. _____ Amount paid with this application \$ _____

Name of Owner _____

Name of each Insured _____

Name of Payor Insured (if applicable) _____

PLEASE ANSWER EACH QUESTION BELOW FOR ALL INSURED(S) COVERED BY THE POLICY HAS ANY INSURED UNDER THIS POLICY OR ANY ATTACHED RIDER, SINCE THE DATE OF THIS POLICY:

1. Consulted or been treated by any physician or practitioner or had any physical impairment, sickness, operation, mental disorder, injury?
2. A. Height _____ Ft. _____ In. B. Weight _____ Pounds
3. Smoked cigarettes or used tobacco in any other form in the past 12 months?
4. Used barbiturates, heroin, cocaine, marijuana or any other illegal, restricted, or controlled substance except as prescribed by a physician? If Yes, when and how often?
5. a. Been advised to limit or cease the use of alcoholic beverages?
b. Been counseled, sought help or treatment, or been advised to undergo counseling or treatment for alcohol problems?
6. Had a driver's license restricted, revoked or suspended?
7. Engaged or intend to engage in hang gliding, racing, mountain climbing, skin, scuba or sky diving? If Yes, complete Hazardous Activities Questionnaire.
8. Taken within five years or intend to take flights other than as a fare-paying passenger on scheduled airlines? If Yes, complete Aviation Questionnaire.
9. Been convicted of a felony or misdemeanor within the past 10 years?
10. Applied for new or reinstatement of insurance? (If Yes, give details - companies; amounts; types of insurance; whether pending, issued, refused, postponed, limited or rated).
11. Been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

	FIRST INSURED		SECOND PAYOR INSURED		CHILDREN	
	Yes	No	Yes	No	Yes	No
1.	<input type="checkbox"/>					
3.	<input type="checkbox"/>					
4.	<input type="checkbox"/>					
5a	<input type="checkbox"/>					
5b	<input type="checkbox"/>					
6.	<input type="checkbox"/>					
7.	<input type="checkbox"/>					
8.	<input type="checkbox"/>					
9.	<input type="checkbox"/>					
10.	<input type="checkbox"/>					
11.	<input type="checkbox"/>					

EXPLAIN ANY "YES" ANSWERS; INDICATE QUESTION #, NAME OF INSURED AND SHOW DISORDER, DATE OF ONSET AND RECOVERY, NAME AND ADDRESS OF PHYSICIAN, CLINIC OR HOSPITAL. IF CHILDREN COVERED, LIST NAMES OF CHILDREN BORN OR ADOPTED SINCE DATE POLICY WAS ISSUED. (USE REVERSE SIDE IF NECESSARY)

I agree that any reinstatement of this Policy, as granted by the Company upon this application and any supplements thereto, copies of which shall be attached to and made a part of the reinstated policy, shall be contestable at any time within two years from the date of the approval hereof. I hereby declare that all the above statements are full, complete and true to the best of my knowledge and belief.

Signed at _____ this _____ day of _____ 20 _____

(Witness - not a beneficiary)

OWNER

SECOND INSURED (if Joint Policy)

INSURED

AUTHORIZATION - A photo copy of this authorization shall be as valid as the original, which shall be valid for 30 months. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give Presidential Life Insurance Company or its reinsurers any such information. This includes data related to drugs, alcoholism or mental illness. **It also includes data obtained in connection with the preparation of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application.** To expedite the collection of data. I authorize all such sources, except the Medical Information Bureau, to give the data to any agency employed by Presidential Life Insurance Company to collect and transmit such data. I further authorize Presidential Life Insurance Company to prepare or obtain any investigative consumer report in connection with this application; if a consumer report is prepared, I elect to be interviewed: Yes No I am aware that I am entitled to receive a copy of this authorization form.

Date _____

INSURED (or Owner)

SECOND INSURED (if Joint Policy)

421 (REV. 9/93)

PAYOR INSURED

NOTICE WITH REGARD TO MIB, INC. DETACH AND KEEP FOR YOUR RECORDS

MIB Disclosure Notice

Information regarding your insurability will be treated as confidential. Presidential Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-profit membership organization of 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 the 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.

Presidential 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.

<i>SERFF Tracking Number:</i>	<i>PRES-125854905</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Presidential Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40546</i>
<i>Company Tracking Number:</i>	<i>MIB</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Life Applications</i>		
<i>Project Name/Number:</i>	<i>MIB/MIB</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: PRES-125854905

State: Arkansas

Filing Company: Presidential Life Insurance Company

State Tracking Number: 40546

Company Tracking Number: MIB

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: Life Applications

Project Name/Number: MIB/MIB

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/13/2008
Comments:
Attachment:
ARKANSAS-COMP.pdf

Review Status:

Satisfied -Name: MIB LETTER 10/13/2008
Comments:
Attachment:
MIB LETTER.pdf

Review Status:

Satisfied -Name: Cover Letter 10/13/2008
Comments:
Attachment:
COVER LTR.pdf

Review Status:

Satisfied -Name: Fee Schedule Form 10/13/2008
Comments:
Attachment:
AR Filing Fee.pdf

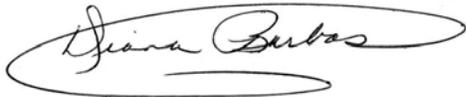
STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

CARRIER: Presidential Life Insurance Company

FORM TITLE(S): Life Insurance Application; Reinstatement Applications

FORM NUMBER(S): 1-2000 (8/00)(FW); 421 (Rev. 9/93)

I hereby certify that to the best of my knowledge and belief the above form submission meets the provisions of Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.



Signature of Officer

Diana Barbas
Name

Second Vice President
Title and/or Business Affiliation

October 13, 2008
Date

To: Medical Director and Chief Underwriter (For Members' Internal Distribution to Interested Parties)

From: Jonathan W. Sager, Vice President & General Counsel
MIB Group, Inc.

Date: June 23, 2008

CHANGE OF ADDRESS FOR MIB PRE-NOTICE AND POST-NOTICE
EFFECTIVE JANUARY 1, 2009

Summary: *MIB Members in the U.S. should insert MIB's new physical (street) address and website address into the MIB Pre-Notice and Post-Notice no later than June 30, 2009 (or January 1, 2009 for certain companies doing business in New York State). Canadian Members are urged to insert the MIB website address into the MIB Pre-Notice at their convenience.*

For over thirty-five years, MIB has used a post office box at a downtown Boston post office branch as the primary address to which consumers could write for copies of their MIB consumer files.¹ Thus, the MIB Pre-Notice² and Post-Notice³ have long given MIB's address as P.O. Box 105, Essex Station, Boston, MA 02112. Because of the increasing costs of maintaining and administering this separate mail facility (among other reasons), MIB management determined that we could reduce operating expenses significantly by closing the P.O. Box and changing the address in the MIB Pre-Notice and Post-Notice to our physical address at 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 effective January 1, 2009. Members are also requested to insert the MIB website address into the MIB Pre-Notice (www.mib.com). A copy of the amended MIB Pre-Notice is provided below.

Early notification of these changes should allow you to use up your current inventory of these forms and then revise and re-print them in the ordinary course of business, thereby making this revision as cost effective as possible. Although we encourage you to change the addresses in your Pre-Notice and Post-Notice by January 1, 2009, we will maintain the post office box (former address) for an additional six months (until June 30, 2009) to ensure that we receive all

¹ The deployment of this P.O. Box came at a time when the MIB Disclosure Office (once known as the MIB Information Office) was housed at a facility that was separate from MIB operations.

² MIB General Rule C. 3 and Comment 1. *See also* General Rule D. 1 (b).

³ MIB General Rule C.4 and Comment 3. As published in the 2008 MIB Handbook and Directory, the MIB Post-Notice currently provides both the P.O. Box address and new MIB street address. Notice under Rule C.4 is also described as the Fair Credit Reporting Act (FCRA) Post-Notice. Section 615(a) of FCRA requires notice to a consumer subjected to "adverse action...based in whole or in part on any information contained in a consumer [credit] report." The Federal Trade Commission has acknowledged that this FCRA requirement is satisfied by a Member's compliance with MIB's General Rule C.4. Since 1995, MIB Members have followed General Rule C.4, which requires them to give notice to consumers when three conditions occur: the member received information from MIB pertaining to the applicant; the information received from MIB was used to alert that member to the possible need for further investigation of the applicant's insurability; and the application for insurance was rated or declined in whole or in part because of information obtained from that investigation. For additional information on the MIB Post-Notice, please go to KnowledgeNow, MIB's Member-only secure extranet.

mail from consumers. Therefore, Members will be required to comply with these changes by no later than June 30, 2009, one full year from this notification. After the closure of the post office box, the United States Postal Service will forward to MIB any first class, priority and express mail for an additional twelve months.

You may rest assured that MIB will continue to be highly accessible to consumers by having an easily navigable public website (www.mib.com), having a toll-free telephone number (866-692-6901 and TTY 866-346-3642), and responding to consumer inquiries by email at infoline@mib.com, privacy@mib.com and canada_disclosure@mib.com. The interactive voice response system tied to our toll free line will also be modified. We will also put a special notice to consumers about the MIB mailing address on the MIB website. Incidentally, the use of the physical address will permit consumers to send correspondence to MIB by UPS, FedEx, DHL and other "next day" services, thereby providing consumers with an express delivery option that has been unavailable to them with the use of an MIB P.O. Box address.

In making the decision to transition from the P.O. Box address to our physical address, we have tried to reduce any burden imposed upon Members. We understand that some Members have included the MIB Pre-Notice in their filed application forms and, therefore, they may have to re-file their applications with state insurance departments to receive approval of these changes to the MIB Pre-Notice. However, in certain jurisdictions, Members may determine that the MIB Pre-Notice is not a "policy form" that has to be filed or approved (or re-filed). We are unaware that any Member has filed the MIB post-notice as a policy form since it is administrative in nature. You should consult your own legal counsel or compliance personnel about your filing obligations, if any.

Members doing business in New York State:

It has been a longstanding position of the New York State Insurance Department that the MIB Pre-Notice is subject to prior approval.⁴ Therefore, to mitigate the potential re-filing burden upon our Members doing business in New York, we have induced the Life and Health⁵ Bureaus of the New York State Insurance Department (NYSID) to "waive" any requirement for Members to re-file the MIB Pre-Notice due to these two changes. We successfully asserted that the address of MIB in our Members' previously approved application forms (containing the MIB Pre-Notice) should be deemed to be "variable material." Further, since the Life and Health Bureaus will have the new MIB address on file, no submission of an amended Pre-Notice should be required. The Life and Health Bureaus agreed with our position.

⁴ The MIB Pre-Notice required under NY Insurance Law Section 321 is considered a part of the individual life insurance application by the Life Bureau of the NYSID and it is subject to prior approval. An argument could be made that the MIB Pre-Notice is an "administrative form" and not a "policy form" requiring the prior approval of the NYSID under NY Insurance Law Section 3201. "Policy forms" include policies, contracts, certificates, and other evidence of insurance or applications therefore. See NY Insurance Law Section 3201(a).

⁵ Although individual basic and major medical insurance is not underwritten in NYS, MIB's Checking Service can be used for individual long-term care, disability income and specified disease insurance, all of which may be individually underwritten. Such products are within the jurisdiction of the Health Bureau.

In any future filings of the MIB Pre-Notice, the Life Bureau would like the MIB address to be bracketed, thereby denoting the fact that it constitutes variable material in the form. Copies of the letters from the Life and Health Bureaus are posted on KnowledgeNow (MIB's Member-only secure extranet or private website) and should be reviewed carefully since they contain very specific terms and conditions for this filing "exception." Indeed, the Health Bureau has conditioned this "waiver" on making these changes by January 1, 2009. The Life Bureau has indicated that it will provide guidance on the NYSID website.

In those other states in which Members have previously filed the MIB Pre-Notice, we feel that state insurance departments should be receptive to the approach that we have taken with the NYSID. We urge you to seek an "exception" from re-filing any previously filed MIB Pre-Notice on this same basis. If we can be of assistance to Members in this process, we would be happy to provide it.

If you have any questions about the revisions to the MIB Pre-Notice, the process of phasing out the MIB Post Office Box or any related matter, do not hesitate to contact me at (800) 343-7404 ext. 6332 or (781) 751-6332, email address jsager@mib.com. Thank you for your cooperation.

KEY DATES FOR NEW MIB ADDRESS CHANGE:

- **July 1, 2008:** Members should begin the process of revising the MIB Pre-Notice, MIB Post-Notice and any other correspondence or forms that refer to the PO Box address of MIB. Members should determine whether to re-file the MIB Pre-Notice with the address change and website address.
- **January 1, 2009:** Members should begin using the revised MIB Pre-Notice and Post-Notice.
- **June 30, 2009:** MIB will close P.O. Box 105, Essex Station, Boston, MA 02112 and submit a request to US Postal Service to forward mail. This will be the final "compliance date" for revisions to the MIB Pre-Notice and Post-Notice.

REVISED MIB PRE-NOTICE EFFECTIVE JANUARY 1, 2009:

Footnotes are intended for Member reference only and should not be included in the actual Pre-Notice. Bold print denotes new material.

*“Information regarding your insurability will be treated as confidential. XYZ Company or its reinsurers may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**⁶, a not-for-profit membership organization of 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).⁷ If you question the accuracy of the 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].

*XYZ 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.**”*

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7, tel. no. 416-597-0590.

⁶ “Medical Information Bureau” changed its name in 1978 to “MIB, Inc.” to reflect its status as a Delaware corporation. As noted in Comment 2 to the MIB General Rules (which was amended in the 2007 MIB Handbook and Directory), the use of “Medical Information Bureau” alone (without the accompanying use of “MIB, Inc.”) is not technically accurate and should be changed.

⁷ The toll free number and hearing impaired facility were added in 2004 in order to comply with the Fair and Accurate Credit Transactions Act of 2003 (FACTA), which amended the Fair Credit Reporting Act and required MIB to provide free annual file disclosure to consumers, among other things.



PRESIDENTIAL LIFE INSURANCE COMPANY

69 LYDECKER STREET
NYACK, NY 10960
(845) 358-2300
FAX: (845) 358-0945

To: AR Insurance Department
From: Geralyn Farm, Form Filing Department
Date: September 8, 2008
Re: MIB Disclosure Notice
Address Change effective 01/01/2009

MIB Group, Inc., formally known as Medical Information Bureau, has instructed its members to revise their previously approved life forms containing the MIB Pre-Notice. A copy of the MIB Group, Inc. memo dated 06/23/2008 is attached for your reference.

We are writing to inform you that the MIB Disclosure Notice portion, of our two previously approved life application forms in your state, has been revised to include the new MIB mailing address and website address. The MIB disclosure information in the applications is the only information revised. There were no changes made to any other part of the two applications and the form numbers have not changed.

The New York State Insurance Department, our state of domicile, has agreed to allow MIB members to make the MIB Disclosure Notice language change to their previously approved life insurance applications without receiving a new approval.

Presidential Life included the MIB Disclosure Notice in our filed life application forms in your state. However, in certain jurisdictions, the MIB Disclosure Notice is not a policy form that must be filed or approved.

Form Number	Form Name	Approval Date
1-2000 (8/00)(FW)	Life Insurance Application	6/29/2001
421 (Rev. 9/93)	Reinstatement Application	5/26/1994

To mitigate the filing burden in your state, we seek an exception from re-filing our two previously approved life application forms for the sole change due to the MIB Disclosure Notice revision. We trust that you will be receptive to our request.

If you have any questions, please contact me at (800) 358-2300, extension 214. Thank you.

ARKANSAS
INSURANCE
DEPARTMENT

1200 West Third Street
Little Rock, Arkansas 72201-1904

Mike Pickens
Insurance Commissioner

501-371-2600

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Presidential Life Insurance Company

Company NAIC Code: 68039

Company Contact Person & Telephone #: Geralyn Farm, 1-800-926-7599 ext 214

** INSURANCE DEPARTMENT USE ONLY *
* * * * *
* ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____ *

*

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS.
UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing. * _____ x \$50 = _____
**Retaliatory _____

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer. * _____ x \$50 = _____
**Retaliatory _____

Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form. * 2 x \$20 = \$40
**Retaliatory _____

Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms. * _____ x \$20 = _____
**Retaliatory _____

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer. * _____ x \$25 = _____
**Retaliatory _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an
Insurer's Certificate of Authority.

* ___ x \$400 = ___

Filing to amend Certificate of Authority.

*** ___ x \$100 = ___

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE
AND REGULATION 57.

**THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK.
CODE ANN. 23-63-102, RETALIATORY TAX.

***THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. §23-61-401.