

SERFF Tracking Number: META-125889777 State: Arkansas
Filing Company: Metropolitan Life Insurance Company. State Tracking Number: 40785
Company Tracking Number: T08-2 MD (AR)
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Group Term Life Insurance & Health Insurance
Project Name/Number: gcert2000 cp/al/afa/T01-8 MD

Filing at a Glance

Company: Metropolitan Life Insurance Company.

Product Name: Group Term Life Insurance & Health Insurance SERFF Tr Num: META-125889777 State: ArkansasLH

TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 40785
Sub-TOI: H21.000 Health - Other	Co Tr Num: T08-2 MD (AR)	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Sandra Bennett	Disposition Date: 11/06/2008
	Date Submitted: 11/05/2008	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: gcert2000 cp/al/afa
Project Number: T01-8 MD
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 11/06/2008
State Status Changed: 11/06/2008
Corresponding Filing Tracking Number: T08-2 MS (AR)
Filing Description:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Association, Trust

Deemer Date:

Please see the the cover letter for a more detail description of the subsubmitted filing.

Company and Contact

Filing Contact Information

Mark Diefenderfer, Senior Consultant

mdiefenderfe@metlife.com

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18210 Crane Nest Drive (813) 983-4927 [Phone]
Tampa, FL 33647 (813) 983-4940[FAX]

Filing Company Information

Metropolitan Life Insurance Company. CoCode: 65978 State of Domicile: New York
MetLife Group Code: -99 Company Type: Life
1095 Avenue of the Americas
New York, NY 10036-6796 Group Name: State ID Number:
(212) 578-2211 ext. [Phone] FEIN Number: 13-5581829

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Filing Fees

Fee Required? Yes
Fee Amount: \$25.00
Retaliatory? No
Fee Explanation: \$25.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company.	\$25.00	11/05/2008	23724423

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/06/2008	11/06/2008

SERFF Tracking Number: *META-125889777* *State:* *Arkansas*
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Disposition

Disposition Date: 11/06/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: META-125889777 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	ARCERTREAD	Approved-Closed	Yes
Supporting Document	industry_rates_lh_trans	Approved-Closed	No
Supporting Document	ARCERTREG19	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GCERTt2000 cp/akk/afa

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GCERT2000	Policy/Cont	Certificate	Initial		40	GCERT2000 cp all afa no EOV.pdf
	0	ract/Fratern					
	CP/ALL/AF	al					
	A	Certificate					

ELIGIBILITY FOR CONTINUATION [OF CERTAIN INSURANCE] WHILE YOU ARE [TOTALLY] DISABLED

If You become Totally Disabled while You are [insured for Continuation Eligible Insurance under this policy], You may qualify to continue certain insurance under this section without premium payment. We will determine if You qualify for this continuation after We receive Proof that You have satisfied the conditions of this section.

If you made payments for Continuation Eligible Insurance during a period of Total Disability, we will refund to you, at the time:

1. we accept your proof of Total Disability; and
2. you qualify to continue certain insurance under this section without premium payment;

any payments made during such period of Total Disability. In no event will the refund be for an amount greater than the payments you made for a two-year period.

Total Disability must start [before You attain age **55** and] while You are insured for Continuation Eligible Insurance.

Your Total Disability [must continue without interruption from the date You became Totally Disabled through the end of the Continuation Waiting Period.]

DEFINITIONS

[Appropriate Care and Treatment means medical care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating Your Disability;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- consistent with a Physician's diagnosis of Your Disability; and
- intended to maximize Your medical and functional improvement.]

For the purpose of this section, "**Continuation Eligible Insurance**" [means

- Basic Life Insurance;
- Optional Life Insurance, if You were insured under the Policyholder's Life Insurance Plan for **6–12** months before Total Disability began;
- Dependent Life Insurance, if You continue Basic Life Insurance or Optional Life Insurance;
- Accidental Death and Dismemberment Insurance, if You continue Basic Life Insurance or Optional Life Insurance;
- Optional Accidental Death and Dismemberment Insurance, if You continue Optional Life Insurance;
- Dependent Accidental Death and Dismemberment Insurance, if You continue Basic Life Insurance or Optional Life Insurance; and
- Voluntary Accidental Death and Dismemberment Insurance, if You continue Basic Life Insurance or Optional Life Insurance]

to the extent that such insurance was in effect for You on the date Your Total Disability began.

[Continuation Waiting Period means the period which starts on the date You become Totally Disabled and ends **1 -12** consecutive months later.]

ELIGIBILITY FOR CONTINUATION [OF CERTAIN INSURANCE] WHILE YOU ARE TOTALLY DISABLED (Continued)

[**Totally Disabled** or **Total Disability** means that due to Sickness or as a direct result of accidental injury You:

- are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- have lost the ability to safely perform **2-4** Activities of Daily Living without another person's assistance or verbal prompting.

For purposes of this definition, **Activities of Daily Living** mean:

- **Bathing**: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Dressing**: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs.
- **Toileting**: getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
- **Transferring**: moving into or out of a bed, chair or wheelchair;
- **Continence**: ability to maintain control of bowel and bladder function; or; when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag); and/or
- **Eating**: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

TOTAL DISABILITY AND PROOF REQUIREMENTS

If You become disabled You should contact Us as soon as reasonably possible. After the Continuation Waiting Period ends, You must send Us Proof that You were Totally Disabled [with no interruption throughout the Continuation Waiting Period. You must do this within the time frame specified in section entitled FILING A CLAIM.]

As part of such Proof, [We may choose a Physician] to examine You to verify that You are Totally Disabled. We will pay for the exam.

After We receive and review Your Proof, We will determine if You qualify. We will notify You in writing of Our decision.

To verify that You continue to be Totally Disabled without interruption, We may require from time to time that You send Us Proof that You continue to be Totally Disabled. [We will not ask for Proof more than once each year.]

IF YOU [OR YOUR DEPENDENT] DIE [OR SUSTAIN A LOSS COVERED BY THE CONTINUED INSURANCE] DURING CONTINUATION

If, during the continuation, You or Your Dependent die or sustain a loss for which You believe benefits may be payable under the continued insurance, Proof of the death or loss must be sent to us. In addition to the Proof which is otherwise required for the insurance, the Proof must show that Your Total Disability continued with no interruption from the date we informed You that the continuation was approved until the date of the death or the date of loss.

ELIGIBILITY FOR CONTINUATION [OF CERTAIN INSURANCE] WHILE YOU ARE TOTALLY DISABLED (Continued)

When we receive such Proof with the claim, We will review the claim and if We approve it, will pay any benefit payable under the insurance continued under this section.

[EFFECT OF PREVIOUS CONVERSION]

If You converted any portion of Your Continuation Eligible Life Insurance to an individual policy, We will only pay the life insurance under this section if the individual policy is returned to Us. If it is returned to Us, We will refund to Your estate the premiums paid for such policy without interest, less any debt incurred under such policy.

If You do not return such individual policy to Us, We will pay the life insurance in effect under the individual policy.

We will not pay insurance under both the Group Policy and the individual policy.]

[EFFECT OF PREVIOUS ELECTION TO PORT COVERAGE]

If You ported any portion of Your Continuation Eligible Insurance to a certificate under another policy, We will only pay insurance under this section if the other policy's certificate is surrendered to Us. If it is returned to Us, We will refund to Your estate the premiums paid under such policy without interest.

If You do not return that certificate to Us, We will pay any insurance which applies under the other policy's certificate.

We will not pay insurance under both this Group Policy and the other policy.]

DATE CONTINUATION ENDS

The continuation of Continuation Eligible Insurance under this section without premium payment [may be continued in a reduced amount on account of Your age or the payment of accelerated benefits and] will end at the earliest of:

1. the date You die;
2. the date Your Total Disability ends;
3. the date You do not give Us Proof of Total Disability, as required;
4. the date You refuse to be examined by [Our Physician], as required;
- [5. if You become Totally Disabled before age 63, the date You reach age 65;
6. if You become Totally Disabled on or after age 63, the date 2 years after Your Total Disability began, but not beyond your 70th birthday;
7. with respect to Dependent Life Insurance and Dependent Accidental Death and Dismemberment Insurance, the date you no longer have any Dependents.]

[Option To Convert Your Continuation Eligible Life Insurance]

When a continuation under this section ends, You may buy an individual policy of life insurance from Us. The details of this option are described in the sections entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU and LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS. For the purpose of those sections, you will be considered to cease to be in an eligible class at the end of this continuation. You may not use the conversion option described in those sections if before the end of the Application Period for conversion You return to Active Work in an eligible class and become insured under the Group Policy. You will not be able to convert any of Your Continuation Eligible Life Insurance which You have already converted to an individual policy.]

ELIGIBILITY FOR CONTINUATION [OF CERTAIN INSURANCE] WHILE YOU ARE TOTALLY DISABLED (Continued)

[Option To Port Your Continuation Eligible Insurance

When a continuation under this section ends, You may elect to port to a different policy the insurance which has been continued under this section. The details of this option are described in the At Your Option: Portability subsection of the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section. For the purpose of that section, you will be considered to cease to be in an eligible class at the end of this continuation. You may not use the portability option described in that section if before the end of the Portability Request Period, You return to Active Work in an eligible class and become insured under the Group Policy. You will not be able to port any of Your Continuation Eligible Insurance which You have already converted to an individual policy.]

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:
Bypassed -Name: Certification/Notice Approved-Closed 11/06/2008
Bypass Reason: The requirement listed above is not applicable for this filing submission.
Comments:

Review Status:
Bypassed -Name: Application Approved-Closed 11/06/2008
Bypass Reason: The requirement listed above is not applicable for this filing submission.
Comments:

Review Status:
Bypassed -Name: Outline of Coverage Approved-Closed 11/06/2008
Bypass Reason: The requirement listed above is not applicable for this filing submission.
Comments:

Review Status:
Satisfied -Name: Cover Letter Approved-Closed 11/06/2008
Comments:
 Cover Letter
Attachment:
 Arkansas Cover Letter.doc

Review Status:
Satisfied -Name: ARCERTREAD Approved-Closed 11/06/2008
Comments:
 ARCERTREAD
Attachment:
 ARCERTREAD.10708.pdf

Review Status:
Satisfied -Name: industry_rates_lh_trans Approved-Closed 11/06/2008
Comments:

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industry_rates_lh_trans

Attachment:

industry_rates_lh_trans.pdf

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Product Name: Group Term Life Insurance & Health Insurance
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Satisfied -Name: ARCERTREG19 **Review Status:** Approved-Closed 11/06/2008
Comments:
ARCERTREG19
Attachment:
ARCERTREG19.pdf

SERFF Tracking Number: *META-125889777* *State:* *Arkansas*
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TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *Group Term Life Insurance & Health Insurance*
Project Name/Number: *gcert2000 cp/al/afa/T01-8 MD*

Attachment "Arkansas Cover Letter.doc" is not a PDF document and cannot be reproduced here.



Metropolitan Life Insurance Company
NAIC Company Number: 65978
NAIC Group Number: 241

ARKANSAS FLESCH CERTIFICATION

I certify that the form shown below has achieved the Flesch Reading Ease Score shown below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form No.	Form Description	Flesch Score
GCERT2000 cp/all/afa	Group term life and accident and health form	40.29

Herbert B. Brown Jr.
Vice President

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Metropolitan Life Ins Co. 1 Metlife Plaza – Area 6E Long Island City, NY 11101	NY		241	65978	13-5581829	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Mark Diefenderfer 18210 Crane Nest Drive Tampa, FL. 33647	813-983-4927	813-983-4940	mdiefenderfe@metlife.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	T08-1MD (Arkansas)
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input checked="" type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input checked="" type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9.	Type of Insurance	Group Life and Health Insurance
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10.	Product Coding Matrix Filing Code	L04G.500 and H03G.000
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11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input checked="" type="checkbox"/> Other – form to use with existing certificate Rates <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____
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12.	Filing Submission Date	November 5, 2008	
13	Filing Fee (If required)	Amount <u> \$25.00 </u>	Check Date <u> EFT </u>
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number <u> EFT </u>
14.	Date of Domiciliary Approval	NA	
15.	Filing Description:		
<p>Please see cover letter.</p>			

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16.	Certification (If required)
I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of _____	
Print Name _____	Title _____
Signature _____	Date: _____

LHTD-1, Page 2 of 2

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		T08-1MD (Arkansas)
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Group certificate form	GCERT2000 cp/all/afa	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name Description	Affected Form Numbers		Previous State Filing Number
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1



Metropolitan Life Insurance Company
NAIC Company Number: 65978
NAIC Group Number: 241

ARKANSAS CERTIFICATION
Rule and Regulation 19
Unfair Sex Discrimination in the Sale of Insurance

I certify that this submission meets the provisions of Rule and Regulation 19, and all applicable requirements of the Arkansas Department of Insurance.

A handwritten signature in black ink, which appears to read "Herbert B. Brown Jr.", is written in a cursive style.

Herbert B. Brown Jr.
Vice President