

SERFF Tracking Number: WESA-125917052 State: Arkansas
Filing Company: S.USA Life Insurance Company, Inc. State Tracking Number: 40934
Company Tracking Number: AR-APP-08-001
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life
Project Name/Number: Individual Life Application Revision/AR-APP-08-001

Filing at a Glance

Company: S.USA Life Insurance Company, Inc.

Product Name: Individual Life

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: WESA-125917052 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: AR-APP-08-001

Co Status:

Author: Westmont Associates

Date Submitted: 11/24/2008

State Tr Num: 40934

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 11/25/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Individual Life Application Revision

Project Number: AR-APP-08-001

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/25/2008

State Status Changed: 11/25/2008

Corresponding Filing Tracking Number:

Filing Description:

Submission of Revised Individual Life Applications

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: This filing was not submitted in the Company's state of domicile.

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Company and Contact

Filing Contact Information

(This filing was made by a third party - westmontassociatesinc)

Jennifer Waldron, Supervisor

jenb@westmontlaw.com

SERFF Tracking Number: WESA-125917052 State: Arkansas
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Company Tracking Number: AR-APP-08-001
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
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Project Name/Number: Individual Life Application Revision/AR-APP-08-001

25 Chestnut Street (856) 216-0220 [Phone]
Haddonfield, NJ 08033 (856) 216-0303[FAX]

Filing Company Information

S.USA Life Insurance Company, Inc. CoCode: 60183 State of Domicile: New York
550 Broad Street Group Code: -99 Company Type:
Newark, NJ 07102 Group Name: State ID Number:
(212) 356-0300 ext. [Phone] FEIN Number: 13-4144857

SERFF Tracking Number: WESA-125917052 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: Standard Filing Fee for Forms.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
S.USA Life Insurance Company, Inc.	\$0.00	11/24/2008	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
31616	\$50.00	11/21/2008

SERFF Tracking Number: WESA-125917052 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	11/25/2008	11/25/2008

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Disposition

Disposition Date: 11/25/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: WESA-125917052 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Letter of Authorization		Yes
Supporting Document	Readability Certification		Yes
Form	Application for Conversion		Yes
Form	Amendment to Application		Yes
Form	Application for Life Insurance - Reinstatement		Yes
Form	Application for Accidental Death Benefit Rider/Total Disability Waiver of Premium Benefit		Yes

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Form Schedule

Lead Form Number: A-58d AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A-58d AR	Application/ Enrollment Form	Application for Conversion	Revised	Replaced Form #: Previous Filing #:		A-58d_AR.pdf
	A-60a AR	Application/ Enrollment Form	Amendment to Application	Revised	Replaced Form #: Previous Filing #:		A-60a_AR.pdf
	A-80c AR	Application/ Enrollment Form	Application for Life Insurance - Reinstatement	Revised	Replaced Form #: Previous Filing #:		A-80c_AR.pdf
	A-90a AR	Application/ Enrollment Form	Application for Accidental Death Benefit Rider/Total Disability Waiver of Premium Benefit	Revised	Replaced Form #: Previous Filing #:		A-90a_AR.pdf



SUSA Life Insurance Company, Inc.

APPLICATION FOR CONVERSION

Toll Free: 866-SUSA-123 (866-787-2123) www.susa.com

<p>1. Name and address of person to be insured (Please type or print):</p> <p>_____</p> <p>First Name M.I. Last Name</p> <p>_____</p> <p>Number & Street Address</p> <p>_____</p> <p>City State Zip Code</p> <p>_____</p> <p>Telephone</p>	<p>6. (a) Primary Beneficiary (If more than one to share equally):</p> <p>_____</p> <p>First Name M.I. Last Name</p> <p>_____</p> <p>Relationship To Insured</p> <p>_____</p> <p>First Name M.I. Last Name</p> <p>_____</p> <p>Relationship To Insured</p>
<p>2. Date of Birth: _____</p> <p style="text-align: center;">Month/Day/Year</p>	<p>3. Male <input type="checkbox"/></p> <p>Female <input type="checkbox"/></p>
<p>4. Name of Current Owner:</p> <p>_____</p> <p>First Name M.I. Last Name</p>	<p>6. (b) Secondary Beneficiary (To receive proceeds if primary beneficiary(ies) not living):</p> <p>_____</p> <p>First Name M.I. Last Name</p> <p>_____</p> <p>Relationship to Insured</p>
<p>5. (a) Type of policy to be converted to:</p> <p>_____</p> <p>(b) Conversion Amount: \$ _____</p> <p>(c) Amount of term insurance to be retained: \$ _____</p>	<p>7. How are Premiums to be paid? Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/></p> <p>8. Is Automatic Premium Loan Desired? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>9. Number of present term policy/certificate to be converted: _____</p> <p>10. For Employer Group conversion only: Last day actively at work. _____ Month/Day/Year</p>

The owner of the above-numbered term policy hereby tenders it, in accordance with its provisions relating to conversion, in exchange for a new policy described above; and in that connection agrees that:

- (1) The new policy shall not take effect until the first premium is paid and the term policy/certificate is surrendered, or if any amount of term insurance is to be retained.
- (2) If this application is made within two years of the date of issue of the above-numbered term policy, this application for conversion and the original application for the term policy shall together constitute the application for the new policy and copies thereof shall be attached to and made a part of the new policy.
- (3) If this application is made two years or more after the date of issue of the above-numbered term policy, this application alone shall constitute the application for the new policy and shall be attached to and made a part thereof.
- (4) The periods in the provisions of the new policy entitled "Incontestability" and "Suicide" shall commence on the date of issue of the above-numbered term policy instead of the date of issue of the new policy.
- (5) If the above conversion applies to Employer or Group term life then upon request, if indicated in question 5(a), the new policy may be preceded by Term Insurance for a period not exceeding one year from the conversion date.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ X _____

Date Signature of Applicant/Owner Social Security Number

This Area For Company and Agency Use Only

Agency Name and Number _____ Agent Number _____

Effective Date _____ OMS _____



SUSA Life Insurance Company, Inc.

AMENDMENT TO APPLICATION

Toll Free: 866-SUSA-123 (866-787-2123) www.susa.com

Having made application on _____ for SUSA Life Insurance Company, Inc.
(Date)

on the life of _____

I make the following new answers to be substituted for my previous answers to corresponding questions in said application:

Part No. _____ Question No. _____

I agree that this amendment shall form a part of the aforesaid application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date: _____ X _____
Signature of applicant

Agent Number: _____ Policy/Certificate Number: _____

7. Explain any "Yes" answers to Questions 4, 5, and 6a, and "No" answer to Question 6b. Give names and addresses of hospitals, physicians, dates, conditions, special tests, duration, and treatment, and names of children and spouse where applicable. If necessary, attach extra pages.

Except as stated above, to the best of my knowledge and belief, I am now in good health, and the statements contained herein are true and together with those contained in Part I and Part II if applicable, of my original application are made for the purpose of inducing the Company to reinstate the above-numbered policy or certificate.

AUTHORIZATION: I authorized any physician, medical professional, hospital, clinic, laboratory, medical care facility, insurer, the Medical Information Bureau, organization or person having knowledge of me or my health, my spouse's health or health of the children named above, including but not limited to drug or alcohol use, mental health and confidential HIV related information, to give the Medical Director of S.USA Life Insurance Company, Inc. this information. This Authorization is for the purpose of underwriting life insurance. It is in effect for 2 years from the date shown below, and a photocopy may be accepted as valid.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature of person to be insured _____
Signature of owner, if other than the person to be insured _____

This Area For Company and Agency Use Only

Agency Number _____ Effective Reinstatement Date _____
Agent Number _____

A-80c AR

11/2008

UNDERWRITING YOUR APPLICATION

As you are considering giving S.USA Life Insurance Company, Inc. the opportunity to help satisfy your life insurance needs, we thought you might be interested in learning about our underwriting process.

- Your application, the initial source of information to help us determine your eligibility for insurance, will be promptly and carefully reviewed by experienced, highly skilled underwriters. To expedite your application, please be certain that all changes and corrections you make are initialed.
- Usually, an underwriter will be able to make a decision without getting additional information from doctors, hospitals, etc., and the handling of your application will be quickly completed. Be sure to answer all questions completely and leave no blank spaces.
- If additional underwriting information is needed, you will be kept informed on the status of your application.

For the most part, we find applicants for S.USA Life Insurance Company, Inc. to be in good health. Not subject to unusual accident hazards, and otherwise falling within our underwriting limits of acceptance for insurance at standard rates. However, some applicants present a greater risk due to adverse medical findings or history, or possibly a dangerous occupation or avocation. In these instances, a higher premium may be charged or an application may be declined.

Every effort is made to fairly place each applicant in his or her proper insurance class, so that each person assumes his or her share of the insurance cost. Otherwise, the vast majority who qualify for standard rates would have to bear the extra cost of insuring those who do not qualify, resulting in unnecessarily high premiums for all insureds.

SB-15c AR

3/2002



APPLICATION FOR ACCIDENTAL DEATH BENEFIT RIDER / TOTAL DISABILITY WAIVER OF PREMIUM BENEFIT

USA Life Insurance Company, Inc.

Toll Free: 866-SUSA-123 (866-787-2123) www.susa.com

1. Name of person to be insured (type or print): _____ <div style="display: flex; justify-content: space-between; font-size: small;"> First Name M.I. Last Name </div>	3. (a) Policy/Certificate Number: _____
2. (a) Home Address: _____ Number & Street Address _____ City State Zip Code	4. Amount of Accidental Death Benefit applied for: 1 x Amount of Insurance <input type="checkbox"/> 2 x Amount of Insurance <input type="checkbox"/> (up to a maximum of \$250,000)
(b) Business Address: _____ Number & Street Address _____ City State Zip Code	5. Male <input type="checkbox"/> Female <input type="checkbox"/>
6. Date of Birth: _____	7. Occupation: _____ Describe duties: _____

8. I would like to apply for the following:	Accidental Death Benefit Rider <input type="checkbox"/>	Total Disability Waiver Premium <input type="checkbox"/>
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9. Have you, since making application for the above-numbered policy or certificate: (Check the applicable items) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"></td> <td style="width: 10%; text-align: center; font-size: small;">Yes</td> <td style="width: 10%; text-align: center; font-size: small;">No</td> </tr> <tr> <td>a. Consulted or been examined or treated by any physician or practitioner?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Had any surgery?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Been treated for or been diagnosed as having any illness or injury?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Been a patient in a hospital, clinic, sanatorium, or other medical facility?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. Had electrocardiogram, X-ray, or other diagnostic test (except for HIV)?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed (except for HIV)?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Yes	No	a. Consulted or been examined or treated by any physician or practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	b. Had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	c. Been treated for or been diagnosed as having any illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	d. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	e. Had electrocardiogram, X-ray, or other diagnostic test (except for HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	f. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed (except for HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"></td> <td style="width: 10%; text-align: center; font-size: small;">Yes</td> <td style="width: 10%; text-align: center; font-size: small;">No</td> </tr> <tr> <td>11. (a) Have you ever been treated for mental disorder, alcoholism or any drug habit?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(b) Do you use alcoholic beverages?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">If "Yes" state amount consumed per week _____</td> </tr> <tr> <td>(c) Have you ever used narcotics, barbiturates, amphetamines, hallucinogens or any prescription drug except in accordance with a physician's instructions?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Yes	No	11. (a) Have you ever been treated for mental disorder, alcoholism or any drug habit?	<input type="checkbox"/>	<input type="checkbox"/>	(b) Do you use alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	If "Yes" state amount consumed per week _____			(c) Have you ever used narcotics, barbiturates, amphetamines, hallucinogens or any prescription drug except in accordance with a physician's instructions?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No																																			
a. Consulted or been examined or treated by any physician or practitioner?	<input type="checkbox"/>	<input type="checkbox"/>																																			
b. Had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>																																			
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d. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>																																			
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10. Have you ever been treated for or been diagnosed as having: (a) disease of the heart, lungs, kidney, prostate, bladder, male or female organs, liver, stomach, intestines, brain or nervous system, lymph, endocrine, or other glands; (b) high blood pressure, stroke, cancer or tumor, diabetes, or blood disorder; (c) AIDS (acquired immuno-deficiency syndrome) or ARC (AIDS Related Complex)? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Do you fly other than as a passenger on a regularly scheduled airline? <input type="checkbox"/> Yes <input type="checkbox"/> No																																				

A-90a AR (Please see other side.) 11/2008

**IMPORTANT: Detach and Read Both Sides Before Completing Application.
NOTIFICATION IN ACCORDANCE WITH FEDERAL AND STATE LAW**

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. The inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request and be given the name and address of the reporting agency. You may inspect and receive a copy of your investigative consumer report from the reporting agency.

NOTIFICATION IN ACCORDANCE WITH MEDICAL INFORMATION BUREAU RULES

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurers which operates an information exchange on behalf of its members. If you apply to another Bureau member insurer for life or health insurance coverage, or a claim for benefits is submitted to such insurer, the Bureau, upon request, will supply such insurer with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We may release information in our file to other life insurers to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted.

13. Since making application for the above-numbered policy or certificate, have you applied for or received any pension or disability benefits or made an application for life insurance which was not accepted or which was postponed or accepted at extra premium? (If "Yes", explain in No. 15 below)..... Yes No

14. In the last 5 years have you been convicted for a crime (other than for a minor traffic violation)? (If "Yes", explain in No. 15 below) Yes No

15. Give details of all "Yes" answers to Questions 9 through 12 above. (Include names and addresses of physicians, hospitals, dates, conditions, tests, duration and treatment). If necessary, attach extra pages. _____

Except as stated above, to the best of my knowledge and belief, I am now in good health and the statements contained herein are true and are made for the purpose of inducing the Company to add the Accidental Death Benefit Rider and/or Total Disability Waiver of Premium Benefit to the above-numbered policy/certificate. I agree that: 1) The rider and/or benefit hereby applied for shall not take effect until the first premium is paid and the Accidental Death Benefit Rider and/or Total Disability Waiver of Premium Benefit is delivered to me while I am in good health; 2) A copy of this application shall be attached to and made a part of the above-numbered policy or certificate; 3) This rider is incontestable after it has been in effect during the insured's lifetime for two years from the date of issue of this rider and/or benefit.

AUTHORIZATION: I authorize any physician, medical professional, hospital, clinic, laboratory, medical care facility, insurer, the Medical Information Bureau, organization or person having knowledge of me or my health, including but not limited to drug or alcohol use, mental health and confidential HIV related information, to give the Medical Director of S.USA Life Insurance Company, Inc. this information. I also authorize S.USA Life Insurance Company, Inc. to get an investigative consumer report as described in S.USA Life Insurance Company, Inc.'s **NOTIFICATION IN ACCORDANCE WITH FEDERAL AND STATE LAW**. This Authorization is for the purpose of underwriting me for life insurance. It is in effect for 2 years from the date shown below, and a photocopy may be accepted as valid.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ X _____
 Signature of person to be Insured Social Security Number Certified Under Penalties of Perjury

For Company and Agency Use Only

Agency Number _____ Agent Number _____

Approved _____ Date _____ Declined _____ 1x _____ 2x _____

A-90a AR 11/2008

UNDERWRITING YOUR APPLICATION

As you are considering giving S.USA Life Insurance Company, Inc. the opportunity to help satisfy your life insurance needs, we thought you might be interested in learning about our underwriting process.

- Your application, the initial source of information to help us determine your eligibility for insurance, will be promptly and carefully reviewed by experienced, highly skilled underwriters. To expedite your application, please be certain that all changes and corrections you make are initialed.
- Usually, an underwriter will be able to make a decision without getting additional information from doctors, hospitals, etc., and the handling of your application will be quickly completed. Be sure to answer all questions completely and leave no blank spaces.
- If additional underwriting information is needed, you will be kept informed on the status of your application.

For the most part, we find applicants for S.USA Life Insurance Company, Inc. to be in good health. Not subject to unusual accident hazards, and otherwise falling within our underwriting limits of acceptance for insurance at standard rates. However, some applicants present a greater risk due to adverse medical findings or history, or possibly a dangerous occupation or avocation. In these instances, a higher premium may be charged or an application may be declined.

Every effort is made to fairly place each applicant in his or her proper insurance class, so that each person assumes his or her share of the insurance cost. Otherwise, the vast majority who qualify for standard rates would have to bear the extra cost of insuring those who do not qualify, resulting in unnecessarily high premiums for all insureds.

SB-15c AR 3/2002

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 11/24/2008
Comments:
Attachment:
Certification of Compliance.pdf

Review Status:

Satisfied -Name: Application 11/24/2008
Comments:
Please note that all applicable applications have been included under the Form Schedule Tab.

Review Status:

Satisfied -Name: Cover Letter 11/24/2008
Comments:
Attached is the cover letter for this submission.
Attachment:
Cover Letter.pdf

Review Status:

Satisfied -Name: Letter of Authorization 11/24/2008
Comments:
Attached is a letter authorizing Westmont Associates to submit this filing on the Company's behalf.
Attachment:
SUSA L of A.pdf

Review Status:

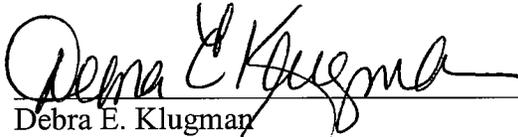
Satisfied -Name: Readability Certification 11/24/2008
Comments:
Attachment:
Readability Certification.pdf

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: S.USA Life Insurance Company, Inc.
Form Title(s) Individual Whole Life/Term Applications
Form Number(s) A-80c AR Individual Application for Reinstatement
A-58d AR Individual Application for Conversion
A-90a AR Individual Application for ADB/WP
A-60a AR Individual Amendment to Application

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Debra E. Klugman
Senior Vice President, General Counsel & Secretary

November 14, 2008
Date



**WESTMONT
ASSOCIATES, INC.**

November 24, 2008

Office of the Commissioner
Arkansas Insurance Department
Life & Health Division
Forms Review Section

RE: S.USA Life Insurance Company, Inc.
NAIC #: 60183
FEIN #: 13-4144857
Individual Life Application Revision Submission
Company Filing #: AR-APP-08-001

Form

Submitted: A-58d AR
A-60a AR
A-80c AR
A-90a AR

To Whom It May Concern:

On behalf of S.USA Life Insurance Company, Inc. (S.USA), please find enclosed S.USA's Individual Life Application Revision filing. An authorization letter permitting Westmont Associates, Inc. to submit this filing is enclosed.

Attached please find revised Individual Life applications which have been amended to include the applicable state required fraud warning language. Also attached are readability and compliance certifications for this submission.

Thank you for your attention to this filing submission. Please review the enclosed items and provide us with your approval. Should you have any questions, please feel free to contact me via e-mail at jenb@westmontlaw.com or by telephone at (856) 216-0220.

Respectfully Submitted,
Jennifer Waldron
Jennifer Waldron
Supervisor

Encl.

cc. E. Catalfumo – S.USA

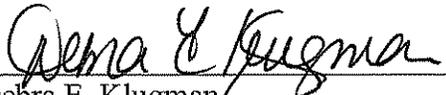


Debra E. Klugman
Senior Vice President,
General Counsel & Secretary
Phone: (212) 356-0327
Fax: (212) 624-0700
dklugman@sbliusa.com

September 24, 2007

RE: S.USA Life Insurance Company, Inc.
NAIC #: 60183 NAIC Group #: 1347
FEIN #: 13-4144857
Letter of Authorization
Filing of Forms, Rates and Rules

In accordance with the applicable statutes and regulations of your state, Nancy Stepanski and Westmont Associates, Inc. is hereby authorized to file form, rate and rule filings on behalf of S.USA Life Insurance Company, Inc.


Debra E. Klugman
Senior Vice President, General Counsel & Secretary

S. USA Life Insurance Company, Inc.
550 Broad Street, Newark, NJ 07102

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: S. USA Life Insurance Company, Inc.

This is to certify that the form(s) referenced below have achieved a Flesch Reading Ease Score as indicated 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 Number	Score
A-80c AR	46
A-58d AR	54
A-90a AR	45
A-60a AR	51



Debra E. Klugman
Senior Vice President, General Counsel & Secretary

November 14, 2008
Date