



*SERFF Tracking Number:* MCHX-125958279                      *State:* Arkansas  
*Filing Company:* OM Financial Life Insurance Company                      *State Tracking Number:* 41169  
*Company Tracking Number:* OMAD 6201 (10-2008)  
*TOI:* L04I Individual Life - Term                      *Sub-TOI:* L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
*Product Name:* OMAD 6201 (10-2008) Indiv Simplified Life Applicat  
*Project Name/Number:* OMAD 6201 (10-2008) Indiv Simplified Life Application - OM Financial Life Ins Co/OMAD 6201 (10-2008) Indiv Simplified Life  
Application - OM Financial Life Ins Co

## Simplified Life Application Filing

Form No: OMAD 6201 (10-2008)

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of OM Financial Life Insurance Company. We have provided an authorization letter for your files.

We are enclosing for your approval a new Simplified Life application, form number OMAD 6201 (10-2008), which will be used exclusively in the Life market. Application OMAD 6201 (10-2008) is new and will not replace any forms currently on file with your Department. This form will be issued by OM Financial Life Insurance Company.

This application will be used with previously approved forms as well as new forms after Departmental approval.

The enclosed application is written in clear and simplified language and has passed the Flesch Reading Test, please see the attached certification. In addition, sections of the application have been bracketed and a statement of variability is attached.

This application will be available electronically so that it may be printed from a computer by an agent for completion and signature.

The forms are in final printed form subject only to changes in font style, margins, page numbers, ink, and paper stock. Printing standards will never be less than those required by law.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call 215-230-7960. Thank you for your assistance.

## Company and Contact

SERFF Tracking Number: MCHX-125958279 State: Arkansas  
 Filing Company: OM Financial Life Insurance Company State Tracking Number: 41169  
 Company Tracking Number: OMAD 6201 (10-2008)  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -  
 Fixed/Indeterminate Premium  
 Product Name: OMAD 6201 (10-2008) Indiv Simplified Life Applicat  
 Project Name/Number: OMAD 6201 (10-2008) Indiv Simplified Life Application - OM Financial Life Ins Co/OMAD 6201 (10-2008) Indiv Simplified Life  
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### Filing Contact Information

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

Diane Gould, Compliance Assistant mcr@mchughconsulting.com  
 McHugh Consulting Resources (215) 230-7960 [Phone]  
 Doylestown, PA 18901 (215) 230-7961[FAX]

### Filing Company Information

OM Financial Life Insurance Company	CoCode: 63274	State of Domicile: Maryland
1001 Fleet Street	Group Code: 2598	Company Type:
Baltimore, MD 21202	Group Name:	State ID Number:
(410) 895-0091 ext. [Phone]	FEIN Number: 52-6033321	

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### Filing Fees

Fee Required? Yes  
 Fee Amount: \$125.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
OM Financial Life Insurance Company	\$125.00	12/19/2008	24641153

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	12/23/2008	12/23/2008

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## **Disposition**

Disposition Date: 12/23/2008

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	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Application		Yes
Supporting Document	Authorization Letter, Form Listing		Yes
Supporting Document	Statement of Variability		Yes
Form	Life Insurance Application		Yes

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## Form Schedule

**Lead Form Number:** OMAD 6201 (10-2008)

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	OMAD 6201 (10-2008)	Application/Life Insurance Enrollment Application Form	Initial		50	OMAD 6201 (10-2008).PDF

**INSURER**

**OM Financial Life Insurance Company**

**PRIMARY INSURED**

Name (First) <u>JANE</u>		(M.I.) <u>Q</u>	(Last) <u>Public</u>	
Home Address <u>11 Two Street</u>		City <u>ANY</u>	State <u>ANYtown</u>	Zip <u>12345</u>
Social Security No. <u>123-45-6789</u>	Sex <u>F</u>	Marital Status <u>S</u>	Date of Birth <u>00-00-000</u>	Place of Birth <u>ANYtown</u>
Currently Employed? <input type="radio"/> Yes <input checked="" type="radio"/> No	Occupation and Duties		Place of Employment	Years w/ Current Employer
Earned Annual Income (from last year's W-2)			Drivers License Number and Issue State <u>P-000-000-000-000 - ANYstate</u>	
Daytime Phone <u>123-456-7899</u>	Evening Phone <u>123-456-5555</u>	Best Time to Call <u>EVENING</u>		Email Address <u>email@email.com</u>

**OTHER INSURED**

Name (First, M.I., Last)			Relationship to Insured			
Home Address			City	State	Zip	
Social Security No.	Sex	Marital Status	Date of Birth	Place of Birth	Height (ft., in.)	Weight (lbs.)
Currently Employed? <input type="radio"/> Yes <input type="radio"/> No	Occupation and Duties		Place of Employment		Years w/ Current Employer	
Earned Annual Income (from last year's W-2)			Drivers License Number and Issue State			
Daytime Phone		Evening Phone		Best Time to Call		Email Address

**OWNER(S)**

(UNLESS OTHERWISE NOTED, THE OWNER WILL BE THE PRIMARY INSURED)

Name (First, M.I., Last)			Relationship to Primary Insured			
Home Address			City	State	Zip	
Home Phone			Email Address			
Date of Birth			Social Security No. or tax I.D.No			

**POLICY/CERTIFICATE INFORMATION**

Product Name <u>Any Product</u>	Amount of Insurance <u>\$100,000</u>	Initial Premium \$\$ <input type="radio"/> Smoker <input checked="" type="radio"/> Non-Smoker
Term: <input checked="" type="radio"/> Level <input type="radio"/> Decreasing	Term Period (Number of Years)	Premium Guarantee Period
Universal Life: <input checked="" type="radio"/> Level <input type="radio"/> Increasing	Planned Premium \$ <u>10,000</u>	
Mode of Payment (For bank draft, complete Bank Draft Plan authorization, and initial payment required.) <input checked="" type="radio"/> Annual <input type="radio"/> Quarterly <input type="radio"/> Bi-Weekly Bank Draft \$ <input type="radio"/> Semi-Annual <input type="radio"/> Monthly Bank Draft <input type="radio"/> Other		Payment in Exchange for Conditional Receipt <u>10,000</u>
Credit Card (See Instructions Page for current company practice) <input type="radio"/> Visa <input type="radio"/> Mastercard	Account Number	Expiration Date Signature to Authorize Credit Card Charge

(No coverage will be effective except in accordance with the terms of the Receipt and unless full initial modal premium payment is submitted.)

**OM FINANCIAL LIFE INSURANCE COMPANY, Baltimore, Maryland**

**ADDITIONAL BENEFITS**

(Not all riders are available with all products or in all states)

- Accelerated Benefit Rider
- Accidental Death Benefit Rider Amount: \$ \_\_\_\_\_
- Critical Illness Rider Amount: \$ \_\_\_\_\_ *Supplemental questionnaire required.*
- Other Insured Rider Amount: \$ \_\_\_\_\_

**PRIMARY INSURED**

- Disability Income Rider
- Accidental Only Disability Income Rider  
Monthly Payout: \$ \_\_\_\_\_  
*Fill out questions 16-19 (pg. 4)*
- 3 month elimination, 2 year benefit
- 6 month elimination, 5 year benefit

**OTHER INSURED**

- Disability Income Rider
- Accidental Only Disability Income Rider  
Monthly Payout: \$ \_\_\_\_\_  
*Fill out questions 16-19 (pg. 4)*
- 3 month elimination, 2 year benefit
- 6 month elimination, 5 year benefit

- Return of Premium Rider  50%  100% (if available)
- Ultimate Income Option Rider (illustration required)
- Waiver of Monthly Deduction Rider  Waiver of Premium Rider (UL only) (Term only)
- Child Rider Amount: \$ \_\_\_\_\_ *Supplemental questionnaire required.*
- Other: \_\_\_\_\_

**BENEFICIARY DESIGNATION –Other Insured Coverage**

*For each beneficiary, list full name, address, date of birth, SSN, relationship to primary insured and % share.*

Primary Beneficiary(ies)	%	Contingent Beneficiary(ies)	%
Child Public	100%		

*Unless otherwise noted on this application, the beneficiary of other persons proposed for coverage will be the Primary Insured.*

**EXISTING INSURANCE**

*List existing personal and business life insurance, disability income, annuity, and long term care coverage. Circle NONE if there is no coverage.*

Insurance Company	Policy Type	Policy #	Life Insurance or Disability			Replacing	NONE
			Income Amount	ADB Amount	Year Issued		1035

1. Have you had any insurance application declined, postponed, rated, modified, or refused for reinstatement? (If yes, provide details):
- Primary Insured**  Y  N  
**Other Insured**  Y  N

**ADDITIONAL INFORMATION**

2. Does any owner, or any person proposed for insurance have any applications or preliminary or informal quote requests currently pending with any other life insurance company, viatical settlement company, or secondary market provider or company?  Y  N

3. Will any portion of the premiums for this insurance be financed by a third party? If yes, a premium financing disclosure statement is required before underwriting can begin.  Y  N

**PERSONAL AND MEDICAL QUESTIONS**

	Primary Insured	Other Insured
1. Is the person proposed for insurance a citizen or permanent resident of the United States? <i>If "No", please complete W8ben form and citizenship questionnaire.</i>	<input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
2. In the past 2 years or within the next 2 years, has the person proposed for insurance traveled or resided outside the United States or Canada? <i>If yes, provide details pg. 4</i>	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
3. In the past 5 years, has the person proposed for insurance made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury? <i>If yes, provide details pg. 4</i>	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
4. In the past 2 years, has the person proposed for insurance filed for bankruptcy? <i>If yes, provide details pg. 4</i>	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
5. In the past 24 months, has the person proposed for insurance contracted for a home mortgage, or refinanced an existing mortgage? <i>If yes, please list the amount and the name of the lending institution.</i>	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
6. In the past 24 months, has the person proposed for insurance gotten married or divorced, had or adopted a child? <i>If yes, please list date here:</i>	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
7. Has the person proposed for insurance ever (a) received care or had treatment for, or (b) been advised by a physician or health care provider to seek treatment for, or (c) consulted with a health care provider regarding:		
a) Coronary Artery Disease, Heart Attack, Coronary Bypass Surgery, Coronary Angioplasty, Coronary Stent, Congenital Heart Disease or Defect, Heart Valve Replacement, Cardiomyopathy, Stroke, TIA (mini stroke), or Aneurysm?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
b) Emphysema, Chronic Obstructive Pulmonary Disease, Sarcoidosis or Cystic Fibrosis?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
c) Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
d) Chronic kidney Disease, end-stage Renal Disease, dialysis, Liver Disease, Cirrhosis, Hepatitis B, or Hepatitis C?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
e) Diabetes with the onset before the age of 35, or insulin dependant, or with complications of vascular or renal disease due to diabetes?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
f) Cancer, Leukemia, Lymphoma, Melanoma or any other internal cancer (do not list basal cell skin cancer)?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
8. Has the person proposed for insurance ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC or HIV by any physician or health care provider?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
9. Is the person proposed for insurance currently bedridden or confined to any hospital, nursing home, or other medical facility?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
10. In the past 5 years, has the person proposed for insurance:		
a) been treated or advised to be treated for alcoholism, alcohol use, any drug/substance use?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
b) been convicted of driving under the influence of alcohol or drugs, been convicted of reckless driving, or had 4 or more moving violations	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
c) been convicted of or pending trial on a felony or are you currently on parole/probation for any offense?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
d) been hospitalized for high blood pressure, any mental nervous disorder, asthma or epilepsy?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
11. In the past 2 years, has the person proposed for insurance engaged in ballooning, bungee jumping, cliff diving, hang gliding, motorized racing, parachuting, mountain or rock climbing, private aviation or any similar hazardous avocation or have plans to engage in any of the above activities in the future?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
12. In the past 12 months, has the person proposed for insurance been advised by a physician to have a surgical operation, diagnostic test, treatment, or other procedure which has not been done?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
13. In the past 12 months, has the person proposed for insurance consulted a physician for chronic cough, unexplained weight loss, fatigue, unexplained gastrointestinal bleeding, shortness of breath or chest pain?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
14. In the past 3 years, has the person proposed for insurance (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication consistently for more than 2 weeks? <i>If yes, please detail the name(s) of medication, dosage and date of last use below.</i>	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
15. In the past 12 months, has the person proposed for insurance smoked cigarettes?	<input type="radio"/> Y <input checked="" type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

Use this space to list medications from question 14:

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Answer the questions on this page ONLY if applying for a disability rider. Page DOES NEED to be included even if not applying for a disability rider.

**ADDITIONAL QUESTIONS**

	Primary Insured	Other Insured
16. In the past 5 years, has the person proposed for insurance been diagnosed with or treated by a physician or medical practitioner for any of the following conditions from which you have not fully recovered: impairment of the eyes or ears, disorder, deformity or pain of the spine, neck, back, arms, hands, legs, feet or joints (including muscles and bones), or any connective tissue disease or auto-immune disorder?	OY <input checked="" type="radio"/> N	OY ON
17. In the past 5 years, has the person proposed for insurance been diagnosed with or treated by a physician or medical practitioner for any type of mental nervous disorder including depression, anxiety or migraines, or any type of reproductive disease or disorder (including complications due to pregnancy)?	OY <input checked="" type="radio"/> N	OY ON
18. In the past 7 years, has the person proposed for insurance had any illness, disease or injury that is not included in other answers?	OY <input checked="" type="radio"/> N	OY ON
19. In the past 6 months, has the person proposed for insurance been working full-time (minimum of 30 hours per week) and performing each and every duty of his/her regular occupation in the usual and customary manner?	OY <input checked="" type="radio"/> N	OY ON

Detail all Yes answers (Include name and address of treating physician, diagnosis, date of diagnosis, and location of medical records).

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**FRAUD WARNING NOTICE**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may be subject to criminal and civil penalties.**

*(Please review the notice that applies in your state)*

- AR/LA:** 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.
- CO:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies
- DC:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- KY/OH:** I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud. \_\_\_\_\_ (Owner's Initials).
- ME:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.
- NJ:** Any person who includes any false or misleading information on an application for an insurance policy/certificate is subject to criminal and civil penalties.
- OK:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- NM/PA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Authorizations/Verifications

I have read the questions and answers on this application. The statements made in this application are: complete; true; and correctly recorded. I agree that: a copy of this application will form a part of any certificate/policy issued; and that no agent can pass on insurability or modify any certificate issued by the Insurer. I also agree, that except as provided in this application's Receipt, if issued, no insurance will take effect unless and until both of the following conditions are satisfied during each proposed insured's lifetime and continued good health: (1) a policy is delivered to and accepted by the Owner; and (2) the full initial premium for the mode of payment chosen is paid at our Home Office.

I acknowledge that I have received, read and understand the notices required by: the Medical Information Bureau, Inc.; and the Federal Fair Credit Reporting Act regarding investigative consumer reports.

I authorize any licensed physician, medical practitioner, hospital, clinic, the Veterans Administration, laboratory or other medical or medically-related facility, the Medical Information Bureau, Inc., insurance companies, a consumer reporting agency, prescription records, Pharmacy Benefit Manager, and my employer to give to the Insurer, its reinsurers, or other designee, medical and other information which may be pertinent to the evaluation regarding me or any member of my family who is applying for life insurance.

I also authorize the Insurer to obtain an investigative consumer report on me or on any member of my family who is also applying for life insurance. I understand that I am entitled to be interviewed by any consumer reporting agency which may be requested to prepare such a report as long as I can reasonably be contacted during normal business hours. Check if interview requested: 0

I understand that if my coverage includes an Accelerated Benefit Rider and I am later diagnosed with a terminal illness as defined by that Rider, I may receive a specified portion of my benefits early, and the amount payable to my beneficiary at the time of my death will be reduced by that amount. I understand that receipt of benefits may be taxable, and that the Insurer recommends that I consult with a tax advisor prior to exercising any rights under this Rider, if applicable.

I further understand that if I am purchasing a life event simplified term life product, the life event information I supplied will be relied upon to determine my eligibility for that product, in conjunction with my health information. As such, inaccurate information about my life event may result in a denial, rating, or rescission of my insurance coverage.

I authorize the Insurer and/or its reinsurer(s) to release information in my file to other insurance companies to which I may apply for life or health insurance coverage or to which a claim may be submitted.

This Authorization will be valid from the date signed for a period of 30 months; a photographic copy of this Authorization will be as valid as the original; I, or any of our representatives are entitled to receive a copy of this Authorization.

I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits. I understand that the policy language and communications with the company will be conducted in English. Tengo entendido que el idioma de la póliza y las comunicaciones con la compañía serán en Ingles.

Certification: Under the penalties of perjury, I certify that my Social Security or Tax Identification Numbers provided on this form are true, correct and complete

Signed at (City and State) on (Date) Antietam USA 10/04/00

Signature of Primary Insured age 15 or more Jane Q Public

Signature(s) of Additional Insured(s) age 15 or more

Signature of Owner(s) (if not the Primary Insured or if Primary Insured is less than age 18)

PRIMARY INSURED IDENTIFICATION

Identification # P-000-000-600-000 State Anystat

Type of Identification:

- State Issued Immigration Military Passport Other (specify)

OTHER INSURED IDENTIFICATION

Identification # State

Type of Identification:

- State Issued Immigration Military Passport Other (specify)

AGENT CERTIFICATION

1) I have asked the questions contained in this application of the Insured(s) and Owner and duly recorded the answers; 2) to the best of my knowledge there is nothing affecting the insurability of any persons proposed for insurance as stated in this application; 3) if the initial premium was paid with the application, I have remitted it to the Insurer and delivered a Conditional Receipt to the Owner; 4) if Disclosure Statements are required by the state, I have given them to the applicant; 5) I have witnessed the signatures on this application. 6) I have verified the identify of the Primary Insured, Other Insured and Owner(if other than insured) through an examination of a state or federal government photo identification card provided by the Primary Insured, Other Insured and/or Owner such as a driver's license or passport.

To the best of my knowledge, this application does replace does not replace existing life insurance or annuities.

If so, will this replacement be considered a 1035 Exchange? Yes No

Signature of Agent Any Agent Date 00/00/0000

Print Agent's Name Any Agent Agent Number 12345

Agent's Phone Number 123-555-1111 Agent's Fax Number 123-555-1111 Agent's Email Address email@email.com

If Bank Representative: Name of Financial Institution Any Bank Branch # 123 Employee # 456

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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 12/19/2008  
**Comments:**  
**Attachments:**  
 Readability Certification.PDF  
 Certification of Compliance Rule 19.PDF  
 Certification of Compliance Bulletin 11-83.PDF  
 Certification of Compliance Regulation 49.PDF

**Review Status:**  
**Satisfied -Name:** Cover Letter 12/19/2008  
**Comments:**  
**Attachment:**  
 Cover Letter.PDF

**Review Status:**  
**Satisfied -Name:** Application 12/19/2008  
**Comments:**  
 Please see Forms Schedule.

**Review Status:**  
**Satisfied -Name:** Authorization Letter, Form Listing 12/19/2008  
**Comments:**  
**Attachments:**  
 Authorization Letter.PDF  
 Form Listing.PDF

**Review Status:**  
**Satisfied -Name:** Statement of Variability 12/19/2008  
**Comments:**

*SERFF Tracking Number:* MCHX-125958279                      *State:* Arkansas  
*Filing Company:* OM Financial Life Insurance Company                      *State Tracking Number:* 41169  
*Company Tracking Number:* OMAD 6201 (10-2008)  
*TOI:* L04I Individual Life - Term                      *Sub-TOI:* L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
  
*Product Name:* OMAD 6201 (10-2008) Indiv Simplified Life Applicat  
*Project Name/Number:* OMAD 6201 (10-2008) Indiv Simplified Life Application - OM Financial Life Ins Co/OMAD 6201 (10-2008) Indiv Simplified Life  
Application - OM Financial Life Ins Co

**Attachment:**

Statement of Variability.PDF



## READABILITY CERTIFICATION

**Company Name:** OM Financial Life Insurance Company

I hereby certify, that the form listed below has the following readability score as calculated by the Flesch Reading Ease Test.

Form Number	Score
OMAD 6201 (10-2008)	50.3



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Jo Ann Grant  
Vice President-Product Implementation

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November 17, 2008  
Date

## **Certificate of Compliance with Arkansas Rule and Regulation 19**

Insurer: OM Financial Life Insurance Company

Form Number(s): OMAD 6201 (10-2008)

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



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Signature of Company Officer

Jo Ann Grant

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Name

Vice President-Product Implementation

---

Title

December 8, 2008

---

Date

**STATE OF ARKANSAS**

**Certification**

Name of Company: OM Financial Life Insurance Company

The above named company certifies that Life Insurance Application Form OMAD 6201 (10-2008) has been reviewed and complies with Arkansas Insurance Department Guidelines identified in its Bulletin No. 11-83.



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Jo Ann Grant  
Print or Type Name

\_\_\_\_\_  
Vice President, Product Implementation  
Title

## CERTIFICATE OF COMPLIANCE

Insurer: OM Financial Life Insurance Company

Form Numbers: OMAD 6201 (10-2008)

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



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Signature of Company Officer

Jo Ann Grant

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Name

Vice President, Product  
Implementation

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Title

December 8, 2008

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Date

.....  
**McHugh Consulting Resources, Inc.**

December 19, 2008

**Submitted via SERFF**

Julie Benafield Bowman  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

**RE: Old Mutual Financial Life Insurance Company**  
NAIC # 63274, FEIN: 52-6033321

**Simplified Life Application Filing**  
Form No: OMAD 6201 (10-2008)

Dear Commissioner Bowman:

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of OM Financial Life Insurance Company. We have provided an authorization letter for your files.

We are enclosing for your approval a new Simplified Life application, form number OMAD 6201 (10-2008), which will be used exclusively in the Life market. Application OMAD 6201 (10-2008) is new and will not replace any forms currently on file with your Department. This form will be issued by OM Financial Life Insurance Company.

This application will be used with previously approved forms as well as new forms after Departmental approval.

The enclosed application is written in clear and simplified language and has passed the Flesch Reading Test, please see the attached certification. In addition, sections of the application have been bracketed and a statement of variability is attached.

This application will be available electronically so that it may be printed from a computer by an agent for completion and signature.

The forms are in final printed form subject only to changes in font style, margins, page numbers, ink, and paper stock. Printing standards will never be less than those required by law.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call 215-230-7960. Thank you for your assistance.

Sincerely,

A handwritten signature in cursive script that reads "Betty Dabrowski".

Betty Dabrowski  
Consultant  
Telephone: (215) 230-7960  
Fax: (215) 230-7960  
[mcr@mchughconsulting.com](mailto:mcr@mchughconsulting.com)



**OLD MUTUAL**  
Financial Network

Old Mutual Financial Network  
1001 Fleet Street  
Baltimore, Maryland 21202  
PH 410.895.0100  
1.888.697.LIFE  
FX 410.895.0162

OM FINANCIAL LIFE INSURANCE COMPANY  
OM FINANCIAL LIFE INSURANCE COMPANY OF NEW YORK

January 1, 2008

NAIC Company Code: 63274

To: The Insurance Commissioner

Re: Authorization

This letter, or a copy thereof, will authorize the consulting firm of McHugh Consulting Resources, Inc., 350 South Main, Suite 103 Doylestown, PA 18901, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

OM Financial Life Insurance Company

BY:

JoAnn Grant  
Vice President

**w w w . o m f n . c o m**

Old Mutual Financial Network is the marketing name for OM Financial Life Insurance Company (Home Office, Baltimore, MD);  
and OM Financial Life Insurance Company of New York (Home Office, Purchase, NY).

**OM Financial Life Insurance Company**

<b>Form Number</b>	<b>Description</b>
OMAD 6201 (10-2008)	Life Insurance Application

## STATEMENT OF VARIABILITY

Simplified Life Application	OMAD6201 (10-2008)
<b><u>Item</u></b>	<b><u>Explanation</u></b>
Primary Insured, Other Insured, Owner(s), Policy/Certificate Information	John Doe Information, varies on new issues.
Additional Benefits	To allow for flexibility in changing rider availability.
Beneficiary Designation	John Doe Information, varies on new issues- Primary and or Contingent Beneficiaries percentages must up to 100%.
Existing Insurance	John Doe Information, varies on new issues
Primary Insured Identification	John Doe Information, varies on new issues
Other Insured identification	John Doe Information, varies on new issues
Agent Certification	John Doe Information, varies on new issues