

SERFF Tracking Number: MTLC-125938817 State: Arkansas
Filing Company: MTL Insurance Company State Tracking Number: 41105
Company Tracking Number: 6300-08
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Insurance Application
Project Name/Number: Life Insurance Application/Form 6300-08

Filing at a Glance

Company: MTL Insurance Company
Product Name: Life Insurance Application SERFF Tr Num: MTLC-125938817 State: ArkansasLH
TOI: L08 Life - Other SERFF Status: Closed State Tr Num: 41105
Sub-TOI: L08.000 Life - Other Co Tr Num: 6300-08 State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Linda Bird
Author: Laura Callahan Disposition Date: 12/17/2008
Date Submitted: 12/11/2008 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: Life Insurance Application Status of Filing in Domicile: Pending
Project Number: Form 6300-08 Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 12/17/2008
State Status Changed: 12/17/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:
Form 6300-08 AR is a new form being submitted for approval. This form is an application for Life Insurance.

Company and Contact

Filing Contact Information

Laura Callahan, Product Filing Coordinator CallahanL@mutualtrust.com
1200 Jorie Blvd. (630) 684-5319 [Phone]
Oak Brook, IL 60522 (630) 684-5487[FAX]

SERFF Tracking Number: MTL-125938817 State: Arkansas
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Filing Company Information

MTL Insurance Company CoCode: 66427 State of Domicile: Illinois
1200 Jorie Blvd. Group Code: -99 Company Type: Life
Oak Brook, IL 60522 Group Name: State ID Number:
(800) 323-7320 ext. [Phone] FEIN Number: 36-1516780

SERFF Tracking Number: MTL-125938817 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: 1 form @ \$50. ea
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MTL Insurance Company	\$50.00	12/11/2008	24482018

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	12/17/2008	12/17/2008

SERFF Tracking Number: MTL-125938817 State: Arkansas
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Disposition

Disposition Date: 12/17/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *MTLC-125938817* State: *Arkansas*
 Filing Company: *MTL Insurance Company* State Tracking Number: *41105*
 Company Tracking Number: *6300-08*
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
 Product Name: *Life Insurance Application*
 Project Name/Number: *Life Insurance Application/Form 6300-08*

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

SERFF Tracking Number: *MTLC-125938817* State: *Arkansas*
 Filing Company: *MTL Insurance Company* State Tracking Number: *41105*
 Company Tracking Number: *6300-08*
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
 Product Name: *Life Insurance Application*
 Project Name/Number: *Life Insurance Application/Form 6300-08*

Form Schedule

Lead Form Number: 6300-08 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 6300-08 AR	Application/Enrollment Form	Life Insurance Application	Initial		54	Form 6300-08 AR.pdf



MTL INSURANCE COMPANY

A member of the MUTUAL TRUST FINANCIAL GROUP

1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269

Toll Free: 1-800-323-7320

APPLICATION FOR LIFE INSURANCE

INSTRUCTIONS:

1. All questions must be answered. Any changes must be initialed by the Applicant. Lines drawn through questions and "N/A" are not acceptable; "NONE" must be used instead.
2. The OWNER'S SOCIAL SECURITY NUMBER OR TAXPAYER IDENTIFICATION NUMBER must be provided in the Application (Question 4d). If the Owner is other than the Insured, the Owner's signature is required. Owner must also complete and sign page ten.
3. Medical Questions 21-28 should be completed even though a medical or paramedical examination is required. Failure to do so may result in an unnecessary delay.

TABLE OF CONTENTS:

Page 2	Conditional Receipt Consumer Notice
Pages 3 - 7	Application for Life Insurance (Part I)*
Page 8	Agent's Report*
Page 9	HIPAA Medical Information Authorization*
Page 10	Owner's Tax Identification Number Certification*
Page 11	Underwriting Authorization*
Page 12	Pre-Authorized Payment Plan Request*

**Signature(s) Required*

How to speed your case through Underwriting

1. Complete all forms legibly and fully. Leaving blanks causes delays and often also means an amendment on delivery.
2. Schedule any necessary requirements, such as an exam, EKG, blood and urine tests promptly.
3. Give full addresses for any doctors named in this application, including phone numbers.
4. Track your applications through our weekly pending report sent to your General Agent or go to our agent website at <https://agent.mutualtrust.com>.
5. Fax completed applications to 800-522-0449.

Received from _____ a check in the amount of \$ _____ paid with this life insurance application to MTL Insurance Company. The Application bears the same date as this Receipt. I have advised each proposed insured and owner of the terms, conditions, and limitations of this Conditional Receipt. No agent is authorized to alter the terms of this Receipt, waive any terms, requirements or conditions, or pass on insurability.

Agent Signature _____ Date _____

TERMS, CONDITIONS AND LIMITS: The life insurance you applied for will not provide insurance coverage unless a contract is delivered to you. However, subject to the terms, conditions, and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy/certificate applied for will become effective as of the Effective Date, which shall be the **latest** date of the following events:

- Signing of all parts of the Application, including any supplement, addenda, or amendment to the Application, and completion of any medical examination portion of the application;
- Date requested in the Application that is agreed to by the Insurer;
- The full initial premium for mode of payment chosen is received at our Home Office;
- Any additional information required by us, including attending physician statements/reports, is received at our Home Office.

This Receipt will provide no life insurance unless **each** of the following Requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- As of the Effective Date, each person proposed to be insured is found to be insurable exactly as applied for in the Application pursuant to the Insurer's underwriting rules and standards, without any modification as to this insurance product, amount of insurance coverage, or premium rate;
- The payment taken with the Application is not less than the full initial premium for the mode of payment chosen and is honored immediately upon presentation;
- All medical information required by the Insurer is received at the Insurer's Home Office within 60 days of the completion of the Application; and

If all requirements are not met, or the person(s) to be insured dies by suicide, the insurer's liability shall be limited to a full premium refund.

The aggregate amount of life insurance provided on the life of any person proposed to be insured which may become effective under this Receipt shall be the **lesser** of the amount applied for or \$250,000.00.

All premium checks must be made payable to the MTL Insurance Company. DO NOT make any check payable to the agent or leave the payee blank. We do not accept third party checks.

CONSUMER NOTICE

****THIS SECTION MUST BE DETACHED AND GIVEN TO THE PRIMARY INSURED AND GIVE A COPY TO EACH ADDITIONAL INSURED****

THANK YOU for your application for insurance. As part of the normal underwriting procedure, an investigative consumer report including information as to your character, general reputation, personal characteristics, and mode of living may be obtained. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our New Business Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs and want to assure you that your application will receive the most prompt and favorable consideration possible.

PLEASE NOTE that information regarding your insurability will be treated as confidential, except that MTL Insurance Company or its reinsurer(s) may make a brief report thereon to the Medical Information Bureau. This is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Bureau will supply that company with information it may have in its files.

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 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 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 617-426-3660 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL INSURANCE COMPANY
 1200 Jorie Boulevard Oak Brook, Illinois 60523-2269
APPLICATION FOR LIFE INSURANCE

1. Persons Proposed for Coverage

Print First Name, Middle Initial, Last Name	Occupation	SSN	Relationship to Primary Insured	State of Birth	Date of Birth			Age Nearest Birthday	Sex	Marital Status	Height		Weight
					Mo.	Da.	Yr.				Ft.	In.	
a.			Primary Insured										
b.													
c.													
d.													
e.													
f.													
g.													

2. Primary Insured's Residence Address (give addresses for 5 years - current first, then most recent former, etc.)

Street Address or Rural Route (No PO Boxes)	City and State	Zip	Phone Number	Time There Yrs. Mos.
			Not Applicable	
			Not Applicable	

3. Primary Insured's Business Address (present employer first, then most recent former employer)

Employer	Street Address	City and State	Zip	Phone Number	Time There Yrs. Mos.
				Not Applicable	

4. OWNER - (Question 4d must always be completed)

a. Give full name of Owner if other than Primary Insured. Relationship to Insured Birth Date
 Owner _____

b. Upon death, the rights of the deceased Owner shall pass to the estate of the Owner, unless otherwise specified below:
 Contingent Owner Relationship to Insured Birth Date

c. All mail to be sent to Owner(s) at: (Complete if different than #2 above.)
 Street Address _____ City & State _____ Zip _____ Phone _____

d. Owner's Social Security or Tax ID Number: Individual Social Security No. Corporation Partnership Trustee

Under penalties of perjury, I certify that this tax number is correct and that I am not subject to backup withholding.

5. Do you have any existing individual life insurance or annuity contracts on the life of any proposed Insured?

YES NO (If "yes", give details below)

Name of Proposed Insured	Company	Policy Number	Amount	Year Issued	Accidental Death Amount	Business Insurance	
						Yes	No
a.							
b.							
c.							
d.							
e.							
f.							
g.							

6. Traditional Life on the _____ Plan

\$ _____ Initial Face Amount

Money Purchase \$ _____ Premium

Waiver of Premium

2 year "own occupation"

5 year "own occupation"

\$ _____ Accidental Death

\$ _____ Children Insurance

Term Rider

Type _____ Amount \$ _____

Paid up Additions Rider

Type _____

Face amount or Premium \$ _____

_____ Years payable (annual rider only)

\$ _____ Purchase Option

Automatic Premium Loan (permanent plans only)

Accelerated Death Benefit Rider

6A. Dividends:

To be paid in cash To apply on premiums

To buy paid up additions One-year term (PUA's)

To accumulate at interest

One Year Term equal to the cash value of the basic plan plus any excess current dividend applied to one of the above (designate which one)

To buy one year term only

Maximum Accumulation Dividend Option (Must have an Annual Paid up Additions Rider with this option)

7. Flexible Premium Adjustable Life on the _____ Plan

\$ _____ Initial Face Amount

Planned Annual Premium \$ _____

Death Benefit Option

A Face Amount plus Account Value

B Face Amount

C Face Amount plus Paid Premiums minus Partial Withdrawals

No Lapse Period

20 Year 30 Year 40 Year

Death Benefit Calculation Test

Guideline Premium Cash Value Accumulation

Waiver of Monthly Deduction Rider

\$ _____ Accidental Death

\$ _____ Children Insurance

\$ _____ Purchase Option

\$ _____ Additional Insured Rider

_____ Proposed Insured

\$ _____

7A. Dividends

To be paid in cash

To apply toward Account Value

8. Mode of premium payment desired:

Annual Semi-Annual Quarterly

Pre-Authorized Check (PAC)

Other _____

9. Has any Proposed Insured, within the last ten years, been declined, postponed or refused reinstatement for life or health insurance or been offered a policy with an extra premium or otherwise not as applied for?

Yes No (If "yes," state person, company, date and details.)

10. Are any other applications for insurance on the life of any Proposed Insured now pending or contemplated?

Yes No (If "yes," state amount, person, company and details.)

11. Is this policy applied for intended to replace existing life insurance or annuities on the life of any Proposed Insured?

Yes No (If "yes," give company, person, policy number, amount, type and issue date of policies.)

12. Are all Proposed Insureds citizens of the U.S.A.?

Yes No (If "no," give details, name of person and the present status.)

13. Has any Proposed Insured ever been indicted for or convicted of a felony?

Yes No (If "yes," explain.)

14. Has any Proposed Insured within the past five years:

a. Engaged in any kind of Racing, Underwater Diving, Sky Diving, Parachuting, Ballooning, Hang Gliding, Climbing or Mountaineering, or does any Proposed Insured intend to do so?

Yes No (If "yes," complete Avocation Supplement.)

b. Been convicted of driving while intoxicated or reckless driving or of two or more other moving violations, or had a drivers license suspended or revoked?

Yes No (If "yes," give details, and name of person.)

c. Give the following information for any Proposed Insured who is a licensed driver:

Name	License No.	State	Exp.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

d. Give the following information for the Owner if other than Primary Insured:

Name	Lic. / ID No. & Type	State	Exp.
_____	_____	_____	_____
_____	_____	_____	_____

15. Has any Proposed Insured, within the past three years, flown in any type of aircraft as a pilot, student pilot or crew member, or does any Proposed Insured intend to do so in the next twelve months?

Yes No (If "yes," complete Aviation Supplement.)

16. Does any Proposed Insured contemplate leaving the U.S.A. for travel or residence?

Yes No (If "yes," explain.)

PART I OF APPLICATION (Continued)

The applicant has made a payment of \$ _____, for which a Conditional Receipt, bearing the same date as this application, has been issued, and the terms and conditions of said Conditional Receipt are hereby accepted. (Do not insert amount unless payment is actually made.)

The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, a policy issued and delivered and the full first premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy shall take effect as of the date of issue shown therein; PROVIDED, however, that if payment is made in exchange for a Conditional Receipt bearing the same date as Part I of this application, insurance shall take effect if the conditions stated in said receipt are satisfied;
3. That if the Company should issue a policy different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by recording the change in the space entitled "Home Office Endorsements," and the acceptance of any policy issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, any amendment relating to amount, classification, plan of insurance or benefits shall be made only with the written consent of the Insured and the Applicant if other than the Insured.

I/We 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, or of any of my minor children who are to be insured, to give to the MTL Insurance Company any such information. This authorization shall permit the above named company, its reinsurer(s) or its representative, and any consumer reporting agency to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. A photocopy of this authorization shall be as valid as the original. This authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and the Medical Information Bureau, and authorize the company to obtain a consumer investigative report if deemed necessary.

I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me during the hours of _____ and _____. Telephone number of Proposed Primary Insured _____.

Signed at _____ Date _____
(City and State)

Signature of Proposed Primary Insured (Age 15 or over)

Signature of Owner if other than Proposed Primary Insured
(Include Title/Relationship)

Signature of Spouse (If proposed for coverage)

Signature of Parent/Legal Guardian if minor (Under Age 15)

Signature of Other Proposed Insured (Age 15 or over)

Signature of Witness (Agent)

Signature of Other Proposed Insured (Age 15 or over)

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.

AGENT'S CERTIFICATION: To the best of my knowledge, a replacement of life insurance or annuities is is not involved in this transaction. I also certify that prior to signing this application, I delivered to the Applicant any proposal, outline of coverage, Buyer's Guide, comparison and/or disclosure statement required by Federal Law or by the law in the state where this application was signed.

Date _____ Signature of Agent _____



MTL INSURANCE COMPANY

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1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269

Toll Free: 1-800-323-7320

Authorization for Release of Medical Information for the purpose of applying for life insurance

This authorization complies with the HIPAA Privacy Rule.

Name of Proposed Insured/Patient:

(Last)

(First)

(Middle)

(Maiden)

(Date of Birth)

I/We authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to MTL Insurance Company ("the Company") and its agents, employees, and representatives including retrieval service companies. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I/we acknowledge that any agreements I/we have made to restrict our protected health information do not apply to this authorization and we instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider to release and disclose our entire medical record without restriction.

I/We understand this authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for life insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I/We understand this consent may be revoked in writing at anytime. This consent may not be revoked to the extent that disclosure of information has already occurred, prior to the receipt of revocation by the Proposed Insured(s). Authorization will be considered valid for a period of time not to exceed 24 months from the date of the policy. A photocopy of this authorization is to be considered as valid as the original. A copy of this authorization will be provided by the Company upon request.

IMPORTANT: This authorization must be signed and dated by all Applicants as required. (This includes your spouse and all dependents age 15 or over who are applying for coverage.) Missing signatures or dates may cause a delay in processing.

Primary Insured's Signature: **X** _____ Date Signed: ____/____/____
Mo. Day Yr.

Spouse's Signature (ONLY if to be insured): **X** _____ Date Signed: ____/____/____
Mo. Day Yr.

Signature of other Proposed Insured (Age 15 or over): **X** _____ Date Signed: ____/____/____
Mo. Day Yr.

Signature of other Proposed Insured (Age 15 or over): **X** _____ Date Signed: ____/____/____
Mo. Day Yr.

Signature of other Proposed Insured (Age 15 or over): **X** _____ Date Signed: ____/____/____
Mo. Day Yr.

Owner's Tax Identification Number Certification

Tax Identification Number _____

Individual Social Security No. Corporation Partnership Trustee Other _____

Under penalties of perjury, I certify that;

1. The number shown on this form is my correct Tax Identification number; and
2. I am not subject to backup withholding because; (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding.
3. I am a U. S. person (including a U.S. resident alien).

You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Date Signed

Signature of Owner



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1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269

Toll Free: 1-800-323-7320

AUTHORIZATION FOR PURPOSES OF DISCLOSURE OF INFORMATION FOR UNDERWRITING PURPOSES

I, the undersigned, authorize MTL Insurance Company to disclose certain personal and confidential information to my MTL Insurance agent and his or her agency for the purpose of reviewing this information and explaining MTL Insurance Company's underwriting procedures and decisions or other insurance related actions concerning my application. I understand that the information covered by this Authorization includes personal information, including, but not limited to, health information about me collected by MTL Insurance Company in the course of its underwriting practices.

I understand that MTL Insurance Company's employees, agents, and representatives are required to adhere to HIPAA policies and are to receive and use personal information for the express purposes of processing my insurance application along with any other necessary and related insurance practice.

I also understand that I may revoke this Authorization at any time by sending MTL Insurance Company written notification of my revocation, except to the extent of any action taken or information received in reliance on this Authorization prior to MTL Insurance Company's receipt of the revocation. If this Authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

This Authorization is valid for a period of twenty-four (24) months from the date of my signature below. A copy of this Authorization may be used in place of the original.

Name of Individual Whose Information is Covered by this Authorization *(Please Print)*

Signature of Individual or Representative

Date

Name of Representative with Authority to Act on Behalf of the Individual Whose Information is Covered by this Authorization, If Applicable *(Please Print)*

Relationship of Representative to Individual *(If Applicable and Proof Required)*



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1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269
Toll Free: 1-800-323-7320

Pre-Authorized Payment Plan Request

New Plan

Add to Existing Plan

Change of Bank

I want to make premium payments through the **Pre-Authorized Payment Plan**. I instruct MTL Insurance Company to make monthly withdrawals from the account I have specified and pay premiums on the policy(ies) listed. Make the deduction on the _____ day of each month, beginning _____ (month / year).

Please Note: The day specified must be the 1st through the 28th only - if you choose the 29th, 30th, or 31st, the deduction will occur on the 28th. If a day is not specified, the deduction will be on the same day of the month as the Policy Issue Date.

Policy Number(s)

Draw an additional \$_____ (minimum \$25.00) each month and apply it to reduce the loan on Policy No._____. If this monthly payment exceeds the amount needed to repay the loan completely, the deduction will be adjusted to the payoff amount and this part of the agreement will end.

I understand and agree that

1. The Plan will be effective when approved by the Company.
2. The Company will send no premium notices for policies on the Plan.
3. This Plan may be stopped by the Owner, the Depositor if other than the Owner, or by the Company at any time upon written notification.
4. If the Plan is terminated for any reason, premiums will be payable as provided in the policy.

Date Signed

Depositor(s)

Owner (other than Depositor)

**Attach Specimen
Check Here**

Bank Name _____

Address _____

Account Number _____

Type of Account _____ Checking _____ Savings

<i>SERFF Tracking Number:</i>	<i>MTLC-125938817</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>MTL Insurance Company</i>	<i>State Tracking Number:</i>	<i>41105</i>
<i>Company Tracking Number:</i>	<i>6300-08</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 Insurance Application</i>		
<i>Project Name/Number:</i>	<i>Life Insurance Application/Form 6300-08</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MTL-125938817 State: Arkansas
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Insurance Application
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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

12/09/2008

Comments:

Attachments:

STATE OF ARKANSAS compliance form.pdf
Readability.pdf

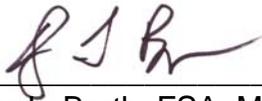
STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Company Name: MTL Insurance Company

Form Title(s): Life Insurance Application

Form Numbers(s): 6300-08 AR

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19 and 49, as well as the other laws and regulations of the State of Arkansas.



Roger L. Barth, FSA, MAAA
Vice President

December 11, 2008
Date

CERTIFICATION OF READABILITY

State of

Form Number

Flesch Readability Score

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations in the state of

_____.

Company

Signature

Name

Title

Date