

SERFF Tracking Number: CSLI-125550478 State: Arkansas
Filing Company: Citizens Security Life Insurance Company State Tracking Number: 38446
Company Tracking Number:
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Group EOI Supplemental Application
Project Name/Number: Voluntary Group Life/

Filing at a Glance

Company: Citizens Security Life Insurance Company

Product Name: Group EOI Supplemental Application SERFF Tr Num: CSLI-125550478 State: ArkansasLH

TOI: L04G Group Life - Term

SERFF Status: Closed

State Tr Num: 38446

Sub-TOI: L04G.500 Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Authors: Rickie Bolduc, James Head

Disposition Date: 04/01/2008

Date Submitted: 03/18/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Voluntary Group Life

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 11/14/2007

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 04/01/2008

State Status Changed: 04/01/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed please find our Evidence of Insurability Supplemental Application for your review and approval. This new form will be used with our Voluntary Group Life product, Master Policy GTL (08/05) and Certificate CERT – GTL (08/05). The master contract and certificate were filed and approved in Arkansas on December 13, 2005.

The Evidence of Insurability Supplemental Application will be completed by employees who are applying for amounts of coverage that are above the guarantee issue amount. Also, employees and dependents whose coverage is subject to

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underwriting approval because they are "late" enrollees, who did not enroll for coverage when they were first eligible, will complete the form.

Company and Contact

Filing Contact Information

Rickie Bolduc, Actarial Associate rbolduc@cslico.com
PO Box 436149 (502) 244-2431 [Phone]
Louisville, KY 40253-6149 (502) 244-2439[FAX]

Filing Company Information

Citizens Security Life Insurance Company CoCode: 61921 State of Domicile: Kentucky
12910 Shelbyville Road, Suite 300 Group Code: 1310 Company Type: Life and Accident
and Health

PO Box 436149
Louisville, KY 40253-6149 Group Name: Citizens Financial State ID Number:
Group
(502) 244-2420 ext. [Phone] FEIN Number: 61-0648389

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/01/2008	04/01/2008

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Disposition

Disposition Date: 04/01/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Cover Letter		Yes
Form	Evidence of Insurability Supp. App.		Yes

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Form Schedule

Lead Form Number: GL EOI 11/07

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	GL EOI 11/07	Application/Evidence of Enrollment Insurability Supp. Form App.	Initial		45	Form GL EOI (11-07).pdf

Part I - To be Completed by Policyholder:		For CSL Use ONLY	Reviewed By:	Date:
Group No:	Location/Branch:	Employee: <input type="checkbox"/> GI: _____ Eff: _____ <input type="checkbox"/> Amount to be UW: \$ _____ <input type="checkbox"/> App. <input type="checkbox"/> Dec. Eff. Date: _____	Spouse: <input type="checkbox"/> GI: _____ Eff: _____ <input type="checkbox"/> Amount to be UW: \$ _____ <input type="checkbox"/> App. <input type="checkbox"/> Dec. Eff. Date: _____	
Group Name:		Child(ren): <input type="checkbox"/> GI: _____ Eff: _____ <input type="checkbox"/> Amount to be UW: \$ _____ <input type="checkbox"/> App. <input type="checkbox"/> Dec. Eff. Date: _____	EE: Plan _____ / _____ / _____ Spouse: Plan _____ Child(ren): Plan _____	

Part II - Voluntary Life Coverage:

Employee Coverage Volume: \$ _____	Spouse Coverage: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000	Child(ren) Coverage: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
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Part III - To be Completed by Employee: (Please Print)

Employee Name: (Last, First, MI)	Date of Birth:	Age:	<input type="checkbox"/> Male	State of Birth:	<input type="checkbox"/> Married
			<input type="checkbox"/> Female		<input type="checkbox"/> Single
Street Address: _____ City: _____ State: _____ Zip Code: _____			Work Telephone No: _____		Home Telephone No: _____
Social Security No: _____	Employee Height: ft. _____ in. _____	Employee Weight: _____ lbs.	Occupation: _____		

List all Eligible Dependents to be insured under this application: (Please Print)

Name of Dependent:	Relationship:	Sex:	Date of Birth:	State of Birth:	Height:	Weight:	Full-Time Student:	Occupation:	Soc Sec No:

Insurability Questionnaire: (Circle condition and record details below)

Question	Employee:	Dependents:
1. Have you been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) or any other immunological disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Within the past 5 years, have you been medically counseled or treated for, or been told by a medical practitioner that you had: heart murmur; high blood pressure; heart attack; any disease of the heart or blood vessels; diabetes; albumin, blood or sugar in urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disease of the stomach, liver or intestines; blood disorder or anemia; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder; or any psychological, emotional disorder or depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the past 5 years, have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you presently receiving any treatment by a medical practitioner or taking any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever used narcotics or other habit forming drugs or been treated by a physician or other medical facility because of alcohol, drug or narcotic use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been rated, declined, postponed or limited in any way for life, health, accident or sickness insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you now disabled and unable to perform normal activities of a person of the same age and sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name and address of family or personal physician: _____

Please provide complete details if any questions above are answered YES. Attach a separate signed and dated sheet if more space is needed.

Question No:	Individual:	Date Consulted:	Reason for Treatment:	Medication:	Complete Recovery?

GL EOI 11/07

INFORMATION NOTICE TO BE RETAINED BY THE PROPOSED INSURED

INVESTIGATIVE CONSUMER REPORT - As required by Public Law 91.508, Citizens Security Life Insurance Company wishes to advise that as part of its procedures for processing your application for insurance an investigative consumer report may be prepared which will include information as to character, general reputation, and personal characteristics, whichever is applicable, of any person to be insured. The information for this investigative consumer report will be obtained through personal interviews with your friends, neighbors, acquaintances or you may request to be interviewed. Upon written request, a complete and accurate disclosure of the nature and scope of the investigative consumer report will be provided to you or your authorized representative.

MEDICAL INFORMATION BUREAU - Information regarding your insurability will be treated as confidential. Citizens Security Life Insurance Company, or its reinsurer(s), may however, make an inquiry to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you or your authorized representative, 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 (TTY) (866) 346-3642 for the hearing impaired). Citizens Security Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Any person who knowingly and with the 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.

Agreements and Authorization: I, the undersigned applicant, have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand that Citizens Security Life Insurance Company shall not be liable for any claim arising prior to the date of approval of this application at Citizens Security Life Insurance Company's Home Office. I authorize deductions from my compensation for the cost of the benefits I have applied for under the Group Policy issued to my employer.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, medical facility, medical provider, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Citizens Security Life Insurance Company's underwriting department or its authorized representative(s) my medical records, or my minor children's, including medical records, information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize Citizens Security Life Insurance Company to disclose the information obtained in the consideration of my application for insurance to its Reinsurers and the MIB Group, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by Citizens Security Life Insurance Company prior to receipt of the revocation.;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws.;
- A photocopy of this authorization shall be as valid as the original.;
- Coverage will not become effective until Citizens Security Life Insurance Company approves my application, provided that I am actively at work on that day.

I, as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon written request to obtain a copy of this authorization from Citizens Security Life Insurance Company.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, Citizens Security Life Insurance Company has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

Dated at (City) _____ (State) _____ this _____ day of _____, Year _____.

Signature of Employee _____ . Signature of Spouse _____.

Signature of Dependent(s) (Age 19 and older) _____.

GL EOI 11/07

To: Proposed Primary Insured or Applicant,

DETACH AND KEEP THIS INFORMATION NOTICE

Thank you,
Citizens Security Life Insurance Company
P.O.Box 436149
Louisville, KY 40253-6143

Toll Free Telephone Number 800-843-7752

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Filing Company: *Citizens Security Life Insurance Company* *State Tracking Number:* *38446*
Company Tracking Number:
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Rate Information

Rate data does NOT apply to filing.

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TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
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Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 03/17/2008
Comments:
Attachment:
Readability.pdf

Review Status:
Satisfied -Name: Application 03/17/2008
Comments:
John Doe'd Application; clean copy of form under Form Schedule tab.
Attachment:
John Doe's Application.pdf

Review Status:
Satisfied -Name: Cover Letter 03/17/2008
Comments:
Attachment:
Cover Letter.pdf

Citizens Security Life Insurance Company
12910 Shelbyville Road, Suite 300
Louisville, KY 40243

Readability Certification

I, James Helton, Executive Vice President, Group Products, Citizens Security Life Insurance Company, hereby certify that Form No. GL EOI 11/07 has a Flesch Scale readability score of 45.5.

I also certify, to the best of my knowledge and belief, the form is in compliance with the statutes and regulations for simplified and readability policy forms of the state for which it is being filed.

Signed for: Citizens Security Life Insurance Company

Date: March 13, 2008

By: 

Title: Executive Vice President,
Group Products

Part I - To be Completed by Policyholder:		For CSL Use ONLY	Reviewed By:	Date:
Group No: 1234	Location/Branch: X124	Employee: <input type="checkbox"/> GI: _____ Eff: _____ <input type="checkbox"/> Amount to be UW: \$ _____ <input type="checkbox"/> App. <input type="checkbox"/> Dec. Eff. Date: _____	Spouse: <input type="checkbox"/> GI: _____ Eff: _____ <input type="checkbox"/> Amount to be UW: \$ _____ <input type="checkbox"/> App. <input type="checkbox"/> Dec. Eff. Date: _____	
Group Name: XYZ COMPANY		Child(ren): <input type="checkbox"/> GI: _____ Eff: _____ <input type="checkbox"/> Amount to be UW: \$ _____ <input type="checkbox"/> App. <input type="checkbox"/> Dec. Eff. Date: _____	EE: Plan _____ / _____ / _____ Spouse: Plan _____ Child(ren): Plan _____	

Part II - Voluntary Life Coverage:

Employee Coverage Volume: \$ **10,000** Spouse Coverage: \$10,000 \$20,000 Child(ren) Coverage: \$5,000 \$10,000

Part III - To be Completed by Employee: (Please Print)

Employee Name: (Last, First, MI) **Doe, John** Date of Birth: **02/01/72** Age: **36** Male Female State of Birth: **AR** Married Single

Street Address: **123 ANY St.** City: **Little Rock** State: **AR** Zip Code: **72201** Work Telephone No: **501-222-2222** Home Telephone No: **501-333-3333**

Social Security No: **123456789** Employee Height: ft. **6** in. **0** Employee Weight: **180** lbs. Occupation: **MANAGER**

List all Eligible Dependents to be insured under this application: (Please Print)

Name of Dependent:	Relationship:	Sex:	Date of Birth:	State of Birth:	Height:	Weight:	Full-Time Student:	Occupation:	Soc Sec No:
Mary Doe	Spouse	F	05/01/72	AR	5'4"	140	NO	Homemaker	222-22-2222
Billy Doe	Son	M	08/01/97	AR	5'0"	70	YPS	Student	333-33-3333

Insurability Questionnaire: (Circle condition and record details below)

	Employee:	Dependents:
1. Have you been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) or any other immunological disorders?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Within the past 5 years, have you been medically counseled or treated for, or been told by a medical practitioner that you had: heart murmur; high blood pressure; heart attack; any disease of the heart or blood vessels; diabetes; albumin, blood or sugar in urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disease of the stomach, liver or intestines; blood disorder or anemia; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder; or any psychological, emotional disorder or depression?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Within the past 5 years, have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Are you presently receiving any treatment by a medical practitioner or taking any medication?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you ever used narcotics or other habit forming drugs or been treated by a physician or other medical facility because of alcohol, drug or narcotic use?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Have you ever been rated, declined, postponed or limited in any way for life, health, accident or sickness insurance?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. Are you now disabled and unable to perform normal activities of a person of the same age and sex?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Name and address of family or personal physician: **Bill Smith 300 Street Little Rock AR 72201**

Please provide complete details if any questions above are answered YES. Attach a separate signed and dated sheet if more space is needed.

Question No:	Individual:	Date Consulted:	Reason for Treatment:	Medication:	Complete Recovery?

GL EOI 11/07

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MEDICAL INFORMATION BUREAU - Information regarding your insurability will be treated as confidential. Citizens Security Life Insurance Company, or its reinsurer(s), may however, make an inquiry to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you or your authorized representative, 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired). Citizens Security Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Any person who knowingly and with the 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.

Agreements and Authorization: I, the undersigned applicant, have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand that Citizens Security Life Insurance Company shall not be liable for any claim arising prior to the date of approval of this application at Citizens Security Life Insurance Company's Home Office. I authorize deductions from my compensation for the cost of the benefits I have applied for under the Group Policy issued to my employer.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, medical facility, medical provider, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Citizens Security Life Insurance Company's underwriting department or its authorized representative(s) my medical records, or my minor children's, including medical records, information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

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- Information disclosed may be redisclosed and no longer protected by federal privacy laws.;
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I, as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon written request to obtain a copy of this authorization from Citizens Security Life Insurance Company.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, Citizens Security Life Insurance Company has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

Dated at (City) Little Rock (State) AR this 14th day of March, Year 2008.

Signature of Employee [Signature] Signature of Spouse [Signature]

Signature of Dependent(s) (Age 19 and older) _____

GL EOI 11/07

To: Proposed Primary Insured or Applicant,

DETACH AND KEEP THIS INFORMATION NOTICE

Thank you,
Citizens Security Life Insurance Company
P.O.Box 436149
Louisville, KY 40253-6143

Toll Free Telephone Number 800-843-7752



March 18, 2008

Arkansas Department of Insurance
Life Division, Forms and Rates
1200 West 3rd Street
Little Rock, AR 72201-1904

Re: Citizens Security Life Insurance Company - **New Submission**
NAIC # 61921 FEIN # 61-0648389
Form # GL EOI 11/07 – Evidence of Insurability Supplemental Application

Dear Sir/Madam:

Enclosed please find our Evidence of Insurability Supplemental Application for your review and approval. This new form will be used with our Voluntary Group Life product, Master Policy GTL (08/05) and Certificate CERT – GTL (08/05). The master contract and certificate were filed and approved in Arkansas on December 13, 2005.

The Evidence of Insurability Supplemental Application will be completed by employees who are applying for amounts of coverage that are above the guarantee issue amount. Also, employees and dependents whose coverage is subject to underwriting approval because they are “late” enrollees, who did not enroll for coverage when they were first eligible, will complete the form.

If you should have any questions or need additional information regarding this filing, please feel free to contact me at (800) 843-7752 ext. #536 or via e-mail rbolduc@cslico.com. Your prompt attention to this filing is greatly appreciated.

Sincerely,

A handwritten signature in black ink that reads 'Rickie Ellen Bolduc'.

Mrs. Rickie Ellen Bolduc, FLMI, AIRC, ACS
Actuarial Associate

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