

SERFF Tracking Number: LSVX-125715092 State: Arkansas  
 Filing Company: USAbLe Life State Tracking Number: 39465  
 Company Tracking Number: GLFAR0006501F01  
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
 Product Name: Group Life Trust Application, APP-IHCA  
 Project Name/Number: Group Life Trust Policy, GTP-LIFE/GLFAR0006501F01

## Filing at a Glance

Company: USAbLe Life

Product Name: Group Life Trust Application, APP-IHCA SERFF Tr Num: LSVX-125715092 State: ArkansasLH

TOI: L04G Group Life - Term

SERFF Status: Closed

State Tr Num: 39465

Sub-TOI: L04G.500 Other

Co Tr Num: GLFAR0006501F01

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: SPI Life and Specialty Ventures

Disposition Date: 06/30/2008

Date Submitted: 06/27/2008

Disposition Status: Approved

Implementation Date Requested: 07/28/2008

Implementation Date:

State Filing Description:

## General Information

Project Name: Group Life Trust Policy, GTP-LIFE

Status of Filing in Domicile:

Project Number: GLFAR0006501F01

Date Approved in Domicile:

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: Discretionary

Filing Status Changed: 06/30/2008

State Status Changed: 06/30/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval is a group life trust application to be used with the group trust policy form GTP-LIFE (6-00), which was approved in Arkansas on June 28, 2000, and with group trust certificate forms GTC-LIFE (8-04) and GTC-LIFE-DL (8-04), which were approved in Arkansas on August 6, 2004.

We will now be using these policy forms to issue group term life coverage to participants in Blue Cross Blue Shield of Tennessee individual health insurance plans that are marketed to individuals under age 65 and not on Medicare. The

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application being submitted is a combined health and life insurance application. The life insurance section of the application (see pages 5 and 6) is the section we will be using to enroll eligible persons in the group life trust.

We plan to issue the previously approved trust policy to the USAbLe Life Group Insurance Trust, which is situated in Arkansas and already registered with the department. It was submitted pursuant to Ark. Code Ann. §23-83-101, et seq. Under the provision of this statute, a "discretionary group" may be approved if it is not contrary to the best interest of the public, would be actuarially sound, would result in economies of acquisition of administration and the benefits will be reasonable in relation to the premium charged. The primary purpose of issuing the policy to the trust is to avoid the special (and more expensive) treatment and additional administrative costs attendant to individual policies. In this way we can offer group life coverage inexpensively to persons who have purchased health coverage through BlueCross Blue Shield of Tennessee.

The USAbLe Life section of the application is marked as variable as the Life insurance section may be included or omitted or the Critical Illness section may be included or omitted. (The Critical Illness section applies to an individual policy we will be filing in Tennessee.)

I hereby certify that to the best of my knowledge the forms submitted are in compliance in all respects with the provisions of the insurance laws, rules and regulations of the State of Arkansas, and the forms contain no provisions previously disapproved by the Department.

An EFT of \$20.00 has been submitted to cover all filing fees. If you have any questions or comments, please call me at (800) 648-0271 ext. 28877. We thank you in advance for your immediate attention.

## Company and Contact

### Filing Contact Information

Suzanne Bilello, Product Compliance Analyst sbilello@usablelife.com  
PO Box 1650 (501) 212-8885 [Phone]  
Little Rock, AR 72203-1650 (501) 378-3333[FAX]

### Filing Company Information

USAbLe Life CoCode: 94358 State of Domicile: Arkansas  
PO Box 1650 Group Code: 876 Company Type: Life & Health

SERFF Tracking Number: LSVX-125715092 State: Arkansas  
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Little Rock, AR 72203-1650

Group Name: Life and Speciality State ID Number:  
Ventures (LSV)

(501) 375-7200 ext. [Phone]

FEIN Number: 71-0505232

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## Filing Fees

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

| COMPANY     | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|-------------|---------|----------------|---------------|
| USable Life | \$20.00 | 06/27/2008     | 21127771      |

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## Correspondence Summary

### Dispositions

| Status   | Created By | Created On | Date Submitted |
|----------|------------|------------|----------------|
| Approved | Linda Bird | 06/30/2008 | 06/30/2008     |

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## **Disposition**

Disposition Date: 06/30/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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| <b>Item Type</b>           | <b>Item Name</b>                | <b>Item Status</b> | <b>Public Access</b> |
|----------------------------|---------------------------------|--------------------|----------------------|
| <b>Supporting Document</b> | Application                     |                    | Yes                  |
| <b>Supporting Document</b> | Certification/Notice            |                    | Yes                  |
| <b>Supporting Document</b> | AR - NAIC TRANSMITTAL DOC       |                    | Yes                  |
| <b>Supporting Document</b> | Cover Letter                    |                    | Yes                  |
| <b>Form</b>                | Individual Coverage Application |                    | Yes                  |

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## Form Schedule

**Lead Form Number:** APP-IHCA (03.08)

| Review Status | Form Number      | Form Type                                        | Form Name   | Action  | Action Specific Data | Readability | Attachment           |
|---------------|------------------|--------------------------------------------------|-------------|---------|----------------------|-------------|----------------------|
|               | APP-IHCA (03.08) | Application/ Individual Coverage Enrollment Form | Application | Initial |                      | 52          | APP-IHCA (03_08).PDF |

# INDIVIDUAL COVERAGE APPLICATION

Use Black Ink Only

Plan Use Only  
Rec: \_\_\_\_\_

IHCA

**SECTION 1 – Primary applicant information and dependents to be covered under this policy**

**PRIMARY APPLICANT**

LAST NAME \_\_\_\_\_ JR, SR, etc. \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ DATE OF BIRTH (mmddyyyy) \_\_\_\_\_ MALE  FEMALE

ADDRESS (P.O. Box is not acceptable – Please provide place of residence) \_\_\_\_\_ HEIGHT (FT / IN) \_\_\_\_\_ WEIGHT (LBS) \_\_\_\_\_ / \_\_\_\_\_

CITY (Please do not abbreviate) \_\_\_\_\_ STATE **T N** ZIP \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_

MAILING ADDRESS IF DIFFERENT (P.O. Box is acceptable) \_\_\_\_\_

CITY (Please do not abbreviate) \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

Have you or any person for whom you are applying had health insurance coverage within the past year?  
 YES  NO If "Yes", Who? \_\_\_\_\_

Are you a citizen or legal resident of the U.S.?  YES  NO  
*You must reside in the state of Tennessee and legally reside in the United States to be eligible for this coverage.*

**SPOUSE**

LEGAL SPOUSE LAST NAME \_\_\_\_\_ JR, SR, etc. \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH (mmddyyyy) \_\_\_\_\_ MALE  FEMALE

HEIGHT (FT/IN) \_\_\_\_\_ WEIGHT (LBS) \_\_\_\_\_ / \_\_\_\_\_

**DEPENDENT**

DEPENDENT LAST NAME \_\_\_\_\_ JR, SR, etc. \_\_\_\_\_ DEPENDENT FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH (mmddyyyy) \_\_\_\_\_ MALE  FEMALE

Natural Child/Stepchild  Adopted/Legal Guardian  Other (specify) \_\_\_\_\_

**DEPENDENT**

DEPENDENT LAST NAME \_\_\_\_\_ JR, SR, etc. \_\_\_\_\_ DEPENDENT FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH (mmddyyyy) \_\_\_\_\_ MALE  FEMALE

Natural Child/Stepchild  Adopted/Legal Guardian  Other (specify) \_\_\_\_\_

**DEPENDENT**

DEPENDENT LAST NAME \_\_\_\_\_ JR, SR, etc. \_\_\_\_\_ DEPENDENT FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH (mmddyyyy) \_\_\_\_\_ MALE  FEMALE

Natural Child/Stepchild  Adopted/Legal Guardian  Other (specify) \_\_\_\_\_

TO INCLUDE ADDITIONAL DEPENDENTS, PLEASE RECORD INFORMATION FOR ADDITIONAL DEPENDENTS ON A SEPARATE SHEET OF PAPER AND ATTACH IT TO THIS APPLICATION.

**SECTION 2 – Benefit Section**

|                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>BENEFIT CODE</b><br/>Please indicate the letter and 2 character code of benefit plan. Also note your choice of Network "P" or "S" in the single box below.</p> <p>_____</p> | <p><b>BlueCross BlueShield of Tennessee Products I am applying for:</b></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <b>MEDICAL</b></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <b>MATERNITY</b> (Maternity may only be purchased with Medical at initial enrollment or within 31 days of the qualifying event of 1. marriage; or 2. spouse's loss of group coverage.)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <b>DENTAL</b> (Dental may be purchased with Medical or as a stand alone product. If purchased with Medical, the applicant, spouse and all dependents will be enrolled. If applying for stand alone, mark first of the month following approval effective date below and then skip to Section 7. )</p> | <p><b>USable Life Products I am applying for:</b></p> <p><i>Life and Critical Illness are products offered independently by USable Life. These are not BlueCross BlueShield of Tennessee products. USable Life is solely responsible. Both Life and Critical Illness may only be purchased with Medical at initial enrollment and are only available to the Applicant and Spouse.</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <b>LIFE</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>CRITICAL ILLNESS</b></p> <p><i>(Do not complete pages 5 &amp; 6 when Life and Critical Illness are both marked "NO")</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**DESIRED EFFECTIVE DATE (CHOOSE ONE):**

1.  First of the month following approval
2.  Day after approval
3.  Day after my BCBST Short Term policy terminates (we will reduce the pre-existing waiting period by the length of the short term policy(ies), for which there is not a gap between the term date and effective date of the policies.
4.  Other Requested Effective Date: \_\_\_\_\_ **2 0** \_\_\_\_\_  
(If you request a specific effective date, this date cannot be changed once the application has been processed. If the requested date is prior to our receipt date, it will be changed to the day after receipt. In addition, you will be responsible for all premiums from this effective date.)

PRIMARY APPLICANT LAST NAME FIRST NAME MI SOCIAL SECURITY NO.

**SECTION 3 – Explanation of Pre-existing Condition Waiting Period and Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

**Pre-Existing Condition Waiting Period** - This coverage has a 12-month Pre-Existing Condition Waiting Period. This means that benefits will not be available until the coverage has been in effect for 12 months for any condition (either physical or mental) that was present during the 12-month period prior to the effective date of your coverage. **If you have experienced symptoms of a condition or if medical advice, diagnosis, care or treatment was recommended, received, or should reasonably have been received from a provider of health care services, the condition would be considered Pre-Existing.** If you are changing coverage from another BlueCross BlueShield of Tennessee individual product, you may be eligible to reduce your Pre-Existing Waiting Period. Information about this can be obtained through your BlueCross BlueShield of Tennessee sales personnel or your insurance representative.

**Your Rights Under HIPAA** - Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you or anyone for whom you are applying may be eligible for waivers of underwriting and our normal Pre-Existing waiting periods. The eligible individual must have had an aggregate of at least 18 months of creditable coverage without a significant break (63 days or more) in coverage. The most recent coverage must be from a group health plan (including COBRA), governmental plan or a church plan. It must also be no more than 63 days since that coverage terminated. COBRA and/or state continuation coverage must be exhausted to exercise your rights under HIPAA.

- Do you or any person for whom you are applying have creditable coverage as outlined in HIPAA?.....  YES  NO If "NO", go to Section 4.
- If you do have creditable coverage, check ONE of the following:
  - I (or any person for whom I am applying) have creditable coverage, but I would like to waive my HIPAA rights and apply for an underwritten plan with Pre-Existing Condition Waiting Periods and medical underwriting. If you select this option, and go to Section 4.
  - I (or any person for whom I am applying) have creditable coverage, but do not wish to waive my HIPAA rights. I would like to apply for a guaranteed issue policy with no Pre-Existing Condition Waiting Period or medical underwriting. If you select this option, STOP. See your agent for a different application for guaranteed issue coverage.

**SECTION 4 – AUTHORIZATION / Consent for Release of Personal and Health Information**

*This form is to authorize the disclosure and use of protected health information to determine eligibility for enrollment in a health plan. If you do not sign and date this authorization, you will not be enrolled.*

My dependents and I authorize any doctor, hospital, clinic, provider of health care, pharmacy or pharmacy benefit manager, health plan, insurance (or reinsuring) company, consumer reporting agency, my insurance agents, employers or any other person or firm having: 1) information as to cause, treatment, diagnosis, prognosis or advice of my physical or mental condition; or 2) any other information needed to determine my eligibility for insurance; to give BlueCross BlueShield of Tennessee, its affiliates, its employees and agents, my broker, or any consumer reporting agency, all such information. This may include (but is not limited to) medical records, prescription history, medications prescribed, information about driving records, mental illness and use of alcohol and drugs.

I (WE) UNDERSTAND:

- The information obtained with this authorization will be used by BlueCross BlueShield of Tennessee to determine eligibility for insurance. A copy of the authorization is as valid as the original. I (We) or my (our) authorized representative may request a copy of this authorization. This authorization will be in force for two years and six months from the date shown below.
- That I (we) may revoke this authorization at any time by writing BlueCross BlueShield of Tennessee. If I (we) revoke this authorization, any action taken by BlueCross BlueShield of Tennessee in reliance on this authorization prior to my (our) revocation will not be affected.
- My (our) signature(s) and date(s) on this application will authorize any doctor, hospital or other provider of treatment to furnish to BlueCross BlueShield of Tennessee, any and all medical records pertaining to any person who is to be covered by this contract. I (we) am responsible for any fees for these records.
- If this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, this information may be re-disclosed by the recipient and no longer protected by federal privacy regulation.

PRIMARY APPLICANT'S SIGNATURE **X** \_\_\_\_\_ DATE (mmddyyyy)           2 0 \_\_\_\_\_ Relationship \_\_\_\_\_  
 (If signed by parent or guardian and primary applicant is under age 18.)

LEGAL SPOUSE'S SIGNATURE **X** \_\_\_\_\_ DATE (mmddyyyy)           2 0 \_\_\_\_\_

DEPENDENT(S) AGE 18 AND OVER SIGNATURE **X** \_\_\_\_\_ DATE (mmddyyyy)           2 0 \_\_\_\_\_

DEPENDENT(S) AGE 18 AND OVER SIGNATURE **X** \_\_\_\_\_ DATE (mmddyyyy)           2 0 \_\_\_\_\_

DEPENDENT(S) AGE 18 AND OVER SIGNATURE **X** \_\_\_\_\_ DATE (mmddyyyy)           2 0 \_\_\_\_\_

PRIMARY APPLICANT LAST NAME FIRST NAME MI SOCIAL SECURITY NO.

**SECTION 5 - Individual Health Coverage Questionnaire**

Please accurately and truthfully answer all of the following questions for all person(s) applying for coverage. All persons applying who are age 18 and older must review these questions and answer appropriately. For persons under age 18, a parent or legal guardian may answer on their behalf. The questions are organized by category. After reviewing all conditions and/or questions within each category, answer NO or YES. For all YES answers, circle all condition/question number(s) that apply for that category and complete Section 6 below. With respect to medical conditions, has anyone applying for coverage ever been diagnosed, treated, or had a recommendation for treatment for any condition listed below?

- A.  NO  YES (Circle all that apply)
  - BONE / SKELETAL / MUSCLE**
  - 1 Abdominal / Inguinal Hernia
  - 2 Back Injury or Impairment
  - 3 Bulging Disc / Herniated Disc
  - 4 Fibromyalgia
  - 5 Knee Injury or Impairment
  - 6 Neck Injury
  - 7 Osteoarthritis
  - 8 Pituitary Dwarfism / Growth Hormones
  - 9 Rheumatoid Arthritis
  - 10 Scoliosis
  - 11 Spina Bifida
  - 12 Osteoporosis
  - 13 Gout
  - 14 Other Bone / Skeletal / Muscular Condition
- B.  NO  YES (Circle all that apply)
  - INTESTINAL / ENDOCRINE**
  - 15 Adult / Juvenile Diabetes (non-gestational)
  - 16 Bleeding Ulcer
  - 17 Chronic Pancreatitis
  - 18 Cirrhosis of the Liver
  - 19 Crohn's Disease
  - 20 Diverticulosis / Diverticulitis
  - 21 Gastroesophageal Reflux Disease (GERD)
  - 22 Hiatal Hernia
  - 23 Hepatitis B
  - 24 Hepatitis C
  - 25 Irritable Bowel Syndrome (IBS)
  - 26 Colon Polyps
  - 27 Ulcerative Colitis / Ulcerative Proctitis
  - 28 Thyroid Disease
  - 29 Other Intestinal / Endocrine Condition
- C.  NO  YES (Circle all that apply)
  - URINARY / KIDNEY**
  - 30 Chronic Prostatitis
  - 31 Dialysis
  - 32 Enlarged Prostate
  - 33 Kidney Stones
  - 34 Neurogenic Bladder
  - 35 Polycystic Kidney Disease
  - 36 Renal Failure
  - 37 Other Urinary / Kidney Condition
- D.  NO  YES (Circle all that apply)
  - LUNG / RESPIRATORY**
  - 38 Asthma
  - 39 Allergies
  - 40 Cystic Fibrosis
  - 41 Emphysema
  - 42 Pneumonia
  - 43 RSV Shots
  - 44 Sleep Apnea
  - 45 Tuberculosis
  - 46 Chronic Bronchitis
  - 47 Chronic Obstructive Pulmonary Disease (COPD)
  - 48 Other Lung or Respiratory Condition
- E.  NO  YES (Circle all that apply)
  - HEART / CIRCULATORY**
  - 49 Anemia
  - 50 Aneurysm
  - 51 Angina
  - 52 Angioplasty and / or Bypass Surgery
  - 53 Congestive Heart Failure
  - 54 Heart Attack
  - 55 Heart Murmur
  - 56 Hemophilia
  - 57 High Blood Pressure / Hypertension
  - 58 High Cholesterol / Lipid Disorders
  - 59 Mitral Valve Prolapse
  - 60 Stroke / Transient Ischemic Attacks (TIA's)
  - 61 Other Heart or Circulatory Condition
- F.  NO  YES (Circle all that apply)
  - BRAIN / NERVOUS**
  - 62 Alzheimer's or Dementia
  - 63 Cerebral Palsy
  - 64 Epilepsy / Seizures
  - 65 Migraine / Chronic or Severe Headache
  - 66 Multiple Sclerosis
  - 67 Muscular Dystrophy
  - 68 Paralysis
  - 69 Parkinson's Disease
  - 70 Developmental Disorders / Delays
  - 71 Other Brain / Nervous Condition
- G.  NO  YES (Circle all that apply)
  - CANCER**
  - 72 Breast Cancer
  - 73 Chemotherapy / Radiation
  - 74 Colon Cancer
  - 75 Hodgkin's / Lymphoma
  - 76 Leukemia
  - 77 Liver Cancer
  - 78 Lung Cancer
  - 79 Melanoma
  - 80 Other Cancer or Malignancy
- H.  NO  YES (Circle all that apply)
  - IMMUNE SYSTEM**
  - 81 AIDS / HIV Infection
  - 82 Connective Tissue Disease
  - 83 Discoid (subcutaneous) Lupus
  - 84 Systemic Lupus Erythematosus
  - 85 Other Immune System Condition
- I.  NO  YES (Circle all that apply)
  - TRANSPLANTS**
  - 86 Bone Marrow Transplant / Organ Transplant
  - 87 Discussed Possible Transplant or Organ Donation
- J.  NO  YES (Circle all that apply)
  - EYES / EARS / NOSE / THROAT / SKIN**
  - 88 Acne
  - 89 Acoustic Neuroma
  - 90 Adenoiditis
  - 91 Cataracts
  - 92 Chronic Ear Infections / Ear Tubes
  - 93 Chronic Sinusitis
  - 94 Chronic Tonsillitis
  - 95 Cleft Lip / Cleft Palate
  - 96 Eczema or Psoriasis
  - 97 Glaucoma
  - 98 Retinopathy
  - 99 TMJ Syndrome
  - 100 Other Eye / Ear / Nose / Throat / Skin Condition
- K.  NO  YES (Circle all that apply)
  - CONSUME ALCOHOL?**
  - 101 If "Yes," please indicate the family members' name(s) and number of drinks consumed per day in Section 6 below.
- L.  NO  YES (Circle all that apply)
  - BEHAVIORAL HEALTH / CHEMICAL DEPENDENCY**
  - 102 ADD / ADHD
  - 103 Alcoholism or Alcohol Abuse
  - 104 Anorexia / Bulimia or Other Eating Disorder
  - 105 Anxiety / Depression
  - 106 Bipolar Disorder / Manic Depressive Disorder
  - 107 Counseling
  - 108 Driving Under Influence (DUI)/Driving While Intoxicated (DWI)
  - 109 Illegal Drug Use (including misuse of prescription medications)
  - 110 Suicide Attempt within the last 10 years
  - 111 Other Behavioral Health Condition
- M.  NO  YES (Circle all that apply)
  - REPRODUCTIVE**
  - 112 Currently Pregnant/Expectant Parent (including Father)
  - 113 Currently in the Process of Adoption
  - 114 Born Premature (<37 weeks)
  - 115 Breast Cyst or Lump
  - 116 Endometriosis
  - 117 History of Pregnancy Complications
  - 118 Polycystic Ovarian Disease
  - 119 Sexually Transmitted Disease
  - 120 Uterine Fibroids
  - 121 Abnormal Pap Smear
  - 122 Other Reproductive System Condition
- N.  NO  YES (Circle all that apply)
  - MISCELLANEOUS**
  - 123 Abnormal Lab Results
  - 124 Advised to have Surgery and / or Testing
  - 125 Currently taking, using or has taken or used any medications, including topical gels and creams, within the last 12 months
  - 126 Seen any physicians and / or practitioners within the last 2 years
  - 127 Resided outside of the U.S. within the last 12 months
  - 128 Breast or Other Fluid Filled Implants
  - 129 Inpatient or Outpatient Surgery
  - 130 Physical Exam with Abnormal Results
  - 131 Unintentional weight loss within the past year
- O.  NO  YES (Circle all that apply)
  - TOBACCO PRODUCTS USED WITHIN THE LAST 5 YEARS**
  - 132 Tobacco use within the past year. If "Yes," please indicate the family member(s) in Section 6 below.
  - 133 Past tobacco use. If "Yes", indicate the family member(s), last date of use, and the number of years used in Section 6 below.

**SECTION 6 - Answer all of the specific information below for any condition with a "YES" above**

| Condition # | Family Member Name | Diagnosis, Treatment including Medications, or Reason for Visit | Date of Onset | Date of Last Treatment | Physician/Provider Name | Was Recovery Complete? |
|-------------|--------------------|-----------------------------------------------------------------|---------------|------------------------|-------------------------|------------------------|
|             |                    |                                                                 |               |                        |                         |                        |
|             |                    |                                                                 |               |                        |                         |                        |
|             |                    |                                                                 |               |                        |                         |                        |

If more room is needed, please record information on a separate sheet of paper and attach it to this application.



|                             |            |    |                     |
|-----------------------------|------------|----|---------------------|
| PRIMARY APPLICANT LAST NAME | FIRST NAME | MI | SOCIAL SECURITY NO. |
|                             |            |    |                     |

**SECTION 9 – Term Life and Critical Illness Benefit Selection - Coverage Provided by USAbLe Life\***

**OPTIONAL CRITICAL ILLNESS COVERAGE**

Underwritten and billed separately by USAbLe Life\*. Critical Illness Coverage is available only on the proposed insured and spouse. (Applicant must be 18 - 64 years of age.) This coverage pays a lump sum cash benefit upon the first positive diagnosis of a covered critical illness.

Choose only one of the following:  Applicant  Applicant and Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts:  \$10,000  \$20,000  \$30,000

If both the applicant and spouse choose Critical Illness Coverage, the coverage amounts will be the same.

**OPTIONAL TERM LIFE**

Underwritten by USAbLe Life\* and billed with your individual medical premiums. Term Life is available only on the proposed insured and spouse. (Applicant must be 18 - 64 years of age.)

Choose only one of the following:  Applicant  Applicant and Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts:  \$10,000  \$20,000  \$30,000  \$40,000

If both the applicant and spouse choose Term Life, the coverage amounts will be the same.

- Benefits will be paid to the designated beneficiary(ies) in one lump sum.
- Premiums are based on the age of each member applying for coverage and increase when that person's age moves to the next age bracket. Your monthly premiums will be billed with your individual medical coverage by BlueCross BlueShield of Tennessee.
- Your Term Life coverage will become effective at the same time as your Personal Health Coverage.

**Beneficiary Designation for Optional Term Life Insurance Benefits**

I hereby designate the following beneficiary(ies) for the USAbLe Life\* Life Term Life Insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive me will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured.

**PRIMARY BENEFICIARY(IES)** (Will receive proceeds if living at death of proposed insured.)

| Name (Last, First, MI) | Address | SSN | Birth Date | Relationship | Percentage Distribution |
|------------------------|---------|-----|------------|--------------|-------------------------|
|                        |         |     |            |              |                         |
|                        |         |     |            |              | +                       |
|                        |         |     |            |              | +                       |
|                        |         |     |            |              | +                       |

Total must equal 100% =

**CONTINGENT BENEFICIARY(IES)** (Will receive proceeds if all primary beneficiary(ies) are not living.)

| Name (Last, First, MI) | Address | SSN | Birth Date | Relationship | Percentage Distribution |
|------------------------|---------|-----|------------|--------------|-------------------------|
|                        |         |     |            |              |                         |
|                        |         |     |            |              | +                       |
|                        |         |     |            |              | +                       |
|                        |         |     |            |              | +                       |

\*USAbLe Life is an independent company that does not provide BlueCross BlueShield of Tennessee products or services. USAbLe Life is solely responsible for the Life and Critical Illness coverage above.

Total must equal 100% =



*SERFF Tracking Number:* LSVX-125715092      *State:* Arkansas  
*Filing Company:* USABLE Life      *State Tracking Number:* 39465  
*Company Tracking Number:* GLFAR0006501F01  
*TOI:* L04G Group Life - Term      *Sub-TOI:* L04G.500 Other  
*Product Name:* Group Life Trust Application, APP-IHCA  
*Project Name/Number:* Group Life Trust Policy, GTP-LIFE/GLFAR0006501F01

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: LSVX-125715092 State: Arkansas  
Filing Company: USAbLe Life State Tracking Number: 39465  
Company Tracking Number: GLFAR0006501F01  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Group Life Trust Application, APP-IHCA  
Project Name/Number: Group Life Trust Policy, GTP-LIFE/GLFAR0006501F01

## Supporting Document Schedules

|                                                          |                       |            |
|----------------------------------------------------------|-----------------------|------------|
| <b>Satisfied -Name:</b> Application                      | <b>Review Status:</b> | 06/27/2008 |
| <b>Comments:</b><br>This is an application filing.       |                       |            |
| <b>Satisfied -Name:</b> Certification/Notice             | <b>Review Status:</b> | 06/27/2008 |
| <b>Comments:</b>                                         |                       |            |
| <b>Attachment:</b><br>AR - READABILITY CERTIFICATION.PDF |                       |            |
| <b>Satisfied -Name:</b> AR - NAIC TRANSMITTAL DOC        | <b>Review Status:</b> | 06/27/2008 |
| <b>Comments:</b>                                         |                       |            |
| <b>Attachment:</b><br>AR - NAIC TRANSMITTAL DOC.PDF      |                       |            |
| <b>Satisfied -Name:</b> Cover Letter                     | <b>Review Status:</b> | 06/27/2008 |
| <b>Comments:</b>                                         |                       |            |
| <b>Attachment:</b><br>Cover Letter.PDF                   |                       |            |

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** USAble Life

This is to certify that the form(s) referenced below has 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.

| <b>Form Number</b> | <b>Score</b> |
|--------------------|--------------|
| APP-IHCA (3-08)    | 51.8         |
|                    |              |
|                    |              |
|                    |              |
|                    |              |

Signed:   
Name: Connie Phillips  
Title: Staff Attorney & Assistant Secretary  
Date: 06/27/2008

**Life, Accident & Health, Annuity, Credit Transmittal Document**

|           |                                  |          |
|-----------|----------------------------------|----------|
| <b>1.</b> | <b>Prepared for the State of</b> | Arkansas |
|-----------|----------------------------------|----------|

|           |                            |  |
|-----------|----------------------------|--|
| <b>2.</b> | <b>Department Use Only</b> |  |
|           | <b>State Tracking ID</b>   |  |
|           |                            |  |

| 3. Insurer Name & Address                               | Domicile | Insurer License Type | NAIC Group # | NAIC # | FEIN #     | State # |
|---------------------------------------------------------|----------|----------------------|--------------|--------|------------|---------|
| USable Life<br>PO Box 1650<br>Little Rock AR 72203-1650 | AR       | L&H                  | 876          | 94358  | 71-0505232 | 04      |

| 4. Contact Name & Address                                      | Telephone #                | Fax #        | E-mail Address          |
|----------------------------------------------------------------|----------------------------|--------------|-------------------------|
| Suzanne R. Bilello<br>PO Box 1650<br>Little Rock AR 72203-1650 | 800-648-0271<br>Ext. 28885 | 501-378-3333 | sbilello@usablelife.com |

|                          |                                                                                                                                                                                                                                                            |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 5. Requested Filing Mode | <input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational<br><input type="checkbox"/> Combination (please explain): _____<br><input type="checkbox"/> Other (please explain): _____ |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                   |                 |
|-----------------------------------|-----------------|
| <b>6. Company Tracking Number</b> | GLFAR0006501F01 |
|-----------------------------------|-----------------|

|                                                              |                                       |                       |
|--------------------------------------------------------------|---------------------------------------|-----------------------|
| <b>7. <input checked="" type="checkbox"/> New Submission</b> | <input type="checkbox"/> Resubmission | Previous file # _____ |
|--------------------------------------------------------------|---------------------------------------|-----------------------|

|                  |                                     |                                                                                                                                                                                                                                                                                                                                                           |  |
|------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>8. Market</b> | <input type="checkbox"/> Individual | <input type="checkbox"/> Franchise                                                                                                                                                                                                                                                                                                                        |  |
|                  | Group                               | <input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large<br><input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket<br><input type="checkbox"/> Discretionary <input checked="" type="checkbox"/> Trust<br><input type="checkbox"/> Other: _____ |  |

|                             |                        |
|-----------------------------|------------------------|
| <b>9. Type of Insurance</b> | L04G Group Life - Term |
|-----------------------------|------------------------|

|                                              |                |
|----------------------------------------------|----------------|
| <b>10. Product Coding Matrix Filing Code</b> | L04G.500 Other |
|----------------------------------------------|----------------|

|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>11. Submitted Documents</b> | <input checked="" type="checkbox"/> <b>FORMS</b><br><input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate<br><input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising<br><input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____<br><br><input type="checkbox"/> <b>RATES</b><br><input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate<br><br><input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b><br>Please explain: _____<br><br><b>SUPPORTING DOCUMENTATION</b><br><input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization<br><input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement<br><input type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications<br><input type="checkbox"/> Actuarial Memorandum<br><input checked="" type="checkbox"/> Other: <u>Transmittal Documents</u> |
|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                        |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>12.</b> | <b>Filing Submission Date</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 06/27/2008                                                                                                                                                             |
| <b>13.</b> | <b>Filing Fee (If required)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Amount <u>\$20.00</u> Check Date <u>EFT Payment</u><br>Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u>EFT Payment</u> |
| <b>14.</b> | <b>Date of Domiciliary Approval</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | AR is the State of Domicile                                                                                                                                            |
| <b>15.</b> | <b>Filing Description:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                        |
|            | <p>Enclosed for your review and approval is a group life trust application to be used with the group trust policy form GTP-LIFE (6-00), which was approved in Arkansas on June 28, 2000, and with group trust certificate forms GTC-LIFE (8-04) and GTC-LIFE-DL (8-04), which were approved in Arkansas on August 6, 2004.</p> <p>We will now be using these policy forms to issue group term life coverage to participants in Blue Cross Blue Shield of Tennessee individual health insurance plans that are marketed to individuals under age 65 and not on Medicare. The application being submitted is a combined health and life insurance application. The life insurance section of the application (see pages 5 and 6) is the section we will be using to enroll eligible persons in the group life trust.</p> <p>We plan to issue the previously approved trust policy to the USABLE Life Group Insurance Trust, which is situated in Arkansas and already registered with the department. It was submitted pursuant to Ark. Code Ann. §23-83-101, et seq. Under the provision of this statute, a "discretionary group" may be approved if it is not contrary to the best interest of the public, would be actuarially sound, would result in economies of acquisition of administration and the benefits will be reasonable in relation to the premium charged. The primary purpose of issuing the policy to the trust is to avoid the special (and more expensive) treatment and additional administrative costs attendant to individual policies. In this way we can offer group life coverage inexpensively to persons who have purchased health coverage through BlueCross Blue Shield of Tennessee.</p> <p>The USABLE Life section of the application is marked as variable as the Life insurance section may be included or omitted or the Critical Illness section may be included or omitted. (The Critical Illness section applies to an individual policy we will be filing in Tennessee.)</p> <p>I hereby certify that to the best of my knowledge the forms submitted are in compliance in all respects with the provisions of the insurance laws, rules and regulations of the State of Arkansas, and the forms contain no provisions previously disapproved by the Department.</p> <p>An EFT of \$20.00 has been submitted to cover all filing fees. If you have any questions or comments, please call me at (800) 648-0271 ext. 28877. We thank you in advance for your immediate attention.</p> |                                                                                                                                                                        |

|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>16.</b> | <b>Certification (If required)</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
|            | <p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p> <p>Print Name <u>Suzanne R. Bilello</u> Title <u>Product Compliance Analyst</u></p> <p></p> <p>Signature _____ Date <u>06/27/2008</u></p> |  |

June 27, 2008

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

RE: Form Filing - Group Life Trust Application, APP-IHCA  
Group Life  
Company Filing#: GLFAR0006501F01  
USable Life NAIC#: 876-94358 FEIN#: 71-0505232  
Lead Form No.: APP-IHCA (03.08) et al

Dear Commissioner Benafield Bowman:

We wish to submit the following Form filing for Group, Group Life for use in Arkansas. This filing is to be effective on or after July 28, 2008.

This filing has been submitted to or is exempt from filing in our domiciliary state of Arkansas.

Policy Form(s) and Endorsement(s) Submitted:

Form Title: Individual Coverage Application  
Lead Form No.: APP-IHCA (03.08)  
Edition Date:  
Form Type: Application with a flesch score of 51.799999999999997

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Ms. Suzanne R. Bilello  
Product Compliance Analyst

Phone: 501-212-8885 Ext.: 28885  
Fax: 501-378-3333  
Email: sbilello@usablelife.com

