

SERFF Tracking Number: NYLM-125538668 State: Arkansas
Filing Company: New York Life Insurance Company State Tracking Number: 38440
Company Tracking Number: LIFE GMA-USLH-P, ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life GMA-USLH-P, et al
Project Name/Number: Life GMA-USLH-P, et al/Life GMA-USLH-P, et al

Filing at a Glance

Company: New York Life Insurance Company

Product Name: Life GMA-USLH-P, et al

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

Implementation Date Requested: On Approval

State Filing Description:

SERFF Tr Num: NYLM-125538668 State: ArkansasLH

SERFF Status: Closed State Tr Num: 38440

Co Tr Num: LIFE GMA-USLH-P, ETState Status: Approved-Closed
AL

Co Status:

Author: Katherine Gagnon

Date Submitted: 03/18/2008

Reviewer(s): Linda Bird

Disposition Date: 04/01/2008

Disposition Status: Approved

Implementation Date:

General Information

Project Name: Life GMA-USLH-P, et al

Project Number: Life GMA-USLH-P, et al

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/01/2008

State Status Changed: 04/01/2008

Corresponding Filing Tracking Number:

Filing Description:

March 18, 2008

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Deemer Date:

Hon. Julie Benafield Bowman

Insurance Commissioner

Arkansas Insurance Department

Division of Compliance

Life and Health

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1200 West Third Street
Little Rock, AR 72201-1904

Re: Informational Filing OF Application Forms
GMA-USLH-REQ and GMA-USLH-P

FEIN No. 13-5582869
NAIC No. 66915

Dear Ms. Benafield Boman

Enclosed for filing on a general basis is a copy of the above referenced applications. We respectfully request approval of these forms for delivery both in and out of Arkansas.

These forms are new and do not replace any forms previously found acceptable by your department nor do they contain any provision or clause currently disapproved by the Department. These forms will be used in connection with previously approved application forms. The applications may be used to supplement an application for term life coverage alone, or in conjunction with other health coverages such as Accidental Death and Dismemberment or Disability coverage, dependent on specific plan design.

The subject application forms will be used as follows:

GMA-USLH-REQ This form may be used to offer upgrades in insurance to a current insured or recently approved applicant.

GMA-USLH-P This form will be used when our underwriting guidelines require that a statement of health made in connection with a pending application, be updated before coverage will be issued. This would generally occur in such instances where there is a delay in receiving physicians' or other reports during the underwriting process. Form GMA-

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USLH-P would enable the applicant to provide us with details of any recent medical history that developed since the date of the original application.

The attached applications reflect compliance with all applicable Arkansas regulations. These forms will be used with our previously approved GMR et al. Forms approved by your department on February 7, 1990.

We wish to confirm that in the future, each group plan using these enrollment forms will qualify as an authorized group in the state of delivery. The forms may be issued as shown, in typeset, in computer-emitted text, in photo-offset or in any combination of these means. Text will always be at least 10-point type.

Should there be any questions or if you need any additional information please contact me as indicated below.

We would appreciate receiving your Department's acceptance of this form at your earliest convenience.

Sincerely,

Bruce E. Dreizen
Corporate Vice President
Bruce_E_Dreizen@newyorklife.com

Company and Contact

Filing Contact Information

Deborah Moffat, Contract Consultant dmoффat@newyorklife.com
One Rockwood Road (914) 846-3448 [Phone]

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Sleepy Hollow, NY 10591 (914) 846-4389[FAX]

Filing Company Information

New York Life Insurance Company CoCode: 66915 State of Domicile: New York
51 Madison Avenue Group Code: -99 Company Type:
New York, NY 10010 Group Name: State ID Number:
(212) 576-5814 ext. [Phone] FEIN Number: 13-5582869

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Filing Fees

Fee Required? Yes
Fee Amount: \$40.00
Retaliatory? No
Fee Explanation:
Per Company: No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
5990383361	\$40.00	03/12/2008

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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		No
Supporting Document	Application		Yes
Form	Application		Yes
Form	Application		Yes

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Form Schedule

Lead Form Number: GMA-USLH-P

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	GMA-USLH-P	Application/ Enrollment Form	Initial		76	APPROVED GMA-USLH-P.pdf
	GMA-USLH-REQ	Application/ Enrollment Form	Initial		74	APPROVED GMA-USLH-REQ.pdf

SUPPLEMENT TO APPLICATION

Underwritten by New York Life Insurance Company • 51 Madison Avenue • New York, NY 10010

COMPLETE THIS FORM AND RETURN TO:

XYZ Administrators, Inc.
Any Street
Any Where, US 00000



Statement to New York Life Insurance Company forming part of Application Dated _____

APPLICANT

Name _____

STATEMENT OF HEALTH

Since the Date of the above referenced application, (Copy Attached) was completed, have you:

- 1. Consulted a physician or any other medical practitioner including a routine or checkup examination, or received medical treatment for any reason, excluding testing for HIV?
2. Been medically diagnosed as having any illness, disease, injury or become pregnant? Pregnancy question does not apply to Life Insurance.
3. Been hospitalized or had an operation?

(Attach a separate sheet if necessary, then sign and date it).

Table with 3 columns: Date, Nature of the illness or injury, symptoms, number of attacks, treatment and results, Names and Addresses of physicians, practitioners and hospitals where confined or treated.

You may be contacted by a service provider on behalf of New York Life to ask about any changes in your medical history

RESIDENTS OF NY: For HEALTH INSURANCE ONLY-- DOES NOT APPLY TO APPLICATION FOR LIFE INSURANCE: Any person who knowingly and with intent to defraud any insurance company or any 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. EXCEPT AS STATED ABOVE FOR RESIDENTS OF NEW YORK AND AS STATED BELOW FOR RESIDENTS OF THE STATES INDICATED, Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. FOR RESIDENTS OF CO, the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. FOR RESIDENTS OF D.C., the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by applicant. RESIDENTS OF FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. RESIDENTS OF LA Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I hereby declare that to the best of my knowledge and belief the statements I have made are true and complete. This Supplement is part of my Application dated _____, a copy of which is attached and I authorize you to rely on the information in such application.

THIS APPLICATION IS TO BE ATTACHED TO AND MADE A PART OF THE POLICY

Applicant's Signature X _____ Date _____

ed06, NY

EXPLANATION OF VARIABLE

GMA USLH-P

GENERAL

1. Variable material appears as bracketed.
2. References to “Applicant” will appear as illustrated. “Employee” may replace or be added to Applicant or the term “Member” may be substituted.
3. References to “ABC” and “XYZ” are illustrative and will be replaced by the Policyholder and plan Administrator.
4. In the bottom right code, the reference to “G-XXXXXX-0” will be replaced by the applicable Policy number assigned to a particular Policyholder for identification purposes.
5. Instructions regarding being contacted for updated medical history may or may not be included.

HEADING

1. The form heading will appear as illustrated or another term may be substituted for a descriptive title of the benefits under the group policy with which the Supplement To Application will be used: Supplement to Life Insurance Application, Supplement to Dependent Life Insurance Application, Supplement to Accidental Death & Dismemberment Insurance Application, Supplement to Disability Income Insurance Application, Supplement to Office Overhead Insurance Application, and Supplement to Hospital Indemnity Insurance Application.
2. The Administrator’s name, logo and address may be changed as required.
3. “Application” will appear as illustrated or synonymous terms such as “Request Form” may be substituted. The Account number may be deleted or replaced by another form of identification for the applicant.

SUPPLEMENTAL APPLICATION

Underwritten by New York Life Insurance Company • 51 Madison Avenue • New York, NY 10010

COMPLETE THIS FORM AND RETURN TO:

XYZ Administrators, Inc.

Any Street

Any Where, US 00000



Statement to New York Life Insurance Company forming part of Application for Insurance Dated _____

APPLICANT

Name _____ Account Number _____

INSURANCE REQUESTED

Amount of Insurance _____

STATEMENT OF HEALTH

Since the Date of the above referenced [application], (Copy Attached) was completed, have you:

- 1. Consulted a physician or any other medical practitioner including a routine or checkup examination, or received medical treatment for any reason, excluding testing for HIV?
2. Been medically diagnosed as having any illness, disease, injury or become pregnant?
3. Been hospitalized or had an operation?

(Attach a separate sheet if necessary, then sign and date it).

Table with 3 columns: Date, Nature of the illness or injury, symptoms, number of attacks, treatment and results, Names and Addresses of physicians, practitioners and hospitals where confined or treated.

You may be contacted by a service provider on behalf of New York Life to ask about any changes in your medical history

RESIDENTS OF NY: For HEALTH INSURANCE ONLY-- DOES NOT APPLY TO APPLICATION FOR LIFE INSURANCE: Any person who knowingly and with intent to defraud any insurance company or any 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

ed06, NY

G-XXXXX-0

I hereby declare that to the best of my knowledge and belief the statements I have made are true and complete.

THIS APPLICATION IS TO BE ATTACHED TO AND MADE A PART OF THE POLICY

Applicant's Signature X _____ Date _____

ed06, NY

G-XXXXX-0

EXPLANATION OF VARIABLE

GMA-USLH-REQ

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:
Bypassed -Name: Certification/Notice 03/12/2008
Bypass Reason: Not applicable to this filing.
Comments:

Review Status:
Satisfied -Name: Application 03/12/2008
Comments:
Attachments:
APPROVED GMA-USLH-P.pdf
APPROVED GMA-USLH-REQ.pdf

SUPPLEMENT TO APPLICATION

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APPLICANT

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I hereby declare that to the best of my knowledge and belief the statements I have made are true and complete. This Supplement is part of my Application dated _____, a copy of which is attached and I authorize you to rely on the information in such application.

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ed06, NY

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SUPPLEMENTAL APPLICATION

**Underwritten by New York Life Insurance Company • 51 Madison Avenue • New York, NY
10010**

COMPLETE THIS FORM AND RETURN TO:

XYZ Administrators, Inc.

Any Street

Any Where, US 00000



Statement to New York Life Insurance Company forming part of **Application** for Insurance Dated _____

APPLICANT

Name _____ **Account Number** _____

INSURANCE REQUESTED

Amount of Insurance _____

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1. Consulted a physician or any other medical practitioner *including* a routine or checkup examination, or received medical treatment for any reason, *excluding* testing for HIV?
____ Yes ____ No (If "Yes" give full details below)
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ed06, NY

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Applicant's Signature X _____ Date _____

ed06, NY

G-XXXXX-0

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GMA-USLH-REQ

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