

<i>SERFF Tracking Number:</i>	<i>FRCS-125782684</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Knights of Columbus</i>	<i>State Tracking Number:</i>	<i>40057</i>
<i>Company Tracking Number:</i>	<i>5050</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.103 Fixed/Indeterminate Premium - Joint (Last Survivor)</i>
<i>Product Name:</i>	<i>Second To Die Joint Application 600D 717 1-09</i>		
<i>Project Name/Number:</i>	<i>KOFC/135/135</i>		

Filing at a Glance

Company: Knights of Columbus

Product Name: Second To Die Joint Application SERFF Tr Num: FRCS-125782684 State: ArkansasLH
600D 717 1-09

TOI: L071 Individual Life - Whole

SERFF Status: Closed

State Tr Num: 40057

Sub-TOI: L071.103 Fixed/Indeterminate
Premium - Joint (Last Survivor)

Co Tr Num: 5050

State Status: Approved-Closed

Filing Type: Form

Co Status: None

Reviewer(s): Linda Bird

Authors: Kevin Wiggs, LaToya
Osborn

Disposition Date: 08/27/2008

Date Submitted: 08/25/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: KOFC/135

Status of Filing in Domicile: Pending

Project Number: 135

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Submitted on or
about this same date.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/27/2008

State Status Changed: 08/27/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The Knights of Columbus is a fraternal benefit society.

This form is new and is not intended to replace any previously approved form.

SERFF Tracking Number: FRCS-125782684 State: Arkansas
 Filing Company: Knights of Columbus State Tracking Number: 40057
 Company Tracking Number: 5050
 TOI: L071 Individual Life - Whole Sub-TOI: L071.103 Fixed/Indeterminate Premium - Joint
 (Last Survivor)
 Product Name: Second To Die Joint Application 600D 717 1-09
 Project Name/Number: KOFC/135/135

This application will be used with the Order's Second-To-Die Whole Life policy, form 717 11-97, which was approved by your Department on 11/04/97.

Our fee of \$20 has been sent by EFT on this same date.

Company and Contact

Filing Contact Information

(This filing was made by a third party - FC01)

Kevin Wiggs, Compliance Specialist kevin.wiggs@firstconsulting.com
 1020 Central (800) 927-2730 [Phone]
 Kansas City, MO 64105 (816) 391-2755[FAX]

Filing Company Information

Knights of Columbus CoCode: 58033 State of Domicile: Connecticut
 1 Columbus Plaza Group Code: Company Type:
 New Haven, CT 06507-3326 Group Name: State ID Number:
 (203) 752-4266 ext. [Phone] FEIN Number: 06-0416470

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: AR fee of \$20.00 per form filing.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Knights of Columbus	\$20.00	08/25/2008	22112112

SERFF Tracking Number: FRCS-125782684 State: Arkansas
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(Last Survivor)
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	08/27/2008	08/27/2008

SERFF Tracking Number: FRCS-125782684 *State:* Arkansas
Filing Company: Knights of Columbus *State Tracking Number:* 40057
Company Tracking Number: 5050
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.103 Fixed/Indeterminate Premium - Joint
(Last Survivor)
Product Name: Second To Die Joint Application 600D 717 1-09
Project Name/Number: KOFC/135/135

Disposition

Disposition Date: 08/27/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: FRCS-125782684 State: Arkansas
 Filing Company: Knights of Columbus State Tracking Number: 40057
 Company Tracking Number: 5050
 TOI: L071 Individual Life - Whole Sub-TOI: L071.103 Fixed/Indeterminate Premium - Joint
 (Last Survivor)
 Product Name: Second To Die Joint Application 600D 717 1-09
 Project Name/Number: KOFC/135/135

Form Schedule

Lead Form Number: 600D-AR 717 1-09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	600D-AR 717 1-09	Application/Insurance Enrollment Form	Application/Insurance Enrollment Form	Initial		52	600D-AR 717 1-09.pdf

Home Office Use

KNIGHTS OF COLUMBUS
A FRATERNAL BENEFIT SOCIETY
1 Columbus Plaza
New Haven, CT 06510-3326
SECOND TO DIE
LIFE INSURANCE APPLICATION

Use space below for plate or Agent's name and code.
(This is for General Agent's use only.)

Is either proposed insured a member of Knights of Columbus? Yes No (If yes, indicate associate member or insurance member. If no, application for membership must be made and approved by council.)

PRINT ANSWERS TO ALL QUESTIONS.

1. Name of Applicant
2. Name of Member:
3. Council No. Membership No. Social Security No. of Applicant

INFORMATION CONCERNING PROPOSED INSURED

4. (a) Legal Name: (last-first-middle initial) Sex
(b) Maiden Name: Relationship to Applicant:
(c) Address Street
City State Zip Code

(d) Date of Birth: Issue Age: Place of Birth:
(mo. day yr.)
(e) Social Security No.
(f) All Present Occupations:

5. (a) Legal Name (last-first-middle initial) Sex
(b) Maiden Name Relationship to Applicant:
(c) Address Street
City State Zip Code
(d) Date of Birth Issue Age Place of Birth
(mo.day yr.)
(e) Social Security No.
(f) All Present Occupations:

6. Plan Description Plan Code
7. Base Contract Amount \$
APB (735) Amount \$
8. Premium Payable: \$
Amount Paid If even dollar premium,
Herewith: check here and indicate
no amount in section 12.
Ann. E.F.T. Withdrawal Day:
Existing EFT Policy (ies)
S.A. Military Allotment (branch of service)
Q.A. Combined Billing Salary Deduction

9. Riders to be included:
a. Disability Waiver on Proposed Insured 4(a) Yes No
Disability Waiver on Proposed Insured 5(a) Yes No
b. Four Year Term Rider Yes No
c. Lapse Protection Rider (840) Yes
d. Other Rider

10. Any dividends payable under the insurance contract hereby applied for are to be:
(1) paid in cash (4) applied to purchase
(2) applied to reduce premium paid-up additions
(3) held at interest (8) paid-up additions as
Inside Additions

APB amount must be \$0, if option 1, 2, 3 or 4 is elected.
11. In event of a default in payment of any premium due on the insurance contract issued, shall the automatic premium loan provision, if applicable, be effective? Yes No
12. Beneficiary -- May Complete Form 113A.

Primary Relationship to Insureds
Contingent Relationship to Insureds

13. Remarks:

DECLARATION OF INSURABILITY FOR PERSON NAMED IN 4(a)

1.

First Name Proposed Insured	Sex	Date of Birth	Height	Weight	Total Insurance in Force

2. Has the **person named in Question 4(a)** ever used tobacco or tobacco substitutes? Yes No
 If yes, give dates of last use below. Proposed insured initial here _____.

Cigarettes	Cigars	Pipe	Snuff	Chewing tobacco	Patch, gum or any nicotine substitute
mo. ___ yr. ___					

	Yes	No	Give details below for "yes" answers, including question number. If needed, use the space provided in number 12 or an attached separate sheet.
3. a. Are there any existing life insurance or annuity contracts on the life of the proposed insured named in 4(a)?			
b. Is the insurance applied for intended to replace any existing insurance or annuities with the Knights of Columbus or another insurer?			
If the answer to either question is yes, please complete Section 14.			
4. a. Are negotiations now pending for life or health insurance on the proposed insured?			
b. Has the proposed insured been declined, postponed or rated for life or health insurance or reinstatement thereof?			
c. Has the proposed insured ever made claim for sickness, accident or pension benefits?			
d. Has the life, accident or health insurance policy issued on the proposed insured been cancelled by the issuer or the renewal thereof been refused?			
5. a. Is the proposed insured contemplating making or in the past three years has the proposed insured made flights as a pilot, student pilot, crew member, or flights in other than commercial planes? If yes, complete Aviation Questionnaire 561.			
b. Is the proposed insured contemplating engaging in or in the past three years has the proposed insured engaged in any type of scuba diving or sky diving, racing, rodeo activities or hang gliding? (If yes, complete questionnaire.)			
c. Has the proposed insured recently traveled overseas, or is foreign travel planned or contemplated?			

6. Has the person named in Question 4(a) ever received treatment, attention or advice from any physician or other practitioner for, or been told by any physician or other practitioner that such person has or had:		
a. Tuberculosis, asthma, emphysema, COPD, pneumonia or other lung disease or disorder?		
b. Stroke, fainting spells, epilepsy, paralysis, depression or mental disorder, dementia, Alzheimer's, autism, nervous system or other brain disorder?		
c. Ulcers, colitis, rectal disorder, indigestion or other disorder of the esophagus, stomach, intestines, liver or gallbladder?		
d. Cancer, tumors, disorder of the blood or lymph glands, or endocrine disorder?		
e. Diabetes, sugar, albumin, pus or blood in the urine or other kidney or bladder disorder?		
f. Disease of the heart or blood vessels, chest pains, shortness of breath, heart enlargement, high or low blood pressure, abnormal heart rhythm or palpitations?		
g. Arthritis, gout, multiple sclerosis, or disorder of the muscles or bones?		
h. Disease or disorder of the ears, eyes, nose or throat?		
i. Disorder of the prostate, reproductive organs or breasts?		
7. Has the person named in Question 4(a) received treatment from any physician, or other practitioner for, or been told by any physician, other practitioner or counselor that such person has or had, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any Disorder of the immune system?		
8. Has any person named in Question 4(a) been hospitalized or consulted a physician or suffered from any illness, disease or syndrome not listed above, or is any such person taking any medication not previously listed?		
9. Has any person named in Question 4(a) ever been advised by a health professional to seek treatment for, been treated for the excessive use of alcohol, narcotics or other habit forming drugs or been convicted of or plead guilty to a drug or alcohol related offense?		
10. Within the past five years, has the person named in Question 4(a) had a license suspended or had a moving traffic violation? (a) Driver's License: _____ (b) State of License: _____		

11. Primary Care Physicians or Health Facilities:

Name of Primary Care Physician or Facility	Name of Specialist
Street Address	Street Address
City State Zip Code	City State Zip Code
Telephone Number	Telephone Number
Date last seen: _____ Reason last seen: _____	Date last seen: _____ Reason last seen: _____

12. Additional remarks in answer to Questions 3 – 11: _____

13. Previous residence addresses, for past ten years, of the proposed insured named on the previous page.

From Year	To Year	Number	Street	City	State

14. List all life insurance, annuities and long term care policies on **any** proposed insured listed in 4(a) (including pending applications and reinstatements).

Company/Person Insured	Face Amount	Accidental Death Amount	Year Issued	List Contract Number if K. of C.

15. Family history: (any history of diabetes, cancer, high blood pressure, heart, kidney disorder, mental illness or suicide),

	Age	If Living State of Health (if poor, give reason)	If Deceased Age at Death	If Deceased Cause of Death
Father				
Mother				
Brothers and Sisters				

16. Citizenship: United States Canada (provide SIN below) Other (provide country and tax I.D. number below)

DECLARATION OF INSURABILITY FOR PERSON NAMED IN 5(a)

1.

First Name Proposed Insured	Sex	Date of Birth	Height	Weight	Total Insurance in Force

2. Has the **person named in Question 5(a)** ever used tobacco or tobacco substitutes? Yes No

If yes, give dates of last use below. Proposed insured initial here _____.

Cigarettes	Cigars	Pipe	Snuff	Chewing tobacco	Patch, gum or any nicotine substitute
mo. ___ yr. ___	mo. ___ yr. ___	mo. ___ yr. ___	mo. ___ yr. ___	mo. ___ yr. ___	mo. ___ yr. ___

	Yes	No	Give details below for "yes" answers, including question number. If needed, use the space provided in number 12 or an attached separate sheet.
3. a. Are there any existing life insurance or annuity contracts on the life of the proposed insured named in 5(a)?			
b. Is the insurance applied for intended to replace any existing insurance or annuities with the Knights of Columbus or another insurer?			
If the answer to either question is yes, please complete Section 14.			
4. a. Are negotiations now pending for life or health insurance on any of the proposed insureds?			
b. Has the proposed insured been declined, postponed or rated for life or health insurance or reinstatement thereof?			
c. Has the proposed insured ever made claim for sickness, accident or pension benefits?			
d. Has the life, accident or health insurance policy issued on any proposed insured been cancelled by the issuer or the renewal thereof been refused?			
5. a. Is the proposed insured contemplating making or in the past three years has the proposed insured made flights as a pilot, student pilot, crew member, or flights in other than commercial planes? If yes, complete Aviation Questionnaire 561.			
b. Is the proposed insured contemplating engaging in or in the past three years has the proposed insured engaged in any type of scuba diving or sky diving, racing, rodeo activities or hang gliding? (If yes, complete questionnaire.)			
c. Has the proposed insured recently traveled overseas, or is foreign travel planned or contemplated?			

<p>6. Has the person named in Question 5(a) ever received treatment, attention or advice from any physician or other practitioner for, or been told by any physician or other practitioner that such person has or had:</p>			
<p>a. Tuberculosis, asthma, emphysema, COPD, pneumonia or other lung disease or disorder?</p>			
<p>b. Stroke, fainting spells, epilepsy, paralysis, depression or mental disorder, dementia, Alzheimer's, autism, nervous system or other brain disorder?</p>			
<p>c. Ulcers, colitis, rectal disorder, indigestion or other disorder of the esophagus, stomach, intestines, liver or gallbladder?</p>			
<p>d. Cancer, tumors, disorder of the blood or lymph glands, or endocrine disorder?</p>			
<p>e. Diabetes, sugar, albumin, pus or blood in the urine or other kidney or bladder disorder?</p>			
<p>f. Disease of the heart or blood vessels, chest pains, shortness of breath, heart enlargement, high or low blood pressure, abnormal heart rhythm or palpitations?</p>			
<p>g. Arthritis, gout, multiple sclerosis, or disorder of the muscles or bones?</p>			
<p>h. Disease or disorder of the ears, eyes, nose or throat?</p>			
<p>i. Disorder of the prostate, reproductive organs or breasts?</p>			
<p>7. Has the person named in Question 5(a) received treatment from any physician, or other practitioner for, or been told by any physician, other practitioner or counselor that such person has or had, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any Disorder of the immune system?</p>			
<p>8. Has the person named in Question 5(a) been hospitalized or consulted a physician or suffered from any illness disease or syndrome not listed above, or is the such person taking any medication not previously listed?</p>			
<p>9. Has the person named in Question 5(a) ever been advised by a health professional to seek treatment for or has such person been treated for or arrested for the excessive use of alcohol, narcotics or other habit forming drugs?</p>			
<p>10. Within the past five years, has the person named in Question 5(a) had a license suspended or had a moving traffic violation?</p> <p>(a) Driver's License: _____</p> <p>(b) State of License: _____</p>			

11. Primary Care Physicians or Health Facilities:

Name of Primary Care Physician or Facility	Name of Specialist
Street Address	Street Address
City State Zip Code	City State Zip Code
Telephone Number	Telephone Number
Date last seen: _____ Reason last seen: _____	Date last seen: _____ Reason last seen: _____

12. Additional remarks in answer to Questions 3 – 11: _____

13. Previous residence addresses, for past ten years, of the proposed insured named on the previous page.

From Year	To Year	Number	Street	City	State

14. List all life insurance, annuities and long term care policies on **any** proposed insured listed in 5(a) (including pending applications and reinstatements).

Company/Person Insured	Face Amount	Accidental Death Amount	Year Issued	List Contract Number if K. of C.

15. Family history: (any history of diabetes, cancer, high blood pressure, heart, kidney disorder, mental illness or suicide),

	Age	If Living State of Health (if poor, give reason)	If Deceased Age at Death	If Deceased Cause of Death
Father				
Mother				
Brothers and Sisters				

16. Citizenship: United States Canada (provide SIN) Other (provide country and tax I.D. number)

Owner:

Unless otherwise designated below, the policy applied for will be owned jointly by the proposed insureds, as stated in the Owner provision of the policy.

Owner _____

Relationship to Insureds _____

Address of Owner _____

City _____ State _____ Zip Code _____

Social Security Number or E.I.N. of Owner _____

Contingent Owner _____

Payor

Premium Payor's Name and Address, if Different from Owner:

- (1) I agree that the statements and answers contained in this application are representations and not warranties and are complete and true to the best of my knowledge and belief. **The Knights of Columbus shall not be bound by any information that is not set out in writing in this application.**
- (2) I agree that the Charter, Constitution and Laws of the Knights of Columbus now in effect or hereafter enacted including any change in the method or amount of insurance premiums, shall be binding upon me and the beneficiary.
- (3) I agree that, except for coverage which may be provided in the Temporary Insurance Agreement, no insurance will be in force because of this application until it has been approved and the minimum required premium has been paid to the Knights of Columbus.
- (4) I agree that the insurance hereby applied for shall be cancelled, if the applicant is a candidate for membership and has not been initiated into the First Degree of the Knights of Columbus within 90 days of the commencement of Temporary Insurance.

Signed at _____ this _____ day of _____, _____
City State Zip Code Year

Signature of Proposed Insured 4(a) _____

Signature of Proposed Insured 5(a) _____

Applicant's Signature _____

Owner's Signature _____
(If other than applicant or proposed insured)

Witness _____
Signature and I.D. Number of Writing Agent

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A) To assist the Knights of Columbus in underwriting an application for insurance, I hereby authorize those persons or organizations listed in section B of this Authorization who possess medical or non-medical information concerning me or my children and stepchildren to permit the Knights of Columbus or its representatives, including, but not limited to: physicians, paramedics, teleunderwriters and consumer reporting agencies; to view, to copy, to be furnished a copy or to be given details of all such information. In addition to other medical or non-medical information, this Authorization applies to any information about psychiatric, drug or alcohol abuse treatment. **Please note that the term "non-medical information" consists of information obtained from a consumer investigative report which would pertain to such items as: confirmation of age, residence, marital status, employment, information as to character, general reputation, personal characteristics, avocation and mode of living.**

B) Those persons or organizations authorized to disclose medical or non-medical information concerning me or my children and stepchildren are: licensed physicians, medical practitioners, paramedics, teleunderwriters, hospitals, clinics or other medical or medically related facilities, government agencies regulating motor vehicles, insurance and reinsurance companies, consumer reporting agencies and the Medical Information Bureau.

C) Notwithstanding the provisions of sections A and B of this Authorization, the Medical Information Bureau may release information only to the Knights of Columbus.

D) I also authorize the Knights of Columbus to release any information regarding me, my children and stepchildren or our health to: the Medical Information Bureau; any company to which my application is submitted for reinsurance purposes; my Knights of Columbus agents; and to other life insurance companies with whom I have policies or to whom I may apply for insurance, or to whom a claim for benefits may be submitted.

E) I authorize the Knights of Columbus to obtain an investigative consumer report on me. I understand that I may request to be interviewed in connection with the preparation of such a report.

F) I acknowledge receiving and reading the notices regarding the Fair Credit Reporting Act, the Medical Information Bureau and Description of Information Practices.

G) This Authorization expires two years from the date shown below unless sooner revoked by writing to us at P.O. Box 1670, New Haven, Connecticut 06510-3326. A photocopy of this signed Authorization shall have the same validity as the original. I understand that I am entitled to receive a copy of this Authorization.

Signature _____ **Signature** _____
Proposed Insured 4(a) Proposed Insured 5(a)

In presence of:

_____ Date _____
Witness

I request that I be interviewed in the event an investigative consumer report is prepared in connection with the application. (Please initial here _____.)

WRITING AGENT'S REPORT

1. Do either of the proposed insureds have any existing life insurance or annuity contracts? ____ Yes ____ No.

Has any life insurance or annuity contract either in force or applied for on the life of either of the proposed insured terminated or is termination of such insurance or annuity contemplated as a result of the issuance of the life insurance contract applied for? Yes No

If the answer to either question is yes, have you complied with the requirements of the Order and your state with regard to this replacement? Yes No (Give full details under Remarks.)

2. Has the application been previously submitted to the Knights of Columbus on the life of any member of this family? Yes No
Contract No. (s) _____

6. Are all children, stepchildren or legally adopted children under attained age 18 years listed in answer to question 1 of page 2 of this application?
Yes No (If not, explain fully under remarks.)

3. Have you any information not fully set forth in this application regarding habits, character and reputation, or state of health of any member of this family which might affect the decision of the Knights of Columbus regarding the issuing of insurance? Yes No

7. If proposed insured is a juvenile, indicate number of brothers ____, sisters ____. Are they insured: Yes No
If yes, indicate amount of insurance on each.

If no, explain below.

4. Did you personally observe every proposed insured member of this family? Yes No

8. If proposed insured is the applicant's spouse, indicate amount of insurance on applicant. _____

5. How well do you know the proposed insured or family?
 Met very recently.
 Known slightly for _____ years.
 Known well for _____ years.
 Are you a relative? Yes No
Relationship _____

9. Applicant's yearly income \$ _____ Net Worth _____
Spouse's yearly income \$ _____ Net Worth _____

10. What is the purpose of the applied for insurance?

Have you issued a receipt with this application? Yes No

I certify that a copy of the notice pursuant to the Fair Credit Reporting Act, the Notice Regarding the Medical Information Bureau and the Description of Information Practices were delivered to the applicant by the undersigned on _____.

I further certify that on the date shown below: (a) I have personally seen the proposed insured; (b) I have separately and fully asked each question on pages 1 through 5 of the application and I have truly and accurately recorded the information supplied by the proposed insured, and the applicant if other than the proposed insured; and (c) the application was completed in the presence of the proposed insured, and the applicant if other than the proposed insured, who signed it in my presence.

I recommend that the Knights of Columbus consider the risk for acceptance subject to remarks below.

Date _____

Signature and I.D. Number of Writing Agent

(_____) _____
Writing Agent's Telephone Number

WRITING AGENT'S REMARKS

RECEIPT

The Knights of Columbus received \$_____ from _____ on the date shown below. This amount was paid when a life insurance application which bears the same date as this receipt was signed in which _____ is named as the proposed insured. This receipt and the Temporary Insurance Agreement set forth below are issued on the condition that any check, draft or other order or authorization for payment of money is good and can be collected.

Date: _____ Agent _____

(The above receipt must not be completed unless payment for the initial premium has been made at the time of application or unless use of existing Knights of Columbus values has been authorized. The premium check, if any, must be made payable to the Knights of Columbus. Do not make the check payable to the agent or leave the payee blank.)

TEMPORARY INSURANCE AGREEMENT

The Knights of Columbus agrees to provide Temporary Insurance as follows:

Payment of Temporary Insurance

The Temporary Insurance will be paid to the beneficiary named in the application if both persons who are covered by the insurance contract applied for die while the Temporary Insurance is in force.

Amount of Temporary Insurance

This Agreement provides Temporary Insurance in the amount applied for or \$300,000, whichever is less.

Commencement of Temporary Insurance

The Temporary Insurance will start when all medical exams, paramedical exams, telemedical exams, laboratory tests and reports required at time of application are completed. If no exams, tests or reports are required, the Temporary Insurance will start on the date of the above Receipt.

Duration of Temporary Insurance

Unless this Temporary Insurance ends sooner for one of the three reasons listed in the Termination of Temporary Insurance section below, it will end 90 days after it starts.

Termination of Temporary Insurance

1. The Temporary Insurance will end when the Knights of Columbus issues the insurance contract as applied for.
2. The Temporary Insurance will end when the Knights of Columbus issues an insurance contract other than as applied for, and the contract is accepted by the contract owner.
3. The Temporary Insurance will end when the Knights of Columbus refunds the initial premium or restores the existing values used to pay the initial premium.

Special Limitations Applicable to Temporary Insurance Agreement

1. In the event that more than one Temporary Insurance Agreement is in force at the time of a proposed insured's death, the maximum total amount payable under all such Agreements will be \$300,000.
2. If any proposed insured dies by suicide, the liability of the Knights of Columbus under this Agreement is limited to a refund of the payment made.
3. No Temporary Insurance will be provided with respect to a child to be insured under the insurance contract applied for or under a Family Insurance Rider or Children's Insurance Rider, if death occurs while such child is less than 15 days old.
4. No Temporary Insurance will be provided with respect to any proposed insured who is to be insured under an insurance contract applied for under the provisions of a Guaranteed Purchase Option Rider or a Youth Purchase Option Rider.
5. No temporary insurance will be provided for any insurance coverage intended to be paid for by funds transferred from another insurer or financial institution at some point subsequent to the time of application.
6. Fraud or material misrepresentation in the application invalidates this Agreement. In the event of fraud or material misrepresentation, the liability of the Knights of Columbus is limited to a refund of any payment made.
7. No change may be made in the terms and conditions of this Agreement. No statement which claims to make such a change will bind the Knights of Columbus.

NOTICE TO PROPOSED INSURED

Fair Credit Reporting Act

Federal and state laws require us to notify you that, in connection with our consideration of this application, we may request and obtain an investigative consumer report. In addition, such a report may be requested subsequently to update our records. We may also request one, if you apply for more coverage.

The report may contain information as to character, general reputation, personal characteristics and mode of living and driving record. It may be obtained through an interview with: you, an adult member of your family, friends, neighbors, business associates, other persons with whom you are acquainted, or government agencies regulating motor vehicles. The report will also consist, when applicable, of a confirmation of your age, residence, marital status, employment and the like.

You have the right, upon written request, to be informed whether or not an investigative consumer report was obtained by us. Send your request to: Medical Director, Knights of Columbus, and P. O. Box 1670, New Haven, Connecticut 06510-3326. If it was obtained, we are required to furnish the name and address of the consumer reporting agency and to furnish detailed information concerning the nature and scope of the report. Where the name and address of the consumer reporting agency are furnished, the report may be inspected and a copy may be obtained by contacting the agency.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

This MIB is a non-profit organization which operates as an information exchange for its members. The Knights of Columbus is a member of the MIB.

We make reports to the MIB on factors affecting your insurability. We will not inform them of our decision on your applications. If you subsequently apply to another MIB member company for life or health insurance or submit a claim for benefits, the MIB will, upon request, supply that company with information in its files. The Knights of Columbus or its reinsurers may also release information in its files 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.

Upon written request, the MIB will arrange disclosure of any information it may have on you in its file. If you feel the information in the MIB file is not correct, you may contact the MIB and seek a correction in accordance with procedures outlined in the Federal Fair Credit Reporting Act.

The MIB's address is: MIB, Inc., P. O. Box 105, Essex Station, Boston, Massachusetts 02112. The MIB's telephone number is: (866) 692-6901 (TTY 866-346-3642 for hearing impaired). The MIB's web address is: www.mib.com.

DESCRIPTION OF INFORMATION PRACTICES

Collection of Information

In order to properly underwrite your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending on the amount and type of coverage applied for. In general, we may seek information about: your age, occupation, physical condition, health history, mode of living, avocations and other personal characteristics.

You are our most important source of information, but we may also collect or verify information by contacting: medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone, or by personal contact.

In some cases, we may ask an insurance support organization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosure of Information

In some circumstances, the Knights of Columbus will make disclosures of personal information to third parties. Following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed: the Medical Information Bureau, our reinsurers, our agents, and other insurance companies to which you have applied for coverage or benefits.

The above describes some of the disclosures which may be made, not disclosures which are always or even often made. In any event, the information disclosed will be only as much as is reasonably necessary to accomplish the intended purpose.

Access and Correction

There are procedures by which you can obtain access to personal information about you appearing in our files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request.

Obtaining Additional Information

We hope that you find this description of our information practices helpful. We take our responsibilities, and your rights, very seriously. If you have any further questions about the items just discussed please write to: Knights of Columbus, at P. O. Box 1670, New Haven, Connecticut 06510-3326.

FRAUD WARNING: 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.

SERFF Tracking Number: FRCS-125782684 *State:* Arkansas
Filing Company: Knights of Columbus *State Tracking Number:* 40057
Company Tracking Number: 5050
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.103 Fixed/Indeterminate Premium - Joint
(Last Survivor)
Product Name: Second To Die Joint Application 600D 717 1-09
Project Name/Number: KOFC/135/135

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: FRCS-125782684 State: Arkansas
Filing Company: Knights of Columbus State Tracking Number: 40057
Company Tracking Number: 5050
TOI: L071 Individual Life - Whole Sub-TOI: L071.103 Fixed/Indeterminate Premium - Joint
(Last Survivor)
Product Name: Second To Die Joint Application 600D 717 1-09
Project Name/Number: KOFC/135/135

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

08/19/2008

Comments:

Attachments:

AR CoC.pdf

AR RDB.pdf

Auth_7-08_dist.pdf

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: Knights of Columbus
Form Title(s): Insurance Application
Form Number(s): 600D-AR 717 1-09

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



Richard B. Carroll
Associate General Counsel

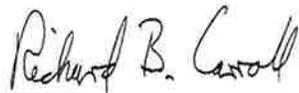
August 21, 2008
Date

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: Knights of Columbus

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.

Form Number	Score
600D-AR 717 1-09	52.4



Richard B. Carroll
Associate General Counsel

August 21, 2008
Date



KNIGHTS OF COLUMBUS

May 1, 2008

To: Department of Insurance

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Knights of Columbus

By: 
Title: Associate General Counsel