

SERFF Tracking Number: NGLI-125788836 State: Arkansas
Filing Company: National Guardian Life State Tracking Number: 40054
Company Tracking Number: 2800PN-AR 05/08
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Series 7 Application
Project Name/Number: /

Filing at a Glance

Company: National Guardian Life
Product Name: Series 7 Application
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form

SERFF Tr Num: NGLI-125788836 State: ArkansasLH
SERFF Status: Closed State Tr Num: 40054
Co Tr Num: 2800PN-AR 05/08 State Status: Approved-Closed
Co Status: Reviewer(s): Linda Bird
Authors: Peggy Kratz, Kim Bolinder 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: Status of Filing in Domicile: Authorized
Project Number: Date Approved in Domicile: 09/20/2007
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Overall Rate Impact: Group Market Type: Association
Filing Status Changed: 08/27/2008
State Status Changed: 08/27/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:

The above captioned enrollment form is enclosed for your review and approval.

Enrollment form 2800PN-AR 05/08 will be used on a general use basis to offer existing group whole life forms that fall under one of the two following categories:

- o The group certificate forms used in conjunction with this application have already been approved for use by your department.
- o The group certificate forms used in conjunction with this application were approved for use in other jurisdictions and have been in use in Arkansas (in compliance with Arkansas regulations for groups situated in other states extending

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coverage to residents of Arkansas).

The following information is therefore enclosed:

- Enrollment Form
- Certifications

Please note that since the filing pertains to group whole life coverage, there is no applicable checklist to include.

If you have any questions or comments, please contact me via the email address or phone number provided.

Company and Contact

Filing Contact Information

Kim Bolinder, Policy Forms Specialist
 2 East Gilman Street
 Madison, WI 53701

kabolinder@nglic.com
 (608) 443-5335 [Phone]
 (608) 443-5365[FAX]

Filing Company Information

National Guardian Life
 P.O. Box 1191
 Madison, WI 53701-1191
 (800) 626-7931 ext. 5790[Phone]

CoCode: 66583
 Group Code:
 Group Name:
 FEIN Number: 39-0493780

State of Domicile: Wisconsin
 Company Type: LAH
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: 1 application @ \$20
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Guardian Life	\$20.00	08/25/2008	22108290

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Correspondence Summary

Dispositions

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

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Disposition

Disposition Date: 08/27/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Readability Certificate		Yes
Form	ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY		Yes

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Form Schedule

Lead Form Number: 2800PN-AR 05/08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	2800PN-AR 05/08	Application/ENROLLMENT Enrollment Form	FORM FOR GROUP INSURANCE/ANNUITY	Initial		50	2800PN-AR 05-08.pdf

ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY - (PLEASE PRINT)

2800PN-AR 05/08 Series 7

National Guardian Life Insurance Company (NGL) • Fax 608.443.5368
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191MAIL POLICY TO: AGENT
 FUNERAL HOME
 OWNERPROPOSED INSURED/ANNUITANT Male Female_____
First Name MI Last Name Phone Number Social Security Number Age Date of Birth**OWNER - Complete only if other than Insured/Annuitant**_____
First Name MI Last Name Social Security Number Relationship to InsuredMAILING ADDRESS INSURED/ANNUITANT OWNER (Where to send information about this Policy)_____
Street Address City State Zip**PAYMENT PLAN**

Funeral Price \$ Face Amount \$

 Single Pay Life Flexible Annuity \$ _____Multi Pay Life: 3 Year 5 Year 10 Year

Initial Premium + Multi Pay Premium = Total Premium Amount (with app)

\$ \$ \$

PAYMENT MODE Annual Quarterly
 Semi-Annual Monthly EFT
(Form on back)
 MC/MISA - Use Monthly Direct Factor Monthly Direct
(Form on back)**STATEMENT OF HEALTH (To be completed by Proposed Insured - If enrolling in a 3, 5, or 10 Pay Life Plan)**Are you currently on oxygen, hospitalized, or confined to a nursing home or long term care facility; or during the past two years have you been advised by a medical professional to have any surgical procedure that has not been performed or have you been treated or are you being treated by a medical professional for any of the following diseases or disorders: YES NOCongestive Heart Failure Immune System Disorder Chronic Obstructive Pulmonary (lung) Disease Amputation (caused by disease)
Heart Disease Cirrhosis of the Liver Emphysema
Stroke Drug or Alcohol Dependency Alzheimer's/Dementia
Cancer (other than skin) Kidney failure (including dialysis) Diabetic Coma/Insulin Shock

If the health question is not answered or answered "Yes" and you are applying for a 3, 5, or 10 Pay Life plan, a Policy with limited death benefits during the first 2 Policy years will be issued.

DIRECTION FOR PAYMENT OF PROCEEDS (These directions may be changed any time before the funeral is provided by giving written notice to the Insurer.)

NGL is directed to pay an amount not to exceed the death benefit of the Policy to the Funeral Provider named below, if any, upon receipt of proof that funeral merchandise and services have been provided. In the event that NGL rescinds or declines to issue the Policy, I also assign to the Funeral Provider (1) the right to receive the premium paid upon receipt of proof that funeral merchandise and services have been provided, (2) the right to compromise claims and (3) the right to agree to rescission.

Name of Funeral Provider Street Address City State Zip_____
Name of Primary Beneficiary Street Address City State Zip Relationship to Insured**APPLICANT SIGNATURES**

To the best of my knowledge and belief, the above information is true and complete. I understand that no insurance will be effective until this form is approved and the Policy is issued while the Insured is living. I authorize NGL to share my nonpublic personal information with any Funeral Provider with whom I have a Prefunded Funeral Agreement. If I am the Owner for insurance on the life of the Proposed Insured, I certify that I have an insurable interest in his or her life.

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 is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____ State

Signature of Proposed Insured/Annuitant Date Signature of Owner (Required if other than Insured) Date

AGENT'S STATEMENT

I certify that any information recorded by me on this form is true and accurate to the best of my knowledge.

Agent(s) Signature Agent Name(s) Printed NGL Agent # Agent State License# %_____
Agent(s) Signature Agent Name(s) Printed NGL Agent # Agent State License# %

ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY



National Guardian Life Insurance Company (NGL) • Fax 608.443.5368
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191

Insured: _____

Agent: _____

IRREVOCABLE ASSIGNMENT OF POLICY

Assignment of Ownership, Death Benefit and Rescission Rights: The Owner hereby irrevocably assigns to the Funeral Provider named in the Direction for Payment of Proceeds all incidents of ownership of the Policy, the right to receive all or part of the death benefit payable under the Policy upon receipt of proof that the funeral merchandise and services have been provided, and, if the Insurer, for any reason either rescinds or declines to issue a Policy, all rights, including the following: (1) the right to receive the premium paid (upon receipt of proof that the funeral merchandise and services have been provided), (2) the right to compromise claims and (3) the right to agree to rescission.

The Owner acknowledges that by making the assignment irrevocable it cannot be canceled. This assignment does not affect the right of the Owner to cancel the Policy under the Right to Cancel provision. By making this assignment irrevocable, the Owner also acknowledges the following:

1. The assignment of death benefit proceeds is permanent and cannot be changed by the Owner.
2. The Owner has waived all rights under the Policy to surrender for cash, to obtain a loan, to change the Owner or beneficiary, or to receive a refund for any premium paid.
3. The Owner remains responsible for the payment of all insurance premiums when due.

It is understood and agreed that this irrevocable assignment in no way inhibits the Owner or the next of kin of the Insured from hereafter selecting another Funeral Provider to perform funeral services and provide funeral merchandise in connection with the funeral of the Insured. The Insurer is not a party to this assignment and the sole responsibility of the Insurer is to pay the death benefit proceeds pursuant to the terms of the Policy as amended by this assignment.

Immediate Transfer (For purposes of Medicaid Eligibility ONLY) - I hereby elect to make this irrevocable assignment effective immediately. I understand that by making this election I give up all rights to cancel the Policy and receive a return of premium under the Right to Cancel provision of the Policy. **To make an immediate transfer election please initial here _____.**

Signature of Owner

Date

AUTOMATIC PAYMENT AUTHORIZATION (Select One)

Monthly Electronic Funds Transfer

I request and authorize NGL to make monthly withdrawals against the financial institution account specified at right or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them, for the purpose of collecting premiums under this plan. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank.

If using a checking account, please include a void check. For savings account, please contact the bank to verify EFT is allowed and verify correct routing and account number.

Date of month to initiate payment (dates available are 1st through 28th) – select one: _____

Bank Name _____

Bank Routing/ABA # _____

Account # _____

Checking Savings

(Signature as it appears on bank records)

(Date)

Monthly Credit Card Authorization - Only available on 3, 5 and 10 Year Plans (Not on Annuity)

I authorize the premiums due to be remitted monthly to NGL through my credit card account indicated at right. This authority will remain in full force and effect until I revoke this authorization by written notification to NGL.

(Account Number)

(Exp. Date)

(Cardholder Signature)

(Cardholder Address)

(Printed Name)

(Date)

Select one only: VISA MasterCard

ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY



National Guardian Life Insurance Company (NGL) • Fax 608.443.5368
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191

ACKNOWLEDGMENT OF PAYMENT

This acknowledges payment from _____ in the amount of \$ _____ in connection with the Policy applied for from NGL. If all of the conditions of the application are met and the application is accepted, a Policy will be issued. If the application is not accepted, the Insurer's only responsibility will be to refund the amount for which this Acknowledgment of Payment was given.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution. For inquiries please call 1-800-988-0826.

Agent Signature

Date

"Policy" is defined as the insurance policy, certificate or annuity contract for which I am applying.

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State Tracking Number: 40054

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Sub-TOI: L08.000 Life - Other

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

08/25/2008

Comments:

Attachment:

AR- Certification Rule 19.pdf

Review Status:

Satisfied -Name: Application

08/25/2008

Comments:

This is an application only filing.

Attachment:

2800PN-AR 05-08.pdf

Review Status:

Satisfied -Name: Readability Certificate

08/25/2008

Comments:

Attachment:

AR- Certificate of Readability.pdf



**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

I, **Mathew J. Dew**, an officer of *National Guardian Life Insurance Company*, hereby certify that, to the best of my information, knowledge and belief the attached filing is in compliance with Rule and Regulation 19 regarding Unfair Sex Discrimination in the Sale of Insurance.

Mathew J. Dew

Signature

August 25, 2008

Date

Mathew J. Dew

Vice President & General Counsel – Company Officer

Individual responsible for this filing:

Name: Kim Bolinder

Title: Form Filing Specialist

Phone #: (608) 443-5335

Email: kabolinder@nglic.com

ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY - (PLEASE PRINT)

2800PN-AR 05/08 Series 7

National Guardian Life Insurance Company (NGL) • Fax 608.443.5368
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191MAIL POLICY TO: AGENT
 FUNERAL HOME
 OWNERPROPOSED INSURED/ANNUITANT Male Female_____
First Name MI Last Name Phone Number Social Security Number Age Date of Birth

OWNER - Complete only if other than Insured/Annuitant

First Name MI Last Name Social Security Number Relationship to InsuredMAILING ADDRESS INSURED/ANNUITANT OWNER (Where to send information about this Policy)_____
Street Address City State Zip**PAYMENT PLAN**

Funeral Price \$ Face Amount \$

 Single Pay Life Flexible Annuity \$ _____Multi Pay Life: 3 Year 5 Year 10 Year

Initial Premium + Multi Pay Premium = Total Premium Amount (with app)

\$ \$ \$

PAYMENT MODE Annual Quarterly
 Semi-Annual Monthly EFT
(Form on back)
 MC/MISA - Use Monthly Direct Factor Monthly Direct
(Form on back)**STATEMENT OF HEALTH (To be completed by Proposed Insured - If enrolling in a 3, 5, or 10 Pay Life Plan)**Are you currently on oxygen, hospitalized, or confined to a nursing home or long term care facility; or during the past two years have you been advised by a medical professional to have any surgical procedure that has not been performed or have you been treated or are you being treated by a medical professional for any of the following diseases or disorders: YES NOCongestive Heart Failure Immune System Disorder Chronic Obstructive Pulmonary (lung) Disease Amputation (caused by disease)
Heart Disease Cirrhosis of the Liver Emphysema
Stroke Drug or Alcohol Dependency Alzheimer's/Dementia
Cancer (other than skin) Kidney failure (including dialysis) Diabetic Coma/Insulin Shock

If the health question is not answered or answered "Yes" and you are applying for a 3, 5, or 10 Pay Life plan, a Policy with limited death benefits during the first 2 Policy years will be issued.

DIRECTION FOR PAYMENT OF PROCEEDS (These directions may be changed any time before the funeral is provided by giving written notice to the Insurer.)

NGL is directed to pay an amount not to exceed the death benefit of the Policy to the Funeral Provider named below, if any, upon receipt of proof that funeral merchandise and services have been provided. In the event that NGL rescinds or declines to issue the Policy, I also assign to the Funeral Provider (1) the right to receive the premium paid upon receipt of proof that funeral merchandise and services have been provided, (2) the right to compromise claims and (3) the right to agree to rescission.

Name of Funeral Provider Street Address City State Zip_____
Name of Primary Beneficiary Street Address City State Zip Relationship to Insured**APPLICANT SIGNATURES**

To the best of my knowledge and belief, the above information is true and complete. I understand that no insurance will be effective until this form is approved and the Policy is issued while the Insured is living. I authorize NGL to share my nonpublic personal information with any Funeral Provider with whom I have a Prefunded Funeral Agreement. If I am the Owner for insurance on the life of the Proposed Insured, I certify that I have an insurable interest in his or her life.

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 is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____ State

Signature of Proposed Insured/Annuitant Date Signature of Owner (Required if other than Insured) Date

AGENT'S STATEMENT

I certify that any information recorded by me on this form is true and accurate to the best of my knowledge.

Agent(s) Signature Agent Name(s) Printed NGL Agent # Agent State License# %_____
Agent(s) Signature Agent Name(s) Printed NGL Agent # Agent State License# %

ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY



National Guardian Life Insurance Company (NGL) • Fax 608.443.5368
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191

Insured: _____

Agent: _____

IRREVOCABLE ASSIGNMENT OF POLICY

Assignment of Ownership, Death Benefit and Rescission Rights: The Owner hereby irrevocably assigns to the Funeral Provider named in the Direction for Payment of Proceeds all incidents of ownership of the Policy, the right to receive all or part of the death benefit payable under the Policy upon receipt of proof that the funeral merchandise and services have been provided, and, if the Insurer, for any reason either rescinds or declines to issue a Policy, all rights, including the following: (1) the right to receive the premium paid (upon receipt of proof that the funeral merchandise and services have been provided), (2) the right to compromise claims and (3) the right to agree to rescission.

The Owner acknowledges that by making the assignment irrevocable it cannot be canceled. This assignment does not affect the right of the Owner to cancel the Policy under the Right to Cancel provision. By making this assignment irrevocable, the Owner also acknowledges the following:

1. The assignment of death benefit proceeds is permanent and cannot be changed by the Owner.
2. The Owner has waived all rights under the Policy to surrender for cash, to obtain a loan, to change the Owner or beneficiary, or to receive a refund for any premium paid.
3. The Owner remains responsible for the payment of all insurance premiums when due.

It is understood and agreed that this irrevocable assignment in no way inhibits the Owner or the next of kin of the Insured from hereafter selecting another Funeral Provider to perform funeral services and provide funeral merchandise in connection with the funeral of the Insured. The Insurer is not a party to this assignment and the sole responsibility of the Insurer is to pay the death benefit proceeds pursuant to the terms of the Policy as amended by this assignment.

Immediate Transfer (For purposes of Medicaid Eligibility ONLY) - I hereby elect to make this irrevocable assignment effective immediately. I understand that by making this election I give up all rights to cancel the Policy and receive a return of premium under the Right to Cancel provision of the Policy. **To make an immediate transfer election please initial here _____.**

Signature of Owner

Date

AUTOMATIC PAYMENT AUTHORIZATION (Select One)

Monthly Electronic Funds Transfer

I request and authorize NGL to make monthly withdrawals against the financial institution account specified at right or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them, for the purpose of collecting premiums under this plan. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank.

If using a checking account, please include a void check. For savings account, please contact the bank to verify EFT is allowed and verify correct routing and account number.

Date of month to initiate payment (dates available are 1st through 28th) – select one: _____

Bank Name _____

Bank Routing/ABA # _____

Account # _____

Checking Savings

(Signature as it appears on bank records)

(Date)

Monthly Credit Card Authorization - Only available on 3, 5 and 10 Year Plans (Not on Annuity)

I authorize the premiums due to be remitted monthly to NGL through my credit card account indicated at right. This authority will remain in full force and effect until I revoke this authorization by written notification to NGL.

(Account Number)

(Exp. Date)

(Cardholder Signature)

(Cardholder Address)

(Printed Name)

(Date)

Select one only: VISA MasterCard

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ACKNOWLEDGMENT OF PAYMENT

This acknowledges payment from _____ in the amount of \$ _____ in connection with the Policy applied for from NGL. If all of the conditions of the application are met and the application is accepted, a Policy will be issued. If the application is not accepted, the Insurer’s only responsibility will be to refund the amount for which this Acknowledgment of Payment was given.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution. For inquiries please call 1-800-988-0826.

Agent Signature

Date

“Policy” is defined as the insurance policy, certificate or annuity contract for which I am applying.



CERTIFICATION OF COMPLIANCE

I, Mathew J. Dew, an officer of *National Guardian Life Insurance Company* hereby certify that I have authority to bind and obligate the company by filing this (these) form(s). I further certify that, to the best of my information, knowledge and belief:

1. The accompanying form(s) as identified by the attached listing complies with all applicable provisions of the **ARKANSAS** Statutes and with all applicable administrative rules of the Commissioner of Insurance;
2. These form(s) do not contain any inconsistent, ambiguous, or misleading clauses;
3. These form(s) do not contain specifications or conditions that unreasonably or deceptively limit the risk purported to be assumed in the general coverage of the policy form(s);
4. The only variations from a form currently on file with the Commissioner of Insurance and the only unconventional policy provisions are clearly marked or otherwise indicated on the attached form(s) or in an attachment; and
5. The attached form(s) are in final printed format or typed facsimile and will be offered for issuance or delivery in **ARKANSAS** after approval by the Commissioner of Insurance, except for hypothetical data and other appropriate variable material.

CERTIFICATION OF READABILITY

I, Mathew J. Dew, an officer of the *National Guardian Life Insurance Company*, certify that the Flesch scores for the submitted forms are listed below:

Forms	Flesch Scores
2800PN-AR 05/08	51.0

Signature

August 25, 2008

Date

Mathew J. Dew

Vice President and General Counsel

Individual responsible for this filing:

Name: Kim Bolinder

Title: Policy Forms Specialist

Phone #: (608) 443-5335

Email: kbolinder@nglic.com