

SERFF Tracking Number: PENS-125800016 State: Arkansas  
Filing Company: Cardif Life Insurance Company State Tracking Number: 40137  
Company Tracking Number:  
TOI: CR04G Group Credit - Life Sub-TOI: CR04G.003 Single Premium  
Product Name: Group Credit Life and Accident & Health Insurance  
Project Name/Number: Resized forms/

## Filing at a Glance

Company: Cardif Life Insurance Company

Product Name: Group Credit Life and Accident & Health Insurance SERFF Tr Num: PENS-125800016 State: ArkansasLH

TOI: CR04G Group Credit - Life

SERFF Status: Closed

State Tr Num: 40137

Sub-TOI: CR04G.003 Single Premium

Co Tr Num:

State Status: Filed-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: Stephen Gardiner

Disposition Date: 09/11/2008

Date Submitted: 09/02/2008

Disposition Status: Accepted For Informational Purposes

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Resized forms

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 09/13/2006

Requested Filing Mode: Informational

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: Other

Filing Status Changed: 09/11/2008

State Status Changed: 09/11/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Re-sized approved policy forms.

## Company and Contact

### Filing Contact Information

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

SERFF Tracking Number: PENS-125800016 State: Arkansas  
Filing Company: Cardif Life Insurance Company State Tracking Number: 40137  
Company Tracking Number:  
TOI: CR04G Group Credit - Life Sub-TOI: CR04G.003 Single Premium  
Product Name: Group Credit Life and Accident & Health Insurance  
Project Name/Number: Resized forms/

Stephen Gardiner, Consultant pmg\_inc@comcast.net  
PMB 69 (941) 698-0385 [Phone]  
Englewood, FL 34224 (941) 698-0325[FAX]

**Filing Company Information**

Cardif Life Insurance Company CoCode: 71455 State of Domicile: Kansas  
14000 SW 119th Avenue Group Code: 3764 Company Type: Life, Accident &  
Health  
Miami, FL 33186 Group Name: Cardif Group State ID Number:  
(305) 234-1771 ext. [Phone] FEIN Number: 37-0857191  
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SERFF Tracking Number: PENS-125800016 State: Arkansas  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Cardif Life Insurance Company	\$50.00	09/02/2008	22242813

SERFF Tracking Number: PENS-125800016 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Linda Bird	09/11/2008	09/11/2008

*SERFF Tracking Number:* PENS-125800016      *State:* Arkansas  
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## **Disposition**

Disposition Date: 09/11/2008

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PENS-125800016 State: Arkansas  
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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Supporting Document</b>	Transmittal Letter		Yes
<b>Supporting Document</b>	Authorization Letter		Yes
<b>Form</b>	Certificate		Yes
<b>Form</b>	Application		Yes

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## Form Schedule

**Lead Form Number:** FA-SPC1-CAR-0906

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FA-SPC1-CAR-0906	Certificate	Certificate	Other	Other Explanation: Informational	40	CALIC CLAH SP Group Certificate (AR).pdf
	FA-SPC1-AAR-0906	Application/ Enrollment Form	Application	Other	Other Explanation: Informational	40	CALIC CLAH SP Group Health Application (AR).pdf

# CARDIF LIFE INSURANCE COMPANY

Administrative Office: 14000 SW 119<sup>th</sup> Avenue • Miami, FL  
Mailing Address: PO Box 77-0250 • Miami, FL 33177-0250  
877-522-7343  
(Herein called the Company, We, Us or Our)

## CERTIFICATE OF INSURANCE

**RIGHT TO EXAMINE CERTIFICATE:** You have the right to return the Certificate for a full refund of premium paid if not satisfied with the Certificate. You must send written notice of termination to the Company or its agent within thirty (30) days of receipt of the Certificate. Any premium paid will be refunded or credited to your indebtedness.

We certify that, if we have been paid the premium shown in the Application, you are insured for the coverage shown in the Schedule, subject to the terms of the Group Policy issued to the Creditor and acceptance by us. Our acceptance will be in accordance with our procedures and practices. The maximum Life Benefit is \$75,000.00 for each insured Borrower per Certificate. The maximum Monthly Disability Benefit is \$1,000.00, \$75,000.00 aggregate for each insured Borrower per Certificate. You and/or the Co-Borrower are eligible to apply for life insurance if you have not attained Age 65 on the Effective Date. You are eligible to apply for disability insurance if you have not attained Age 65 on the Effective Date. Upon the 66<sup>th</sup> birthday of either you or the insured Co-Borrower, whichever shall occur first, all life insurance will terminate. Upon your 66<sup>th</sup> birthday, all disability insurance will terminate. All benefit payments are made to the Creditor shown in the Schedule to pay off or reduce your debt. If benefit payments are more than the balance of your debt, we will pay the difference to you or to a named Second Beneficiary. If no Second Beneficiary has been named, payment will be made to your estate.

### LIFE INSURANCE

*The Life Insurance Benefit shall at no time exceed \$75,000.00 per Certificate issued under the Group Policy.*

**DEATH BENEFIT:** We will only pay one death benefit, which will be the amount of insurance in force at the time of death.

**PAYMENT OF A DEATH BENEFIT:** If you or the insured Co-Borrower dies while insured, we will pay the amount of insurance then in force after we receive proof of death. Only one death benefit is payable under this Certificate. Payment of a death benefit terminates all insurance coverage under this Certificate.

### AMOUNT OF LIFE INSURANCE:

**Gross Decreasing Insurance:** For loans with an initial loan balance that is less than the Maximum Life Benefit shown in the Application, the amount of gross decreasing life insurance during the first month after the Effective Date is the Initial Amount of Life Insurance. After the first month of insurance, the amount of life insurance will decrease each month by an amount determined by dividing the Initial Amount of Life Insurance by the Insurance Term. The death benefit is only payable if death occurs during the Insurance Term. This benefit will include up to two (2) delinquent monthly payments, but no other charges by the Creditor in connection with the loan. If you are ahead in making monthly payments to the Creditor, the insurance benefit will not be reduced by any payments you made in advance.

**Net Decreasing Insurance:** For loans with an initial loan balance that is less than the Maximum Life Benefit shown in the Application, the amount of net decreasing life insurance during the first month after the Effective Date is the Initial Amount of Life Insurance. After the first month of insurance, the amount of life insurance will decrease each month so that it remains equal to the scheduled unpaid loan (excluding unearned finance charges). The benefit provided at death may not pay off the total loan even though the loan amount is paid on a current basis. This benefit will include up to two (2) delinquent monthly payments, but no other charges by the Creditor in connection with the loan. If you are ahead in making loan payments to the Creditor, the insurance benefit will not be reduced by any payments you made in advance.

**Truncated Net Decreasing Insurance:** For loans with an initial loan balance that is less than the Maximum Life Benefit shown in the Application, the amount of truncated net decreasing life insurance during the first month after the Effective Date is the Initial Amount of Life Insurance. After the first month of insurance, the amount of life insurance will decrease each month so that it remains equal to the scheduled unpaid loan (excluding unearned finance charges). The Insurance Term shown in the Application may be shorter than the Loan Term. If the Loan Term exceeds the Insurance Term, the death benefit is only payable if death occurs during the Insurance Term. The Expiration Date of the insurance may be earlier than the maturity date of your loan. The benefit provided at death may not pay off the total loan even though the loan amount is paid on a current basis. This benefit will include up to two (2) delinquent monthly payments, but no other charges by the Creditor in connection with the loan. If you are ahead in making loan payments to the Creditor, the insurance benefit will not be reduced by any payments you made in advance.

**Level Insurance:** The amount of level life insurance is at all times equal to the Initial Amount of Life Insurance, but not more than the Maximum Life Benefit shown in the Schedule.

**For All Life Plans:** If the Initial Amount of Life Insurance is more than the Maximum Life Benefit shown in the Application, the amount of insurance decreases and is only a portion of the unpaid indebtedness. (See the definition of "Truncated Net Decreasing Insurance" above). The reduced benefit is determined as follows: First, the ratio of the Maximum Life Benefit to the Initial Amount of Life Insurance will be determined. That ratio will then be multiplied by the scheduled unpaid debt (excluding unearned finance charges when net decreasing or net truncated decreasing insurance is elected) to determine the amount of coverage. If the Initial Amount of Life Insurance is greater than the Maximum Life Benefit and a premium for the excess amount is charged, we have the right to refund the excess premium to the Creditor. The Company must make this refund within ninety (90) days of receipt of the Application. However, we can not amend the Initial Amount of Life Insurance if a claim has been filed prior to any amendment. The Initial Amount of Life Insurance will remain in force as issued.

**LIFE INSURANCE EXCLUSION:** No death benefit will be paid if your death results from: (1) flight in a non-scheduled aircraft; or (2) suicide, within two (2) years from the Effective Date of coverage. In such event, we will return the life premium if single life coverage is in effect. If joint life coverage is in effect, insurance will continue on the surviving insured Borrower and our liability will be limited to a refund of the premium received in excess of the single life premium.

**RULES FOR FILING A LIFE CLAIM:** We must be given a certified copy of the death certificate as proof of a life claim.

## TOTAL DISABILITY INSURANCE

*The Monthly Benefit shall at no time exceed \$1,000.00 (\$75,000.00 aggregate), per Certificate issued under the Group Policy.*

**TOTAL DISABILITY BENEFIT:** This coverage provides disability insurance on you only. Upon your total disability, we will pay the amount of the Monthly Benefit insured under this Certificate. Total disability benefits will not be paid for any period of total disability continuing after the Expiration Date shown on the Application.

**CRITICAL PERIOD DISABILITY BENEFIT:** If you become totally disabled, as defined below, we will pay the amount of the Monthly Benefit insured under this Certificate for the maximum number of Total Disability Benefit periods as elected in the Application and for which premium was paid. After such period, you will have to resume making payments to the Creditor as scheduled. Your total disability can either be due to one consecutive total disability or a total of several total disability periods, subject to the scheduled waiting period.

**DEFINITION OF TOTAL DISABILITY:** For the initial twelve (12) months of disability, total disability means that you are not able to perform the duties of your own occupation at such time total disability occurred. Thereafter, total disability means that you are not able to perform the duties of any occupation for which you are reasonably suited by education, training or experience. Total disability must result from a medically determined sickness or accidental injury. You must be under the care and treatment of a qualified licensed physician. This physician cannot be you, the insured Co-Borrower, an immediate family member or an employer. If the condition that caused the total disability recurs within thirty (30) days after recovery from that condition, benefits will be paid without having to satisfy a new waiting period. If the same condition recurs after thirty (30) days, a new waiting period must be satisfied. **Total disability must begin while this Certificate is in force.**

**PAYMENT OF TOTAL DISABILITY BENEFITS:** We will pay a benefit if your total disability starts while you are insured and continues without interruption for the number of consecutive days (waiting period) shown in the Application. After meeting the scheduled waiting period, benefits are payable to the date of total disability as medically determined, and will continue as long as you are totally disabled while the Certificate is in force. If benefits are payable for less than one month, an amount equal to 1/30<sup>th</sup> of the Monthly Benefit will be due for each day of such period. The total amount of disability benefits payable will never be more than the amount owed on the loan. No benefits will be payable for any total disability period after the end of the Insurance Term stated in the Application.

**Retroactive:** Benefits begin on the first day of total disability after the scheduled waiting period.

**Non-Retroactive:** Benefits begin on the day after the scheduled waiting period.

**TOTAL DISABILITY EXCLUSIONS:** No disability benefits will be paid if total disability: (a) results from normal pregnancy; or (b) results from any intentionally self-inflicted injury; or (c) results from flight in a non-scheduled aircraft; or (d) or war or act of war; or (e) foreign travel or residence; or (f) was caused by a pre-existing medical condition for which you received medical advice, diagnosis, consultation or treatment by a physician or practitioner within six (6) months before the Effective Date of coverage, and which caused loss within six (6) months after the Effective Date of coverage. Total Disability starting after that from the same condition will be covered.

**RULES FOR FILING A TOTAL DISABILITY CLAIM:** You must write to us or our Agent about your disability claim within twenty (20) days after your disability began or as soon thereafter as you can. We will send you claim forms within fifteen (15) days after you tell us about your claim. If we do not send the forms within fifteen (15) days, you can send us written proof of your disability. The proof must show the date, cause and seriousness of your disability. A qualified licensed physician must also sign it. The physician cannot be you, the insured Co-Borrower, an immediate family member or an employer. The proof of total disability must be sent to us no later than ninety (90) days after your total disability began. Failure to send us proof within ninety (90) days will not invalidate a claim if it is shown that proof was given as soon as was reasonably possible. Unless you have been legally incapable of filing the proof of loss, we will not accept it if it is filed after one (1) year from the date your disability began. You cannot start legal action until sixty (60) days from the date you sent us the proof of your total disability and no legal action may be brought after three (3) years from the time written proof of loss is required to be furnished.

We will not deny a claim due to your or the insured Co-borrower's unemployment or retirement during the Insurance term.

**CONTINUATION OF A TOTAL DISABILITY CLAIM:** A disability of a continuing nature will require completion of additional proof of loss forms. These forms must verify that you are under the continual care of a qualified licensed physician. The physician cannot be you, the insured Co-Borrower, an immediate family member or an employer. You must still be unable to work at any occupation. We will provide these forms to you at reasonable intervals. The nature of your disability will be considered when requiring these forms.

**WHEN TOTAL DISABILITY BENEFITS STOP:** Benefits stop the earliest of the date: (a) when you are no longer totally disabled; or (b) when the maximum number of disability payments have been made; or (c) you stop submitting the required claim forms; or (d) benefits have been paid to the end of the Insurance Term; or (e) there is no loan balance. If a balloon payment or residual value is part of your loan, that payment is not covered under this Certificate as part of your Total Disability coverage.

If the remaining Term of Loan exceeds the Maximum Disability Benefit Period shown in the schedule when you become totally disabled, you will have to resume payments to the Creditor after the Maximum Disability Period ends.

## GENERAL PROVISIONS

*General Provisions will relate to life insurance benefits and total disability benefits.*

**ENTIRE CONTRACT:** The Group Policy, the Application for the Group Policy, any and all Riders, Endorsements, written Amendments, the Application for insurance and this Certificate are the entire contract of insurance.

**INCONTESTABILITY:** We will not contest this insurance: (a) except for nonpayment of premium, after it has been in force two (2) years during your lifetime; or (b) during the first two (2) years it is in force unless the contest is based on a written statement signed by you or your insured Co-Borrower and furnished to you or the beneficiary. All statements made by you or your insured Co-Borrower, in the absence of fraud, are deemed representations, not warranties.

**PAYMENT OBLIGATION OF THE BORROWER(S):** You are obligated to make the required payments to the Creditor during the period your claim is pending. This obligation does not stop until we approve payment of your claim.

**TIME PAYMENT OF CLAIMS:** Life insurance benefits payable under the Certificate are payable immediately upon receipt of written proof of loss. All accrued benefits for total disability benefits, subject to written proof of loss, will be paid monthly. Any balance remaining unpaid upon the end of the claim will be paid immediately upon receipt of due written proof.

**RENEWAL OR REFINANCING:** If this insurance is issued in connection with a previously insured, renewed or refinanced debt, the effective date of any Policy provision will be deemed to be the date the original insurance took effect under the Certificate. Benefits will be limited to the amount and term of the debt outstanding at the time of the renewal and refinancing.

**WHEN INSURANCE STOPS-REFUND:** Your insurance coverage stops; (a) at the end of the term shown in the Schedule of the Application; or (b) on the date your loan is paid off, renewed, refinanced, or otherwise stops; or (c) when any scheduled payment is in default in whole or in part for a period of ninety (90) days; or (d) on the repossession of any secured collateral.

If insurance stops before the scheduled Expiration Date, a prompt refund or credit of any unearned premium will be made to the Creditor for credit to your account. Refunds or credits for decreasing life insurance, net decreasing life insurance, truncated net decreasing life insurance and total disability will be computed by the Rule of 78 method. Refunds or credit for level life insurance will be computed using the "Pro-Rata" method. If we pay a life insurance benefit, the life premium will be fully earned and any unearned disability premium will be refunded to your beneficiary, if any, other than the Creditor or to your estate. If we pay the amount of insurance in force as a disability insurance benefit, the disability premium will be fully earned and any unearned life premium will be refunded to you, if living or to your beneficiary, if any, other than the Creditor or to your estate. To determine the unearned premium refund, a month is considered earned when sixteen (16) days or more have passed, and unearned if fifteen (15) days or less have passed. Any premium that we may have been paid by you for insurance after the date your insurance stops will be refunded or credited to your account. No refund or credit will be made if the amount is less than five dollars (\$5.00). To receive a refund or credit of any unearned premium that may be due, you or your beneficiary (in the event termination of insurance is the result of your death), must give us written notice of early termination of this insurance. Notice should be mailed to us at the Company's address stated on the Certificate of Insurance, or to the agent that sold you this insurance. The refund will be made in accordance with the refund method stated in the Certificate of Insurance. We have the right to require proof of the date of termination of the insurance. If you have any questions as to the refund procedure, call 1-877-522-7343.

Termination of insurance before the scheduled Expiration Date will be without prejudice to any claim existing on the date insurance terminates.

**REPOSSESSION:** If repossession occurs, our only obligation is to refund the unearned premium to the Creditor. We are absolved of any other obligation under this Certificate.

**OVERPAYMENT OF BENEFITS:** If, based on inaccurate information, we overpay benefits, you or the Creditor is obligated to return the overpayment within thirty (30) days of notification. Notice will be sent by certified mail.

**MISSTATED TERMS:** If we provided an incorrect amount of insurance to you because we were given wrong information, we will amend your coverage to provide the correct amount of insurance. Any excess premium will be refunded to the person entitled to it. If we do not refund the excess premium, your coverage will remain in force as submitted.

**MISSTATED AGE:** You are eligible for insurance only if your age is not older than the Maximum Age as shown in the Application Schedule when your debt begins. If you state you are not older than the Maximum Age when your debt begins, but you are, we will refund the entire premium paid when we discover this and will not pay any benefits. If joint insurance is in effect and the Insured Co-Borrower is older than the Maximum Age when the debt begins, we will refund the difference in premium between joint and single coverage. If you or the Insured Co-Borrower becomes disabled or dies before we return premium, coverage will remain in force as submitted.

**PHYSICAL EXAM AND AUTOPSY:** We, at our own expense, have the right and you must allow us the opportunity to arrange an examination of your person as often as is reasonably required while a total disability claim is pending. We also have the right to make an autopsy in case of death if allowed by law.

**TERMINATION:** If the Group Policy should terminate for any reason, your insurance coverage shall continue for the entire period for which the premium has been paid, subject to your right to cancel the insurance at any time. You must make your cancellation request in writing. A refund will be calculated based upon the date of your written notice.

**CONFORMITY WITH STATE STATUTES:** Any provision of the Certificate, which on the Effective Date is in conflict with the statutes or regulations of the state where the Certificate was delivered to you, is hereby amended to conform to the minimum requirements of those statutes or regulations. Any such provision, however, will be enforced to the maximum extent permitted by law.

**POLICY NON-PARTICIPATING:** The Group Policyholder will not be entitled to share in our surplus or earnings.

CARDIF LIFE INSURANCE COMPANY



President

**CARDIF LIFE INSURANCE COMPANY**

Administrative Office: 14000 SW 119<sup>th</sup> Avenue • Miami, FL 33186

Mailing Address: PO Box 77-0250 • Miami, FL 33177-0250

877-522-7343

(Called the Company, We, Us or Our)

THE MAXIMUM LIFE BENEFIT AVAILABLE UNDER THIS APPLICATION AND/OR CERTIFICATE IS **[\$75,000.00.]** THE MAXIMUM MONTHLY DISABILITY BENEFIT IS **[\$1,000.00 (\$75,000.00 AGGREGATE)]** PER CERTIFICATE. YOUR BENEFIT IS DETERMINED BY THE AMOUNT OF COVERAGE ACCEPTED BY CARDIF LIFE INSURANCE COMPANY AND CAN NEVER BE GREATER THAN YOUR ACTUAL DEBT.

Primary Borrower (Called You)		Sex	Date of Birth	Social Security #	Account/Loan#	Interest rate %
Borrower Address			Second Beneficiary		Effective Date	Expiration Date
Co-Borrower (if insured)		Sex	Date of Birth	Social Security #	Insurance Term	Loan Term
Creditor/First Beneficiary (Name and Address)					Amount of Loan	First Payment Date
LIFE INSURANCE <input type="checkbox"/> SINGLE <input type="checkbox"/> JOINT				LIMITS OF LIABILITY		TERM PREMIUM
<input type="checkbox"/> Level				INITIAL AMOUNT OF LIFE INSURANCE		\$
<input type="checkbox"/> Gross Decreasing <input type="checkbox"/> Net Decreasing <input type="checkbox"/> Truncated Net Decreasing				INITIAL AMOUNT OF LIFE INSURANCE		\$
DISABILITY INSURANCE <input type="checkbox"/> SINGLE    (Primary Borrower Only)				MONTHLY BENEFIT		\$
<input type="checkbox"/> Full	<input type="checkbox"/> Critical Period	Maximum Benefit Period				\$
		<input type="checkbox"/> 12 <input type="checkbox"/> 18 <input type="checkbox"/> 24 Months				\$
<input type="checkbox"/> Retroactive <input type="checkbox"/> Non-Retroactive				TOTAL PREMIUM		\$
BENEFITS BEGIN AFTER A PERIOD OF _____ DAYS						

**NOTICE: THE PURCHASE OF THIS INSURANCE IS OPTIONAL AND NOT A CONDITION TO OBTAINING CREDIT APPROVAL.**

**I am not eligible to apply for any life insurance coverage if I have attained age 65 as of the Effective Date. I am not eligible to apply for any disability insurance if I have attained age 65 as of the Effective Date.**

Upon the 66<sup>th</sup> birthday of either the Primary Borrower or the Insured Co-Borrower, whichever shall occur first all life insurance coverage will terminate. Upon the 66<sup>th</sup> birthday of the Primary Borrower all disability insurance coverage will terminate.

**ELIGIBILITY QUESTIONS:** *To assist you in understanding the following questions/statements, our use of the words disease/disorder mean a chronic or persistent condition that has been diagnosed or treated which causes unnatural, irregular impairment or weakening of normal functioning.*

- |  |  |  |
|--|--|--|
|  | <b>Primary Borrower</b>                                  | <b>Co-Borrower</b>                                       |
| 1. During the past 2 years, have you been seen, diagnosed or treated (including medication) by a doctor or member of the medical profession for any of the following: (a) a disease or disorder of the Brain; Heart; Lung; Liver; Kidney; Respiratory System; Circulatory System; Digestive System; Neurological/Muscular System; (b) Cancer; High Blood Pressure (prescribed and/or taking more than one medication); Edema; Stroke; Diabetes; Alcoholism; Drug Abuse; Morbid Obesity (and/or complications directly related to) or a Psychological or Psychiatric Illness; (c) an HIV Positive test result or (d) weight reduction surgery (had or recommended to have)? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <i>I understand that if I answer YES to question # 1, above, I have no insurance coverage.</i>   |  |  |
| 2. During the past 2 years, have you been seen, diagnosed or treated (including medication) by a doctor or member of the medical profession for: (a) a disease or disorder of the Bones, Joints, Back, Spine, Neck or Knees; or (b) Macular Degeneration?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| <i>I understand that if I answer YES to question #2, above, I have no Disability coverage.</i>   |  |  |
| 3. Are you actively at work, in the full performance of all the essential duties of your own regular occupation, for one employer, for wages or profit, for at least 30 hours or more per week for one (1) month prior to and on the Effective Date?   | <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| <i>I understand that if I answer NO to question #3, above, I have no Disability coverage.</i>  |  |  |
| 4. Are you receiving Social Security Disability Benefits, Workers Compensation Disability Benefits or not working due to any type of leave, medical or otherwise?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| <i>I understand if I answer YES to question # 4 above, I have no Disability coverage.</i>  |  |  |

**SEE REVERSE SIDE FOR IMPORTANT INFORMATION**

**YOUR CERTIFICATE MAY NOT BE IN FORCE WHEN YOU HAVE A CLAIM! PLEASE READ!**

Your Certificate is issued based on the information entered in this Application. If, to the best of your knowledge and belief, there is any misstatement in this Application or if any information concerning the medical history of any insured person has been omitted, you should advise the Company, otherwise your Certificate may not be a valid contract.

My signature below acknowledges that I have read and understand the above Insurability Requirements and represent that I meet both the Eligibility Requirements and the Questions of Insurability and am eligible for the coverage as requested in the Schedule. I further understand and agree that I am insured only if I have signed below and I agree to pay the premiums for this insurance. I have received and retained the "BORROWERS COPY" of this form and the Certificate for my records.

**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.**

Primary Borrower \_\_\_\_\_  
Date

Co-Borrower \_\_\_\_\_  
Date

**NOTICE OF 30 DAY RIGHT TO RETURN CERTIFICATE:** Please read your Certificate. This Certificate of Insurance may be returned to the Creditor identified in the Schedule above within 30 days of the date of the loan for a full refund of the premium paid, if after examination, you are not satisfied with the insurance for any reason.

**IF THE AMOUNT OR TERM OF THIS INSURANCE IS LESS THAN THE AMOUNT OR TERM OF YOUR LOAN, THIS INSURANCE WILL NOT BE ENOUGH TO COMPLETELY PAY OFF YOUR LOAN.  
DISABILITY RESULTING FROM PRE-EXISTING INJURY OR SICKNESS MAY NOT BE COVERED.  
ANY BORROWER INDEBTED PRIMARILY AS A RESULT OF A PARTNERSHIP, CORPORATION OR ASSOCIATION IS NOT ELIGIBLE FOR ANY INSURANCE.**

*SERFF Tracking Number:* PENS-125800016      *State:* Arkansas  
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*Project Name/Number:* Resized forms/

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: PENS-125800016 State: Arkansas  
Filing Company: Cardif Life Insurance Company State Tracking Number: 40137  
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TOI: CR04G Group Credit - Life Sub-TOI: CR04G.003 Single Premium  
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## Supporting Document Schedules

**Review Status:**  
**Satisfied -Name:** Certification/Notice 09/02/2008  
**Comments:**  
**Attachment:**  
Certification Form.pdf

**Review Status:**  
**Satisfied -Name:** Application 09/02/2008  
**Comments:**  
**Attachment:**  
Prior Approval Letter.pdf

**Review Status:**  
**Satisfied -Name:** Transmittal Letter 09/02/2008  
**Comments:**  
**Attachment:**  
Transmittal Letter.pdf

**Review Status:**  
**Satisfied -Name:** Authorization Letter 09/02/2008  
**Comments:**  
**Attachment:**  
CLIC Authorization.pdf

## CERTIFICATION

The Company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted is consistent and complies with the requirements of Rule & Regulation 19 as well as all applicable requirements of the state of Arkansas and the regulations promulgated pursuant thereto.

 Stephen G. Gark, Const. Hout

Signature and title

8/31/08

Date



Financial American Life Insurance Company  
A member of the Cardif Group

August 16, 2006

Ms. Linda Bird  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little Rock, AR 72201-1904

**RECEIVED**

AUG 21 2006

**LIFE AND HEALTH**  
ARKANSAS INSURANCE DEPARTMENT

**APPROVED**

AUG 29 2006

**LIFE AND HEALTH**  
ARKANSAS INSURANCE DEPARTMENT

RE: Financial American Life Insurance Company, NAIC # 71455, FEIN # 37-0857191  
Group Credit Life and Accident & Health Insurance  
Master Policy  
Application for Master Policy  
Borrower Application  
Certificate of Insurance  
Form Submission

FA-SPC1-PAR-0906  
FA-SPC1-GAR-0906  
FA-SPC1-AAR-0906  
FA-SPC1-CAR-0906

Dear Ms. Bird,

Attached for your review and approval are the above captioned forms in final print format. This is a new filing for our company and will replace our previously approved form filing approved on 7/12/06 and 1/11/05. We have attached copies of the approval letters for your review.

We plan to retain the use of the Credit Life and Accident & Health premium rates approved on 1/11/05.

All language revisions to the previously approved forms of 7/12/06 and 1/11/05 have been underlined for easy reference. All variable policy language has been bracketed. At no times will the variable information be more restrictive or prejudicial to the applicant/insured Borrower per Arkansas regulation.

The language revisions were made for various reasons, primarily to make the forms consistent with forms approved by the Company in other jurisdictions and for cosmetic reasons. Additionally, we added new language to the Refund provision to clarify the refund procedure. We are aware of several other insurance companies (American National, Central States, JMIC, etc.) including similar refund language in their forms in recent years.

In all other regards, the policy forms are identical to the approved single premium policy forms on file with the Arkansas Department of Insurance. We certify that we made no revisions to the forms other than what is mentioned in this letter and indicated on the policy forms.

The program will be offered to borrowers of a creditor. The initial amount of credit life insurance shall not exceed the total amount repayable in installments, not to exceed the greater of the scheduled or actual amount of unpaid installments. The credit accident and health indemnity shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness, and the periodic indemnity shall not exceed the original indebtedness divided by the number of periodic installments.

Also enclosed is a Readability Certification attesting that the forms achieve a score not lower than 40 using the Flesch Readability Test.

Unless otherwise advised by the Department, we may find it necessary to vary the layout (not change content) of the insurance information in the Schedule of the Application. These changes will only be cosmetic and will only be necessary in order to accommodate the data processing system needs of the creditor.

We respectfully request that this filing be effective upon approval for new business.

Please use the self-addressed, postage paid envelope to indicate your approval of this filing. Please do not hesitate to contact our designated filing person at 941-698-0385, Fax at 941-698-0325 or e-mail at [pmg\\_inc@comcast.net](mailto:pmg_inc@comcast.net) if you have any questions or if you require additional information.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Gardiner", with a long horizontal flourish extending to the right.

Stephen Gardiner  
Consultant for Financial American Life Insurance Company



**CARDIF**

A BNP PARIBAS company

August 31, 2008

Ms. Linda Bird  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little rock, AR 72201-1904

RE: Cardif Life Insurance Company, NAIC # 71455, FEIN # 37-0857191  
Group Credit Life and Accident & Health Insurance  
Borrower Application FA-SPC1-AAR-0906  
Certificate of Insurance FA-SPC1-CAR-0906  
Informational Form Submission

Dear Ms. Bird,

Attached for your review and information are the above captioned forms in final print format. These forms are exactly the same as approved on 8/29/2006 (see approval letter) . The only change we have made to the approved forms is that we have revised the form size from legal (8.5 x 14) to letter size (8.5 x 11) and that the company name and masthead information has been revised on these resized forms compared with the approved forms of 2006. The masthead information is different because the company legally changed its name from Financial American Life Insurance company to Cardif Life Insurance Company with your Department last year. We also received approval from your Department to retain and use all approved form and rate filings under the former company name with the new company name.

The current change is being done to accommodate the data processing need (laser printing) needs of our customers. In all other respects, the forms are exactly as approved other than what is mentioned above regarding the masthead information.

We plan to retain the use of the Credit Life and Accident & Health premium rates approved on 8/29/06.

Please do not hesitate to contact me at 941-698-0385, Fax at 941-698-0325 or e-mail at [pmg\\_inc@comcast.net](mailto:pmg_inc@comcast.net) if you have any questions or if you require additional information.

Sincerely,

Stephen Gardiner  
Consultant for Cardif Life Insurance Company



**CARDIF**

A BNP PARIBAS company

January 1, 2008

Mr. Stephen R. Gardiner  
President  
Peninsula Marketing Group, Inc.  
PMB 69  
2828 S. McCall Rd., Suite 32  
Englewood, FL 34224

RE: Product Submission Authorization

Dear Mr. Gardiner,

I, Michael Casale, President of the insurance company listed below, hereby authorize Stephen R. Gardiner or other authorized employees of Peninsula Marketing Group, Inc. to file and submit insurance policy forms and rates on our behalf with all state insurance departments.

<u>COMPANY</u>	<u>NAIC Group #</u>	<u>NAIC Company #</u>	<u>FEDERAL TAX ID #</u>
Cardif Life Insurance Company	3764	71455	37-0857191

Sincerely,

President

- Cardif Property and Casualty Insurance Company
- Cardif Life Insurance Company
- Cardif Services Inc.

**Mailing Address:**  
Post Office Box 77-0250  
Miami, Florida 33177-0250

Tel.: 305 234 1771 Fax: 305 234 1774  
Toll Free: 877 522 7343  
[www.cardifus.com](http://www.cardifus.com)