

SERFF Tracking Number: WKLY-126008428 State: Arkansas
Filing Company: Sterling Investors Life Insurance Company State Tracking Number: 41946
Company Tracking Number: SILIC AR LEGACY
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: SILIC AR LEGACY
Project Name/Number: /

Filing at a Glance

Company: Sterling Investors Life Insurance Company

Product Name: SILIC AR LEGACY

SERFF Tr Num: WKLY-126008428 State: ArkansasLH

TOI: L071 Individual Life - Whole

SERFF Status: Closed

State Tr Num: 41946

Sub-TOI: L071.101 Fixed/Indeterminate
Premium - Single Life

Co Tr Num: SILIC AR LEGACY

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: Karen Nowlan

Disposition Date: 01/30/2009

Date Submitted: 01/27/2009

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/30/2009

State Status Changed: 01/30/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Wakely and Associates, Inc. has been authorized to file the above captioned form on behalf of Sterling Investors Life Insurance Company. This is a new application filing to solicit a settlement option from the Sterling Investor's Whole Life policy filed and approved in your state on August 26, 2005 (SERT−6DSS22133)

This will give the policy owner the option to send a set dollar amount to their beneficiary each year for a period of ten or twenty years.

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Thank you for your assistance. If you have any questions or comments, please contact me at 1-877-777-2443, extension 2171 or by e-mail at Karen.Nowlan@iasadmin.com.

Company and Contact

Filing Contact Information

(This filing was made by a third party - WAI01)

Karen Nowlan, Compliance Analyst karen.nowlan@wakelyinc.com
 Wakely and Associates, Inc. (727) 584-8128 [Phone]
 Largo, FL 33773-1502 (727) 584-5613[FAX]

Filing Company Information

Sterling Investors Life Insurance Company CoCode: 89184 State of Domicile: Georgia
 210 E. Second Avenue, Suite 105 Group Code: -99 Company Type: Life and Health
 Rome, GA 30161 Group Name: State ID Number:
 (706) 235-8154 ext. [Phone] FEIN Number: 59-1838073

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Investors Life Insurance Company	\$20.00	01/27/2009	25297311

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	01/30/2009	01/30/2009

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Disposition

Disposition Date: 01/30/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: WKLY-126008428 *State:* Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Authorization Ltr		Yes
Form	Application		Yes

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Form Schedule

Lead Form Number: SI LL APP 200901 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SI LL APP 200901 AR	Application/ Enrollment Form	Application Enrollment Form	Initial			SI LL APP 200901 AR.pdf

STERLING INVESTORS LIFE INSURANCE COMPANY

Home Office: Rome Georgia

Administrative Office: P.O. Box 10846, Clearwater, FL 33757-8846

APPLICATION FOR LIFE INSURANCE

PROPOSED INSURED

Name (First, Middle, Last)	Birth Date (mm/dd/yyyy)	Age	Sex	Social Security Number
Street	City	State	Zip Code	Telephone Number
Marital Status	Place of Birth (state)	Height	Weight	

OWNER, IF DIFFERENT FROM PROPOSED INSURED

Name (First, Middle, Last)	Birth Date (mm/dd/yyyy)	Relationship	Social Security Number	
Street	City	State	Zip Code	Telephone Number

COVERAGE, PREMIUM MODE, PREMIUM AMOUNT & REPLACEMENT INFORMATION

Face Amount of Life Insurance Applied For: \$ _____

Monthly Bank Draft: \$ _____ Draft Initial Payment: Yes / No Policy Effective Date: _____

Initial Bank Draft on: Policy Issue Date or Policy Effective Date (if not answered draft on Issue Date)

Quarterly: \$ _____ Semiannual: \$ _____ Annual: \$ _____

Will this life insurance being applied for replace existing life insurance or annuity coverage? Yes No

If yes, provide the name of company and policy number(s): Company: _____ No.: _____

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the last 5 years? Yes No
(If answer is "No", you are eligible for Preferred rates, if "Yes", Standard rates will apply.)

ELIGIBILITY QUESTIONS *(If you answer "Yes" to one or more questions you are not eligible for coverage)*

1. Have you been treated for or diagnosed with a terminal illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you bedridden, confined to a wheelchair, or require the assistance of a motorized mobility aid; or, in the past two years have you suffered two or more falls within a six month period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. In the past two years, has surgery or tests been advised by a physician but not performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had or been told by your physician you needed amputation due to disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:		
a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Lupus, Alzheimer's Disease, or Dementia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Insulin Dependent Diabetes or any Kidney Disease requiring dialysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Congestive Heart Failure (CHF), or Peripheral Vascular Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Within the past two years have you had a heart attack, stroke, or heart valve surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. During the last six months, have you been declined for life insurance or had a life insurance application rejected or postponed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mail Policy to the Agent or the Insured (if unanswered will mail to agent)

BENEFICIARIES

Name of Beneficiary	Relationship	Sex	Birth Date	Greeting Name in Card	Sender Name in Card
Occasion Card (1 to 5)	Occasion Date	Message in Card			
Name of Beneficiary	Relationship	Sex	Birth Date	Greeting Name in Card	Sender Name in Card
Occasion Card (1 to 5)	Occasion Date	Message in Card			

*Occasion Card Selection: 1 – Happy Holidays 2 – Happy Birthday 3 – Happy Anniversary 4 – On Your Special Day 5 – With Love

DIRECTIVE TO STERLING INVESTORS LIFE INSURANCE COMPANY

It is my intention to memorialize the cherished moments of those dear to me by providing a monetary gift on an annual basis for a period of (enter 10 or 20) _____ years upon my death. Please see that upon my death each named beneficiary receives a card and equal annual payments on the date specified in the amount of \$_____, or such other amount the net proceeds allow, with a lump sum being paid if the annual amount is less than \$75. It is my desire that this annual gift be funded with the proceeds from my Whole Life Insurance Policy underwritten by Sterling Investors Life Insurance Company.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the insurance plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information requested is necessary for evaluation and underwriting of my application for the insurance policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company will result in the rejection of the insurance policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION: No applicant or individual family member who is presently covered under a policy or plan shall be required to be the subject of a genetic test or release genetic test information or to be subjected to questions relating to the genetic information or medical conditions of persons not being insured under such policy or plan.

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.

Signed At: _____

(City /State)

Proposed Insured's Signature _____

Date (Month/Day/Year) _____

Owner's Signature (if different from Proposed Insured) _____

Date (Month/Day/Year) _____

Agent's Signature _____

Date (Month/Day/Year) _____

Agent's Printed Name _____

Agent's Number _____

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Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification

01/27/2009

Comments:

Attachments:

AR Certificate of Compliance.pdf

Flesch Cert .pdf

Review Status:

Satisfied -Name: Authorization Ltr

01/27/2009

Comments:

Attachment:

2009 Sterling Letter of Authorization.pdf

ARKANSAS COMPLIANCE CERTIFICATION

Name and Address of Insurer:

**Sterling Investors Life Insurance Company
Rome, Georgia**

The Company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted complies with the requirements of Rules and Regulation 19 and Rule and Regulation 49.

Signed for the Company by an Officer

A handwritten signature in cursive script, appearing to read "W. H. W. W. W.", is written in black ink.

Title: President

Date: January 26, 2009

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

**Sterling Investors Life Insurance Company
Rome Georgia**

I hereby certify that the Flesch Reading Ease Test Score for form number SI LL APP 200901 AR meets the minimum reading ease score of 40 required by IC 27-1-26-3.

Signed for the Company by an Officer



Signature

President

Title

January 16, 2009

Date

210 E. Second Avenue
Ste. 105
Rome, Georgia 30161
Tel (706) 235-8154
Fax (866) 889-4054

January 21, 2009

Ms. Darcey Shaffer, ACS, FLMI
Compliance Manager
Wakely and Associates, Inc.
8545 126th Avenue North, Suite 200
Largo, Florida 33773-1502

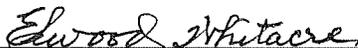
RE: Life and Health Filings for Rate Increases, Forms and Reporting
Requirements for Sterling Investors Life Insurance Company

Dear Ms. Shaffer:

This letter authorizes Wakely and Associates, Inc. to file on behalf of Sterling Investors Life Insurance Company, rate increases, forms and reporting requirements for the Company's Life and Health Insurance Policies with the State Insurance Departments. Wakely and Associates, Inc. may correspond with the State Insurance Departments regarding any questions they may have concerning the filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,



Elwood Whitacre
Secretary and Treasurer