

SERFF Tracking Number: IASL-126339849 State: Arkansas  
Filing Company: Sterling Investors Life Insurance Company State Tracking Number: 43812  
Company Tracking Number: SIAR COMBO APP  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: SIAR Combo App  
Project Name/Number: /

## Filing at a Glance

Company: Sterling Investors Life Insurance Company

Product Name: SI AR Combo App

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: IASL-126339849

SERFF Status: Closed-Approved-  
Closed

Co Tr Num: SI AR COMBO APP

Author: Karen Nowlan

Date Submitted: 10/16/2009

State: Arkansas

State Tr Num: 43812

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 10/21/2009

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/21/2009

Deemer Date:

Submitted By: Karen Nowlan

Filing Description:

Ms. Bird,

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 10/21/2009

Created By: Karen Nowlan

Corresponding Filing Tracking Number:

Insurance Administrative Solutions, L.L.C. has been authorized to submit this filing on behalf of Sterling Investors Life Insurance Company. A letter of authorization is included with this filing.

The application has been revised to comply with the Section 5 item C of Arkansas Rule 97 Life Insurance and Annuities Replacement. No other changes have been made.

Thank you for your assistance. If you have any questions or comments, please contact me at 1-877-777-2443,

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extension 2171 or by e-mail at Karen.Nowlan@iasadmin.com.

Karen Nowlan

## Company and Contact

### Filing Contact Information

Karen Nowlan, Compliance analyst karen.nowlan@iasadmin.com  
 8545 126th Avenue North 727-584-0007 [Phone] 2171 [Ext]  
 Suite 200 727-584-5613 [FAX]  
 Largo, FL 33773-1502

### Filing Company Information

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

Sterling Investors Life Insurance Company	CoCode: 89184	State of Domicile: Georgia
210 East Second Avenue, Suite 105	Group Code: -99	Company Type: Life and Health
Rome, GA 30161	Group Name:	State ID Number:
(706) 235-8706 ext. [Phone]	FEIN Number: 59-1838073	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$20.00
Retaliatory?	No
Fee Explanation:	one form X \$20 = \$20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Investors Life Insurance Company	\$20.00	10/16/2009	31336077

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/21/2009	10/21/2009

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## Disposition

Disposition Date: 10/21/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Authorization Letter		Yes
<b>Form</b>	Application		Yes

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## Form Schedule

**Lead Form Number: SIMSLAPP200910AR**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	SIMSLAPP200910AR	Application/ Enrollment Form	Revised	Replaced Form #: SIMSLAPP200901A R Previous Filing #: 41402		SIMSLAPP200910AR.pdf



**PART I – HEALTH QUESTIONS CONTINUED – MEDICARE SUPPLEMENT ONLY**

**IF YOU ANSWER YES TO ANY OF THE HEALTH QUESTIONS 1-13,  
YOU ARE NOT ELIGIBLE FOR MEDICARE SUPPLEMENT INSURANCE**

- 8. Have you had an organ transplant or been advised to have an organ transplant?  Yes  No
- 9. Is surgery anticipated in the next twelve months?  Yes  No
- 10. Are you currently using the services of a home health care agency?  Yes  No
- 11. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?  Yes  No
- 12. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease, Rheumatoid Arthritis, Transient Ischemic Attack (TIA), heart surgery, a cardiac pacemaker replaced or implanted, been treated with a heart defibrillating device, or Hepatitis?  Yes  No
- 13. Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture, Muscular Dystrophy, Organic Brain Syndrome, Chronic Kidney Disease, Renal Insufficiency, or Renal Failure?  Yes  No

**Primary Physician Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**PART II – IF APPLYING FOR LIFE INSURANCE, PLEASE COMPLETE PART II**

**LIFE APPLICATION #:** \_\_\_\_\_

**IF YOU ANSWER "YES" TO EITHER QUESTION 1 OR 2, LIFE INSURANCE COVERAGE IS NOT AVAILABLE.**

- 1. Have you been treated for or diagnosed with a terminal illness?  Yes  No
- 2. During the last six months, have you been declined for life insurance or had a life insurance application rejected or postponed?  Yes  No

**Place of Birth (state)** \_\_\_\_\_

**Initial Amount of Life Insurance Applied for: \$** \_\_\_\_\_

**Amount of Accidental Death Benefit Applied for: \$** \_\_\_\_\_

**Beneficiary: Name** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address** \_\_\_\_\_

**Contingent Beneficiary: Name** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address** \_\_\_\_\_

**Secondary Addressee:** (An individual who will receive notice of an impending lapse of your life insurance coverage.)

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

Is Automatic Premium Loan provision elected?  Yes  No

**PART II – IF APPLYING FOR LIFE INSURANCE CONTINUED**

Does the applicant have existing life insurance or annuity coverage?  Yes  No

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_ Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

*If the answer to the above question is "No, the agent has no further replacement duties. If the answer is "Yes, the Replacement Notice and the Replacement Memorandum must be completed and submitted with this application. A copy of each completed form must be left with the applicant.*

**COMPLETE ONLY IF OWNER OF LIFE INSURANCE POLICY IS NOT PROPOSED INSURED**

Owner Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security/Tax ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Area Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Owner Signature: \_\_\_\_\_

**PLEASE SELECT THE METHOD OF PAYMENT YOU WANT**

Bank Draft\*     Annual     Semiannual     Quarterly     Monthly Bank Draft

\*Draft Preference:     Draft on Effective Date     Draft on Issue    If not answered, will draft on issue.

**PREMIUM CALCULATION**

<b>MEDICARE SUPPLEMENT PREMIUM</b>	<b>\$</b>
<b>LIFE INSURANCE PREMIUM (including Policy Fee)</b>	<b>\$</b>
<b>ACCIDENTAL DEATH BENEFIT RIDER (Optional/Only Available with Whole Life Policy)</b>	<b>\$</b>
 <b>SUBTOTAL</b>	 <b>\$</b>
 <b>LESS SPOUSAL DISCOUNT (IF APPLICABLE)</b>	 <b>\$</b>
 <b>TOTAL PREMIUM PAID WITH APPLICATION</b>	 <b>\$</b>

**PART III – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)**

**If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."**

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program?  Yes  No

NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.

**IF YES,**

- (a) Will Medicaid pay your premiums for this Medicare Supplement policy?  Yes  No

- (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?  Yes  No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START      END  
/ /      / /

If yes, with what company? \_\_\_\_\_

Company telephone number \_\_\_\_\_ Policy number \_\_\_\_\_

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No

- (c) Was this your first time in this type of plan (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)?  Yes  No

- (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

3. (a) Do you have another Medicare Supplement policy in force?  Yes  No

(b) If so, with which company: \_\_\_\_\_

with which plan: \_\_\_\_\_

and what paid-to-date do you have? \_\_\_\_\_

- (c) If so, do you intend to replace your current Medicare Supplement policy with this policy?  Yes  No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?  Yes  No

- (a) If yes, with what company and what kind of policy?

\_\_\_\_\_  
Company telephone number \_\_\_\_\_ Policy Number \_\_\_\_\_

- (b) What are your dates of coverage under the other policy? START      END  
/ /      / /

## IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

- (1) You do not need more than one Medicare Supplement Insurance Policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## MEDICARE SUPPLEMENT OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-13 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:** The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- (a) Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual; or the individual leaves the plan, whether the plan is primary or secondary with Medicare; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.

**Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.**

## 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 health 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. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement 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 Medicare Supplement 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 Medicare Supplement 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.

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: \_\_\_\_\_  
(City /State)

Dated: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_  
(Month/Day/Year)

**AGENT'S CERTIFICATION**

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

**TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)**

1. List any other health insurance policy you have sold to the Applicant that is still in force.

\_\_\_\_\_

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

\_\_\_\_\_

I certify that:

- 1. I have accurately recorded the information supplied by the Applicant; and
- 2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

\_\_\_\_\_  
**Agent's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agent's Printed Name**

\_\_\_\_\_  
**Agent Number**

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> Flesch Cert .pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> The application has been attached to the form schedule tab. <b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Authorization Letter <b>Comments:</b> <b>Attachment:</b> 2009 05 SILIC IAS Authorization letter.pdf		

# 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 SIMSLAPP200910AR 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

October 9, 2009

\_\_\_\_\_  
Date

STERLING<sup>TM</sup>

## STERLING INVESTORS LIFE INSURANCE COMPANY

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

May 22, 2009

Ms. Darcey Shaffer, FLMI, ACS  
Compliance Manager  
Insurance Administrative Solutions, L.L.C.  
8545 126<sup>th</sup> 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 Insurance Administrative Solutions, L.L.C. 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. Insurance Administrative Solutions, L.L.C. 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