

<i>SERFF Tracking Number:</i>	<i>VLIC-126356470</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>VantisLife Insurance Company</i>	<i>State Tracking Number:</i>	<i>43916</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Medical Examination Form</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: VantisLife Insurance Company
 Product Name: Medical Examination Form
 TOI: L071 Individual Life - Whole

SERFF Tr Num: VLIC-126356470 State: Arkansas
 SERFF Status: Closed-Approved-
 Closed State Tr Num: 43916

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

Co Tr Num: State Status: Approved-Closed
 Reviewer(s): Linda Bird
 Disposition Date: 10/29/2009
 Date Submitted: 10/28/2009 Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval
 State Filing Description:

Implementation Date:

General Information

Project Name:
 Project Number:
 Requested Filing Mode:
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 10/29/2009

Status of Filing in Domicile: Authorized
 Date Approved in Domicile: 10/26/2009
 Domicile Status Comments:
 Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 10/29/2009
 Created By: Lisa Conti
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Lisa Conti
 Filing Description:

Form CMP EX-10-1 is intended for use with application 2808-1, which was approved by your Department August, 2007, and is used with our Individual Whole Life Insurance product, Forms CMP L209 AR, and CMP L109 AR, approved by your Department on December 3, 2008 and December 12, 2009 respectively.

Application 2808 -1 is also used with our Individual Level Term Life Insurance product, Form CMP 0501 AR, approved by your Department May 24, 2006.

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 Company Tracking Number:
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Medical Examination Form
 Project Name/Number: /

Company and Contact

Filing Contact Information

Lisa Conti, Compliance Specialist
 200 Day Hill Rd
 Windsor, CT 06095

lconti@vantislife.com
 860-298-5448 [Phone]
 860-298-5479 [FAX]

Filing Company Information

VantisLife Insurance Company
 200 Day Hill Road
 Windsor, CT 06095
 (860) 298-6008 ext. [Phone]

CoCode: 68632
 Group Code:
 Group Name:
 FEIN Number: 06-0523876

State of Domicile: Connecticut
 Company Type:
 State ID Number:

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
VantisLife Insurance Company	\$50.00	10/28/2009	31609374

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/29/2009	10/29/2009

SERFF Tracking Number: VLIC-126356470 *State:* Arkansas
Filing Company: VantisLife Insurance Company *State Tracking Number:* 43916
Company Tracking Number:
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life
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Disposition

Disposition Date: 10/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: VLIC-126356470 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Certification of Compliance		Yes
Form	Application Medical Examination		Yes

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Form Schedule

Lead Form Number: CMP EX-10-1

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	CMP EX-10-1	Application/Enrollment Form	Application Medical Examination	Initial		52.600	CMP EX-10-1.pdf

Full Name of Proposed Insured (Please Print) _____ Birth Date _____ Name of Agency _____
 _____ Month _____ Day _____ Year _____

	YES	NO		
1. Have you ever been diagnosed or treated by a licensed physician for: (If yes, give details in #5)			4. Full name, address and phone number of your regular personal physician: Name: _____ Address: _____ Phone #: _____ Date last seen: _____ Reason for visit: _____	
a. Disease of heart, blood vessels, high blood pressure, heart murmur, coronary artery disease, chest pain, palpitation or other abnormal heart rate or rhythm, or heart attack?.....	<input type="checkbox"/>	<input type="checkbox"/>		
b. Disease or disorder of lungs, nose, sinus or throat, including asthma, tuberculosis, emphysema, chronic bronchitis, cough, shortness of breath, or sleep disorder/apnea?	<input type="checkbox"/>	<input type="checkbox"/>		
c. Disease or disorder of the pancreas, esophagus, stomach or intestinal tract including abdominal pain or internal bleeding, ulcer or jaundice?..	<input type="checkbox"/>	<input type="checkbox"/>		
d. Disease of kidney, urinary bladder, liver or gall bladder, prostate, or protein, blood or sugar in urine?.....	<input type="checkbox"/>	<input type="checkbox"/>		
e. Disease or disorder of the brain or nervous system including headache, dizziness, epilepsy or seizures, paralysis, stroke, depression, anxiety or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>		
f. Diabetes, thyroid condition or other glandular disorder or gout?	<input type="checkbox"/>	<input type="checkbox"/>		
g. Disorder of the skin, lymph glands, muscles, bones, joints, arthritis or back disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
h. Disorder of the eye or ear, or any impaired sight or hearing?	<input type="checkbox"/>	<input type="checkbox"/>		
i. Tumor, cancer, anemia, or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
j. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions?	<input type="checkbox"/>	<input type="checkbox"/>		
2. Have you ever:				5. Full details for each "Yes" answer (state condition, dates, doctor's name, address, phone number and medications). Continue on reverse side, if necessary. _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
a. Been treated or counseled for alcoholism, alcohol abuse or addiction?	<input type="checkbox"/>	<input type="checkbox"/>		
b. Used amphetamines, heroin, narcotics, barbiturates, cocaine, hallucinogens, or marijuana or any drugs except prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>		
c. Had a positive result on an HIV test? (If yes, explain in #5)	<input type="checkbox"/>	<input type="checkbox"/>		
3. Other than above are you now under observation or receiving treatment or counseling of any kind? (If yes, explain in #5).....	<input type="checkbox"/>	<input type="checkbox"/>		

6. Family Record	Age if Living	Age at Death	Cause of Death	
Father				7. To be completed if proposed insured is a woman. a. Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes" indicate no. of months _____ b. Have you ever had any uterine, ovarian or breast disease or complication of pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes" give details in #5)
Mother				
Brothers/Sisters				
No. Living				
No. Dead				

I have read the statements and the answers to the above questions and hereby agree that they are complete and true to the best of my knowledge and belief. I agree that a copy of this Part II of my application, together with a copy of Part I of my application, shall be attached to and form a part of any policy of insurance issued, and that no information acquired by any representative of the Issuer shall bind the Issuer unless it shall have been set out in writing in the application. I have read and acknowledge the attached fraud notice required by state law.

Dated at _____ on _____ 20_____
 City State Month Day Signature of Proposed Insured or Parent or Guardian if a Juvenile

Examiner _____



For residents of AR, DC, IA, IL, OH, PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact materials thereto commits a fraudulent insurance act, which is a crime.

For residents of FL, KY, LA, TN, TX: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, or incomplete or misleading information is guilty of a felony of the third degree.

For residents of MD: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

For residents of ME, ND, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

For residents of NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for payment of a loss or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and prison.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: ARKANSAS Cert Readability.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Please see Company's cover letter.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment: AR Exam Form Filing Letter.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certification of Compliance		
Comments:		
Attachment: CERTIFICATION OF COMPLIANCE CMP-EX-10-1.pdf		

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: VantisLife Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
CMP EX-10-1	52.6

Diane A. Maestrono

Diane A. Maestrono, ALHC
AVP, Claims and Compliance

October 26, 2009

Date



October 22, 2009

Arkansas Insurance Department
Life & Health Division
1200 West Third Street
Little Rock, AR 72201

Re: NAIC # 68632
Form Filing
CMP EX-10-1 – Application: Medical Examination

Dear Sirs:

The above referenced forms are being submitted for your approval.

Form CMP EX-10-1 is intended for use with application 2808-1, which was approved by your Department August, 2007, and is used with our Individual Whole Life Insurance product, Forms CMP L209 AR, and CMP L109 AR, approved by your Department on December 3, 2008 and December 12, 2009 respectively.

Application 2808 -1 is also used with our Individual Level Term Life Insurance product, Form CMP 0501 AR, approved by your Department May 24, 2006.

We do not have a form of this type approved for use in the state of Arkansas therefore, we do not have another form with which to make comparison.

If you have any questions, please feel free to call me at 860-298-6008 or email me at dmaestrone@vantislife.com.

Sincerely,

A handwritten signature in cursive script that reads "Diane A. Maestrone".

Diane A. Maestrone, ALHC
AVP, Claims and Compliance



CERTIFICATION OF COMPLIANCE

COMPANY NAME: VantisLife Insurance Company

FORM NUMBER AND DESCRIPTION: CMP EX-10-1: Application-Medical Examination

I hereby certify, that the forms submitted herewith, comply with all laws, rules, bulletins and published guidelines applicable to the particular type of form.

A handwritten signature in cursive script that reads "Diane A. Mastrone".

Diane A. Mastrone, ALHC
AVP, Claims and Compliance

October 23, 2009
Date