

SERFF Tracking Number: ACTR-126376772 State: Arkansas
Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company State Tracking Number: 44037
Company Tracking Number: FLAF1047E
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: Fidelity F1047E Electronic Application
Project Name/Number: Fidelity F1047E Electronic Application/FLAF1047EAPP

Filing at a Glance

Company: Fidelity Life Association, A Legal Reserve Life Insurance Company

Product Name: Fidelity F1047E Electronic Application SERFF Tr Num: ACTR-126376772 State: Arkansas

TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- Closed State Tr Num: 44037

Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium Co Tr Num: FLAF1047E State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird
Author: Sherry Wommack Disposition Date: 11/13/2009
Date Submitted: 11/12/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Fidelity F1047E Electronic Application

Project Number: FLAF1047EAPP

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/13/2009

Deemer Date:

Submitted By: Sherry Wommack

Filing Description:

Application submitted for review and approval: F1047E

Status of Filing in Domicile: Authorized

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: 11/13/2009

Created By: Sherry Wommack

Corresponding Filing Tracking Number:

On behalf of Fidelity Life Association, a Legal Reserve Life Insurance Company, the application described above is submitted for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal industry standards. The submitted application is new and does not replace any previously approved forms. The

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products associated with this application are not illustrated.

Fidelity Life will offer certain term life insurance products through electronic means:

F4200 Level Death Benefit Renewable Term (Hybrid Life)
F3600 Level Death Benefit Term Life Insurance (Rapid Decision Term)
F3800 Level Death Benefit Term Life Insurance (Mortgage Term)

The new application will be virtually identical in content to previously approved application F1045E.

In addition, Fidelity Life reserves the right to modify the format of the application questions from time-to-time as described below. Such modification in format will not change the content of the filed application unless specifically noted.

First, the order of the questions themselves may be changed. This will allow questions to be grouped together in a logical way dictated by the specific product for which the application will be used. For example, an affirmative response to a given question may disqualify a customer for coverage on one product, while it may not disqualify a customer for a different product. In this instance, the question would be grouped with other, similar "knockout" questions for that particular product.

Second, there are specific questions that are asked as dictated by the requirements of the product for which the application will be used. For example, the question about mortgage or refinance activity will appear when the application is used in conjunction with policy form F3800. The question will not appear, however, when the application is used in conjunction with form F4200.

Third, some questions may be consolidated into fewer, albeit longer questions. Likewise, some questions may be de-consolidated into shorter, more numerous questions. This will be done without changing the content of the questions themselves. For example, a given question may ask "Have you in the past five years been diagnosed as having medical condition a, b, or c?" We may revise this question so that a separate question is asked for each condition (three questions instead of one) without changing the meaning of the question.

Fidelity Life requests that if there are objections to the aforementioned three features, that the Department approve the application form if satisfactory, but disapprove the use of these additional features in practice until such objection is satisfied. Fidelity Life warrants that it will not implement such features until approval thereof is received.

Please note that previously approved replacement notices, disclosures, HIPAA information practices forms and other

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documents will be provided to the applicant when the applicant signs or when the policy is approved, as appropriate.

Please find attached a letter from Fidelity Life authorizing Actuarial Risk Management to make this filing on its behalf. If you should have any questions or further information, please contact me at (866) 480-7475, or by e-mail at swommack@actrisk.com.

Sincerely,
Sherry B. Wommack, FLMI
Director, Regulatory Compliance

Company and Contact

Filing Contact Information

Sherry Wommack, Director, Regulatory Compliance swommack@actrisk.com
6500 River Place Blvd. 512-345-5200 [Phone]
Bldg. 2, Suite 204 512-346-1249 [FAX]
Austin, TX 78730

Filing Company Information

(This filing was made by a third party - ActRisk01)
Fidelity Life Association, A Legal Reserve Life Insurance Company CoCode: 63290 State of Domicile: Illinois
1211 West 22nd Street Group Code: 3413 Company Type: Life
Suite 209 Group Name: State ID Number:
Oak Brook, IL 60523 FEIN Number: 36-1068685
(512) 345-5200 ext. [Phone]

Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fidelity Life Association, A Legal Reserve Life Insurance Company	\$50.00	11/12/2009	31994585

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/13/2009	11/13/2009

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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 - Acturial Memo		No
Supporting Document	Third Party Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance		Yes

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Form Schedule

Lead Form Number: F1047E

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	F1047E	Application/ Enrollment Form	Application for Life Insurance	Initial		51.000	F1047E Elect Life Application.pdf

PROPOSED INSURED	Full Legal Name of the Proposed Insured: _____ Gender: _____
	Legal Residence Address: _____
	Best Time to Call: _____ Preferred #: _____ Alternate #: _____
	Email Address: _____
	Date of Birth: _____ Place of Birth (Country): _____ Social Security Number: _____
	Drivers License Number: _____ State of Issue: _____

COVERAGE	Product: _____ Face Amount: \$ _____ Term Period: _____ years
	<input type="checkbox"/> Accelerated Death Benefit for Terminal Illness: \$ _____ }
	<input type="checkbox"/> Accidental Death Benefit: \$ _____ }
	<input type="checkbox"/> Accident Disability Income Rider }
	<input type="checkbox"/> Dependent Child Rider: \$ _____ }
	<input type="checkbox"/> Involuntary Unemployment Rider }
	<input type="checkbox"/> Return of Premium/Cash Value (where applicable) Rider }
	<input type="checkbox"/> Waiver of Premium on Total Disability Rider }
<input type="checkbox"/> Other Rider or Option }	

OTHER COVERAGE	Do you have any existing life insurance in force or is any application for life insurance, or reinstatement, now pending? ... <input type="checkbox"/> Yes <input type="checkbox"/> No
	If this policy is issued, will any other existing life insurance or annuity be cancelled, terminated, lapsed or not renewed?... <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced: <input type="checkbox"/> Yes <input type="checkbox"/> No

POLICY OWNER	Policyowner <i>(Different than the Proposed Insured)</i>
	Name of Policyowner: _____ Relationship to Insured: _____ SSN/Tax ID: _____
	Policyowner Address: _____
	Trust Name: _____ Authorized Signature Name: _____
	SSN/Tax ID: _____
Policyowner Address: _____	

SECONDARY ADDRESSEE	Secondary Addressee <i>(This person will receive copies of your overdue premium and lapse notices)</i>
	Secondary Addressee Name: _____
	Secondary Mailing Address: _____

NAME OF PROPOSED INSURED:

BENEFICIARY	Beneficiary <i>(Complex beneficiary designations should be dealt with within the context of a Will)</i>			
	Primary:	% of Benefit:	Relationship to Insured:	SSN/Tax ID:
	_____	_____	_____	_____
	Primary:	% of Benefit:	Relationship to Insured:	SSN/Tax ID:
_____	_____	_____	_____	
Contingent:	% of Benefit:	Relationship to Insured:	SSN/Tax ID:	
_____	_____	_____	_____	

QUESTIONS TO THE PROPOSED INSURED	1. Are you a legal resident and have you resided in the United States for more than 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	2. Have you had a Mortgage or a Refinance approved within the last 13 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. Are you currently employed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. Do you have a Primary Care Physician?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	5. Have you seen a Physician within the past 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	6. What is your Height? _____ ft/in		
	7. What is your Weight? _____ lbs		
	8. Has your weight changed in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	9. Have you, within the past 10 years, been treated by a Physician for, or been diagnosed as having Irregular Heart Beat (Arrhythmia), Blockage or Narrowing of the Arteries or Stroke or Congestive Heart Failure (CHF), Atherosclerosis, Coronary Artery Disease (CAD), Malignant Neoplasm, Lymphoma, Melanoma or Leukemia, Liver Disease other than Hepatitis, Memory Loss or Dysfunction, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease), Cerebral Palsy, Systemic Lupus Erythematosus (SLE) or Connective Tissue Disorders (Lupus, Scleroderma), Cystic Fibrosis, Alzheimer's Disease, Schizophrenia, Dementia or Mental Retardation (including Down's Syndrome), Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any Immune System Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	10. Have you, within the past 10 years, been treated by a Physician for, or been diagnosed as having Chest Pain, Heart Murmur, Heart Attack (Myocardial Infarction), Transient Ischemic Attack (TIA or mini stroke) or Aneurysm, Thrombosis, Circulatory Disorder or any other Disease or Disorder of the Heart or Blood Vessels?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	11. Have you, within the past 10 years, been treated by a Physician for, or been diagnosed as having, Kidney Disease, Hyperthyroid or Pancreatitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	12. Have you, within the past 10 years, been treated by a Physician for, or been diagnosed as having Arthritis, Muscular Atrophy, Muscular System Disorder, Myasthenia Gravis or Paralysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	13. Have you, within the past 10 years, been treated by a Physician for, or been diagnosed as having Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea, Emphysema, Asthma or other Respiratory or Lung Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	14. Have you, within the past 10 years, been treated by a Physician for, or been diagnosed as having Learning Disorders, Depression/Anxiety, Eating Disorder or other Psychological (Emotional), Mental or Nervous Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	15. Have you, within the past 10 years, been treated by a Physician for, or been diagnosed as having a Tumor or Cancer, Cyst, Seizures, Hepatitis, Disorder of the Breast, Crohn's Disease, Colitis, Abnormal PAP Test, Anemia, Ulcer, or any Disorder of the Bladder, Digestive System, Skeletal System, Stomach, Genito-Urinary Tract, Prostate, Blood or Platelets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	16. Have you, within the past 10 years, been treated by a Physician for, or been diagnosed as having Diabetes, High Blood Sugar, Sugar in the Urine, Elevated Cholesterol or Hypertension (High Blood Pressure)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

NAME OF PROPOSED INSURED:

QUESTIONS TO THE PROPOSED INSURED (Continued)

- | | |
|--|---|
| 17. Have you, within the past 5 years, been treated for, advised to Discontinue, Decrease or seek treatment for Drug or Alcohol Use? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Have you, within the past 5 years, used Controlled Substances such as Narcotics, Cocaine, Heroin, Marijuana, Amphetamines, Hallucinogens or Barbiturates not prescribed by a Physician or have you abused over the counter Medications?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Have you, within the last 24 months, used any form of Tobacco, Nicotine or Nicotine Products of any kind? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Have you, within the past 5 years, been a patient in any Dependency Program or Halfway House? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Have you, within the past 5 years, been admitted to an Emergency Room (ER) or Urgent Care Facility, or been a patient in any Hospital, Clinic, Nursing Home, Assisted Living Facility or other Medical Facility? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Have you, within the past 5 years, been advised to have any Tests (except HIV tests), Treatments, Hospitalizations, Surgeries or Consultations with any Medical Professionals, which have yet to be completed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Have you ever requested or received a worker's compensation or disability income payment, excluding a pregnancy related payment or been disabled for more than 30 days? | <input type="checkbox"/> Yes <input type="checkbox"/> No. |
| 24. Within the past 5 years, have you been prescribed any medication, suffered from any disease or received any Medical, Mental or Surgical health treatment for any condition that you have not previously disclosed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Have you, within the past 5 years, had an Application for Life or Health Insurance Rated Up, Postponed, Declined or Denied Reinstatement? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Have you, within the past 5 years, been convicted of, pled guilty or no contest to a Felony, or are you currently on Probation for a Felony offense? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Have you, within the past 5 years, had a Drivers License Denied, Suspended, Revoked or been convicted of more than three Moving Violations? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28. Have you, within the past 5 years, been convicted of Reckless Driving or Driving while Under the Influence of Alcohol or Drugs?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 29. Have you, within the past 2 years, engaged in, or do you plan to engage in, any Aviation Activity other than as a Fare-Paying Passenger on commercial airlines? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 30. Have you, within the past 2 years, engaged in, or within the next 2 years do you plan to engage in, any form of, Skin or Scuba Diving, Hang-Gliding, Ultralight Flying, Cave Exploration, Parachuting or Sky Diving, Mountain, Rock or Ice Climbing, Rodeo, Bungee Jumping, Ballooning, Competitive Skiing, Snowmobiling or Snowboarding, Motor Racing or any other hazardous or extreme sports? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 31. To the best of your knowledge or belief has any Natural Parent or Sibling died of Diabetes, Cancer or Heart Disease prior to age 60? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 32. Do you intend to Travel, Live or Work outside the United States or Canada? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 33. Have you, within the last 12 months, received, advised to receive or are you currently receiving Chemo, Radiation or any other therapy for Cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 34. Have you, within the last 12 months, been diagnosed as being terminally ill? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 35. Have you, within the last 12 months, been subject of any voluntary or involuntary bankruptcy proceedings or are you currently in bankruptcy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 36. Do you require any assistance with two or more of the following activities: bathing, dressing, toileting, indoor or outdoor mobility, eating or do you use oxygen for a medical condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 37. Are you a member of the armed forces including the reserves and are you currently or expecting to be Deployed outside of the US ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 38. Have you, within the past 5 years, been treated by a Physician for, or been diagnosed as having Kidney Stones, Fibromyalgia, Gaucher's Disease, Gastro Esophageal Reflux Disease, Gout, Hypothyroid, Hyperlipidemia or Migraine? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

NAME OF PROPOSED INSURED:

DEPENDENT CHILD RIDER	Dependent Children to be Insured:		
	Full Legal Name of Dependent Child: _____	Gender: _____	Date of Birth: _____
	Full Legal Name of Dependent Child: _____	Gender: _____	Date of Birth: _____
	Full Legal Name of Dependent Child: _____	Gender: _____	Date of Birth: _____
	1. Has any Child to be insured have been diagnosed with, or treated by a Physician for any Physical Disability, Mental Retardation or Special Need? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Has any Child to be insured been diagnosed with, or treated by a Physician for any Disorder of the Heart, or has any Surgeries or Hospitalization been suggested, which has yet to be completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			

ADDITIONAL INFORMATION	Additional Information from the Proposed Insured(s):

PREAUTHORIZED PAYMENT AUTHORIZATION	As a convenience to me, I authorize Fidelity Life Association, A Legal Reserve Life Insurance Company (Fidelity Life) to make electronic debits or other forms of preauthorized withdrawals from my financial institution as indicated below. I understand that if a debit or withdrawal is not honored by the financial institution, Fidelity Life will consider the premium unpaid. Any debit or withdrawal returned due to insufficient funds may be re-deposited by Fidelity Life at its sole discretion. This authorization will remain in effect until written notice by the depositor/card holder is received by Fidelity Life. I further agree that if any such debit or withdrawal is not honored, whether with or without cause, Fidelity Life shall be under no liability whatsoever even though such dishonor results in the lapse of insurance, in accordance with the grace period.
	Payor is _____
	Name of Payor: _____ Payor Address: _____
	Mode of Payment: _____ Draw Date (Day of the Month): ____
	Payment Method: _____
	PRE-AUTHORIZED CHECK <i>(This selection will apply to all payments)</i>
	I request that my premium payments be debited from my bank account as shown.
	Name of Bank: _____ Transit Number: _____ Account Number: _____
	PRE-AUTHORIZED CREDIT / DEBIT CARD <i>(This selection will apply to all payments)</i>
	I request that my premium payments be debited from the _____ shown below.
Card Type: _____ Card Number: _____ Expiration Date: ____	

Printed Name <i>(As it appears on file with the financial institution)</i>	
<u>Electronically Signed By:</u> _____	
AUTHORIZED SIGNATURE	
<u>Voice Signature on File:</u> _____ <u>Reference #:</u> _____	
AUTHORIZED SIGNATURE	

NAME OF PROPOSED INSURED:

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION	<p>I declare that each answer and statements given to the questions contained in this application is complete and true to the best of my knowledge and belief. I understand and agree that the Fidelity Life Association, A Legal Reserve Life Insurance Company (Fidelity Life) will rely on these answers, and the answers and statements I may give in any other form, taken as a part of this application, as representations and not warranties and that no such statement shall void the policy unless it is contained in a written application and a copy of such application shall be endorsed upon or attached to the policy when issued. I also understand that the Fidelity Life reserves the right to accept or deny this application after taking into account whatever information may be available to it, including availability as to coverage by its reinsurers.</p> <p>The coverage will be effective on its date of issue if the: (a) health; (b) avocations; (c) occupation; and (d) any other condition relating to the Proposed Insured are as described in the application. The effective date will be shown on page 3 of the Policy, provided one is issued.</p> <p>I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (MIB), consumer reporting agency or employer to give to Fidelity Life any information they might have regarding the diagnosis, treatment, prescription and prognosis of any physical or mental condition, my driving record, avocations, credit history, insurance history, occupation, character and hobbies, as applicable. To facilitate the rapid transmission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Fidelity Life to collect and transmit such information.</p> <p>I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization shall be used to evaluate my application for insurance. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization. I also understand that I have the right to revoke this authorization at any time.</p> <p>All or part of such information may be disclosed to a physician of my choosing, my insurance agent, the Medical Information Bureau (MIB), to other persons or organizations performing business or legal services in connection with this application, including reinsuring companies and as may be required by law.</p> <p>Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of criminal offense under state law.</p> <p>Signed at: _____ Date: _____</p> <p>Electronically Signed By: _____ Signature of Proposed Insured</p> <p>Voice Signature on File: _____ Reference #: _____ Signature of Proposed Insured</p>
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AGENT	<p>To the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of any proposed insured? (If yes, complete appropriate state replacement forms) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does any Proposed Insured have existing Life Insurance or Annuity contracts in force? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Printed Name of Agent: _____</p> <p>Agent ID: _____ General Agent ID: _____ State License Number: _____</p> <p>Email Address of Agent: _____ Telephone Number of Agent: _____</p> <p>Electronically Signed By: _____ Signature of Licensed Agent:</p>
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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: F1047E Readability Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Application attached to form schedule for approval.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: Application filing, not applicable.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Third Party Authorization Letter		
Comments:		
Attachment: FLA Third Party Authorization.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		

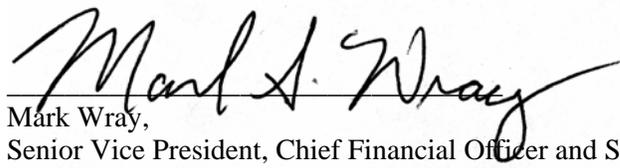


Fidelity Life Association, A Legal Reserve Life Insurance Company

Readability Certification

I, Mark Wray, duly authorized to give this certification on its behalf, hereby certify that the form described below complies with all laws, rules, bulletins, and published guidelines applicable to the particular type of form. Furthermore, the Readability Score for this form is:

<u>Form</u>	<u>Description</u>	<u>Score</u>
F1047E	Application for Life Insurance	51



Mark Wray,
Senior Vice President, Chief Financial Officer and Secretary and Treasurer

November 10, 2009

*When scored with the base contract.



FIDELITY LIFE ASSOCIATION, A LEGAL RESERVE LIFE INSURANCE COMPANY
1211 West 22nd Street, Suite 209, Oak Brook, IL 60623

November 1, 2009

To Whom It May Concern:

I hereby authorize Actuarial Risk Management and its employees to file policy forms and other associated forms including, but not limited to riders, amendments, and applications and respond to inquiries on our behalf. This authority shall continue until we revoke in writing.

Sincerely,

A handwritten signature in black ink that reads 'Mark S. Wray'. The signature is written in a cursive style with a large, sweeping 'M' and 'W'.

Mark S. Wray

Senior Vice President, Chief Financial Officer, Secretary and Treasurer

Fidelity Life Association, A Legal Reserve Life Insurance Company
Statement of Variability
Life Insurance Application
F1047E

The following items are indicated as variable items in the application with brackets.

Page	Variable Items	Justification
Title of all pages	The product name (marketing name)	This information is marked variable. The company will be offering its term life products with this application. The marketing names for the term products to be offered are "Mortgage Term" or "Rapid Decision Term". This information will print in the title of each page. The policy forms numbers previously approved in your state are given in the cover letter.
1 Coverage Section	Accelerated Death Benefit for Terminal Illness; Accidental Death Benefit; Accident Disability Income Rider; Dependent Child Rider; Involuntary Unemployment Rider; Return of Premium/Cash Value (where applicable) Rider; Waiver of Premium on Total Disability Rider; Other Rider or Option	This information is marked variable should the company offer new riders or discontinue riders. The company will not market a new rider until it is filed and accepted for use. The company may discontinue offering certain riders and therefore a rider may be deleted from the application. Only the elected riders will print.

*These changes will be made in an equitable manner and be applied to all issues of this product on a given day and in a manner that does not discriminate between applicants.