

SERFF Tracking Number: AMLC-126328480 State: Arkansas
Filing Company: Liberty National Life Insurance Company State Tracking Number: 43969
Company Tracking Number: LKANLS-2
TOI: H07I Individual Health - Specified Disease - Sub-TOI: H07I.002A Dread Disease - Cancer Only
Limited Benefit
Product Name: Cancer Policy
Project Name/Number: Cancer Policy/LKANLS-2

Filing at a Glance

Company: Liberty National Life Insurance Company

Product Name: Cancer Policy SERFF Tr Num: AMLC-126328480 State: Arkansas
TOI: H07I Individual Health - Specified Disease SERFF Status: Closed-Approved- State Tr Num: 43969
- Limited Benefit Closed
Sub-TOI: H07I.002A Dread Disease - Cancer Co Tr Num: LKANLS-2 State Status: Approved-Closed
Only
Filing Type: Form/Rate Reviewer(s): Rosalind Minor
Authors: Toni Thompson, Linda Newell Disposition Date: 11/04/2009
Date Submitted: 11/03/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: Cancer Policy Status of Filing in Domicile: Pending
Project Number: LKANLS-2 Date Approved in Domicile:
Requested Filing Mode: 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: 11/04/2009 Explanation for Other Group Market Type:
State Status Changed: 11/04/2009
Deemer Date: Created By: Linda Newell
Submitted By: Linda Newell Corresponding Filing Tracking Number:
Filing Description:
Enclosed for your review and approval is our lump sum Cancer Policy form LKANLS-2 and Application form LKANLS-AP(03). These forms are submitted as a new filing. They will not replace any previously approved forms.

This product will be marketed to individuals through licensed agents.

The Outline of Coverage, form DS-LKANLS-2(03), will be provided to the applicant at the time of application for policy

SERFF Tracking Number: AMLC-126328480 State: Arkansas
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form LKANLS-2. The Outline of Coverage is attached under the Supporting Documentation tab.

The Actuarial Memorandum and rates are also enclosed.

The Benefit Amounts on the application are bracketed to allow us to offer varying amounts in the future to cater to market trends.

I hereby certify that I have carefully reviewed these forms and determined:

1. The forms conform to all insurance statutes and Department requirements of your jurisdiction.
2. The forms contain no provisions previously disapproved by your department.
3. The forms do not contain any unusual or unorthodox provisions and wording.
4. The forms are being filed in Nebraska, our state of domicile, and other jurisdictions in which we are licensed to do business.

Company and Contact

Filing Contact Information

Linda Newell, Compliance Analyst lnewell@torchmarkcorp.com
 3700 S. Stonebridge Drive 214-544-5379 [Phone]
 McKinney, TX 75070 972-569-3728 [FAX]

Filing Company Information

Liberty National Life Insurance Company CoCode: 65331 State of Domicile: Nebraska
 2001 Third Avenue South Group Code: 290 Company Type: Life and Health
 Birmingham, AL 35233 Group Name: Liberty National Life State ID Number:
 (800) 288-2722 ext. 2912[Phone] FEIN Number: 63-0124600

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: 1 policy form filing @\$50 each, and one rate filing @\$50 each = \$100.00; Nebraska, our state of domicile, does not charge a fee for this type of filing.
 Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty National Life Insurance Company	\$100.00	11/03/2009	31747810

SERFF Tracking Number: AMLC-126328480 State: Arkansas
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TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/04/2009	11/04/2009

SERFF Tracking Number: *AMLC-126328480* *State:* *Arkansas*
Filing Company: *Liberty National Life Insurance Company* *State Tracking Number:* *43969*
Company Tracking Number: *LCANLS-2*
TOI: *H071 Individual Health - Specified Disease - Limited Benefit* *Sub-TOI:* *H071.002A Dread Disease - Cancer Only*
Product Name: *Cancer Policy*
Project Name/Number: *Cancer Policy/LCANLS-2*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Cancer Policy	Approved-Closed	Yes
Form	Application for Insurance	Approved-Closed	Yes
Rate	LCANLS-2 Rate Page	Approved-Closed	Yes

SERFF Tracking Number: AMLC-126328480 State: Arkansas
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 43969
 Company Tracking Number: LCANLS-2
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only
 Product Name: Cancer Policy
 Project Name/Number: Cancer Policy/LCANLS-2

Form Schedule

Lead Form Number: LCANLS-2

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/04/2009	LCANLS-2	Policy/Contract/Certificate	Cancer Policy	Initial		57.800	LCANLS-2-AR.pdf
Approved-Closed 11/04/2009	LCANLS-AP(03)	Application/Enrollment Form	Application for Insurance	Initial		47.940	LCANLS-AP(03).pdf

CANCER POLICY

BENEFITS FOR FIRST DIAGNOSIS OF CANCER. THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE; THE COMPANY RESERVES THE RIGHT TO CHANGE PREMIUMS ON A CLASS BASIS BY STATE.

LIBERTY NATIONAL LIFE INSURANCE COMPANY

P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

CONSIDERATION

This policy is issued in consideration of statements made in Your application and the payment of premium shown in the Policy Schedule. Your application is attached and is a part of this policy. We will pay You the benefit amount for Cancer which is first diagnosed 30 days after the Effective Date of this policy.

RIGHT TO EXAMINE POLICY

If You are not satisfied with this policy, You may return it for a full refund of premiums. You must return the policy within 30 days after You receive it. You may return the policy by delivering it or mailing it to the agent who took Your application or to Our Administrative Offices. Upon such return, We will void the policy as of the Effective Date, and We will refund the premium paid.

IMPORTANT NOTICE: This policy was issued based on the information in Your application, a copy of which is attached to this policy. Advise Us immediately if any of the information is incorrect. Incorrect information could result in the denial of a claim or the termination of this policy.

THIS IS A LEGAL CONTRACT – READ YOUR POLICY CAREFULLY

CAUTION: THIS IS A LIMITED POLICY

RENEWAL PROVISION

You are guaranteed the right to renew this policy for Your lifetime by the payment of the premium in effect on the date it is due. The premium must be paid on or before the due date, or within the 31 days that follow.

We may change the premium on a class basis for all policies of this same form in Your state. Class is based on gender, issue age and year of issue.

POLICY SCHEDULE

POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM	BENEFIT AMOUNT
[12345678	11/01/2009	12/01/2009	\$ 00.00]	
[INSURED:	John Doe			\$10,000]
[SPOUSE:	Jane Doe			\$10,000]
[CHILD 1:	One Doe			\$10,000]
[CHILD 2:	Two Doe			\$10,000]
[CHILD 3:	Three Doe			\$10,000]
[CHILD 4:	Four Doe			\$10,000]

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DEFINITIONS

CANCER: Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, melanoma, leukemia, or Hodgkin's disease, or any form of malignant growth positively diagnosed as Cancer (malignant neoplasm) by a legally licensed doctor of medicine certified by the American Board of Pathology or a certified Osteopathic Pathologist. Cancer is further defined for the purposes of this policy to include cancer in situ, which is in the natural or normal place; confined to the site of origin without having invaded neighboring tissue. Pre-malignant conditions or conditions with malignant potential are not to be construed as Cancer in interpreting this policy.

Criteria for malignancy are those accepted by the American Board of Pathology or the Osteopathic Board of Pathology. This diagnosis must be based on a microscopic study of body tissue or fluid. The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis of Cancer will be accepted as evidence that cancer exists in a Covered Person when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of Cancer and the Covered Person received treatment of Cancer.

COVERED FAMILY MEMBER: The spouse of the Insured and all unmarried children of the Insured, under age 19, on the Effective Date. To be covered, each existing member must be named in the application. Any member who has had Cancer diagnosed is excluded from coverage. Stepchildren and legally adopted children can be included if listed in the application.

Any newborn or newly adopted children of the Primary Insured will automatically be a Covered Person from the moment of birth or adoption if such birth or adoption occurs after the Effective Date of the policy. This will also cover children You have filed a petition to adopt.

You may apply for coverage on other dependents acquired after the Effective Date of the policy, subject to Our approval. Coverage on Your children terminates when they marry. It also terminates on the policy anniversary date following their 25th birthday, unless they are still dependent on You due to a physical or mental handicap. You must furnish Us proof of the disability and dependency status within 31 days of the termination date. If a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 25th birthday, then the child will continue to be a Covered Person for as long as such disability continues. Proof of such incapacity or disability must be furnished upon Our request, but not more often than annually.

COVERED PERSON: Refers to either You or a Covered Family Member.

FIRST DIAGNOSIS: "First Diagnosis" means the first time a Covered Person is diagnosed as having internal Cancer or malignant melanoma (this excludes all other Skin Cancer); provided the diagnosis is after the Waiting Period and while this policy is in force with respect to the Covered Person.

PHYSICIAN: A person who is a practitioner of the healing arts, other than yourself or a member of Your immediate family or household, and who is duly licensed to practice, and is practicing, medicine in the United States to treat an injury or illness.

SKIN CANCER: Any form of malignant growth positively diagnosed as Cancer (malignant neoplasm) which is confined to the epidermis, dermis (corium) and/or subcutaneous tissue. Such diagnosis must be based on a microscopic study performed by a recognized pathologist. **Skin Cancer is not covered under this policy.**

WAITING PERIOD: No benefit is payable if Cancer first manifests itself before the policy has been in force for 30 days from the Effective Date shown in the Policy Schedule. Cancer is manifested when symptoms exist

WE, US, OUR and COMPANY: Liberty National Life Insurance Company.

YOU, YOUR and INSURED: The Covered Person whose name is shown in the Policy Schedule.

BENEFITS

We will pay You the Cancer Benefit Amount as shown in the Policy Schedule when We receive due proof of a Covered Person's First Diagnosis of Cancer while this policy is in force. No benefit is payable if the Cancer first manifests itself before the end of the 30-day Waiting Period. In such case, You may void the policy from the beginning and receive a full refund of premium, provided You request the refund within 60 days after the end of the Waiting Period. **A Covered Person is limited to only one First Diagnosis benefit. Coverage for such person terminates upon payment of their benefit.**

LIMITATIONS AND EXCLUSIONS

1. This policy pays a benefit only for First Diagnosis of Cancer while this policy is in force. Proof of First Diagnosis of Cancer must be provided. Pathologic or clinical diagnosis proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness, disability or incapacity.
2. This policy contains a 30-day Waiting Period. No benefit is payable to anyone who has Cancer manifested before the policy has been in force for 30 days from the Effective Date shown in the Policy Schedule.
3. This policy will not pay benefits if the First Diagnosis of Cancer is made outside the United States of America.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by Us. This approval must be noted on or attached to this policy.

No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the policy Effective Date only fraudulent misstatements in the application may be Used to void this policy or deny any claim resulting from First Diagnosis of a covered Cancer after the expiration of the 2-year period. No claim for loss incurred that starts after 2 years from the Effective Date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before that Effective Date of coverage.

PREMIUM PAYMENTS: This policy is issued based on the application and the payment of the first premium. A copy of the application is a part of this policy. This policy takes effect at 12 o'clock noon, Standard Time at the place where You reside, and remains in effect until the same hour on the date of which the initial term expires.

The Effective Date of this policy, the first premium and the date the initial term expires are shown in the Policy Schedule. All premiums, except the first premium, shall be due and payable at Our Administrative Offices.

GRACE PERIOD: The policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period this policy will stay in force.

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Us (or by Our agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If We or Our agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless We have written You earlier of its disapproval.

The reinstated policy will cover only First Diagnosis of Cancer that is manifested more than 10 days after the date of reinstatement. In all other respects Your rights and Our rights will remain the same, subject to any provision endorsed on or attached to the reinstated policy.

NOTICE OF CLAIM: Written notice of claim must be given within 60 days after First Diagnosis of Cancer or as soon as reasonably possible. The notice can be given to Us at Our Administrative Offices or to one of Our agents. Notice should include Your name, the name of the Covered Person who suffered the loss, and the policy number.

CLAIM FORMS: When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of First Diagnosis requirements by giving Us a statement from the pathologist or Physician that describes the occurrence, nature and extent of the diagnosis within the time limit stated in the "Proof of First Diagnosis" provision.

PROOF OF FIRST DIAGNOSIS: Written proof of First Diagnosis must be given to Us within 90 days after the date of such First Diagnosis. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. However, the proof required must be given no later than one year from the time specified unless You were legally incapacitated.

TIME OF PAYMENT CLAIMS: Benefits provided by this policy will be paid as soon as We receive proper written proof of First Diagnosis.

PAYMENT OF CLAIMS: Benefits will be paid to You unless You assign them to the doctor or hospital. Any benefit unpaid at death will be paid to Your named beneficiary or, at Our option, to Your estate. If benefits are payable to Your estate, We can pay benefits up to \$3,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATION: We have the right to have a Covered Person examined, at Our expense, as often as reasonably needed while a claim is pending

LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of First Diagnosis has been given as required by this policy. No such action may be brought after 3 years from the time written proof of First Diagnosis is required to be given.

MISSTATEMENT OF AGE: If a Covered Person's age has been misstated, the benefit will be such as the premium paid would have purchased at the correct age. In the event coverage would not have become effective, or would have terminated, Our liability will be limited to a refund. Such refund must be requested by You and will be equal to the portion of the premiums paid for the period not covered by this policy.

CONFORMITY WITH STATE STATUTES: Any provision of this policy that, on its Effective Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment under this policy shall be binding upon Us unless the original (or a copy of it) is on file at Our Administrative Offices. We do not assume any responsibility for the validity of any assignment. We will pay the benefits of this policy to any state agency (such as Medicaid) when required by state law.

REFUND OF UNEARNED PREMIUMS ON DEATH: Upon the death of a Family Member insured under this policy, We will refund any premiums paid in behalf of the member, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

This policy is signed for Us by Our President and Secretary.


Secretary


President

Countersigned:

Licensed Resident Agent where required by law.

Child 2	<input type="text"/>	M.I. <input type="text"/>	<input type="radio"/> Male	Height	<input type="text"/>	<input type="text"/>
First Name	<input type="text"/>		<input type="radio"/> Female	(ft. in.)	<input type="text"/>	<input type="text"/>
Last Name	<input type="text"/>			Weight	<input type="text"/>	<input type="text"/>
Age	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		(mm-dd-yyyy)	-	-		
				I, the agent, have personally seen this person. <input type="radio"/> Yes <input type="radio"/> No		

Child 3	<input type="text"/>	M.I. <input type="text"/>	<input type="radio"/> Male	Height	<input type="text"/>	<input type="text"/>
First Name	<input type="text"/>		<input type="radio"/> Female	(ft. in.)	<input type="text"/>	<input type="text"/>
Last Name	<input type="text"/>			Weight	<input type="text"/>	<input type="text"/>
Age	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		(mm-dd-yyyy)	-	-		
				I, the agent, have personally seen this person. <input type="radio"/> Yes <input type="radio"/> No		

IF THE ANSWER TO ANY QUESTION IS "YES," THE PROPOSED INSURED IS NOT ELIGIBLE FOR COVERAGE.

	PRIMARY INSURED	SPOUSE	CHILD 1	CHILD 2	CHILD 3
	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
1. Has this person ever been diagnosed or treated by a physician for internal or skin cancer, melanoma, malignant growth, leukemia, Hodgkins disease or premalignant lesions?	<input type="radio"/>				
2. Has this person ever been treated for, diagnosed, or tested positive as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or immune deficiency related disorders or tested positive for antibodies to the AIDS (HIV) virus?	<input type="radio"/>				
3. Within the past 2 years has this person been advised by a physician to have medical tests or examinations to diagnose a possible malignancy but not yet done so?	<input type="radio"/>				
4. Are you covered under a state Medicaid program?	<input type="radio"/>				

AGREEMENT: I hereby apply to Liberty National Life Insurance Company ("Company") for a policy to be issued in reliance on my written answers to all questions. The applicant(s) represent(s) to the Company that the agent asked each and every question that appears on the application and that all the answers are true, correct and complete. I agree the policy shall not be effective unless it has actually been issued by the Company. I acknowledge that no agent has the authority to make, alter, modify or discharge any policy or any of its provisions for or on behalf of the Company; nor is the Company bound by any statement or representation made to any agent unless the statement or representation is included in this application.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to Liberty National Life Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB Inc., reinsuring companies or other persons or organization performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I may request a copy of this authorization. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

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 understand that no benefits are payable for a diagnosis of cancer in the first 30 days after the effective date of this policy.

- - at ,

Date Application Signed (mm-dd-yyyy) City State

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

To the best of your knowledge as writing agent, is the insurance applied for intended to replace any existing insurance? Yes No

Agent's Last Name

Applicant's Signature _____

I certify I have given an outline of coverage for the policy applied for to the Applicant.

Agent No.

SEND POLICY TO:
 Agent Insured

Amount paid to Agent: \$, .

for first months premium.

Agent's Signature

Initials of Proposed Insured

SERFF Tracking Number: AMLC-126328480 State: Arkansas
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 43969
 Company Tracking Number: LKANLS-2
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only
 Product Name: Cancer Policy
 Project Name/Number: Cancer Policy/LKANLS-2

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 11/04/2009	LKANLS-2 Rate Page	LKANLS-2	New		LNL LKANLS-2 Rate Page 50% 091029 - AR.pdf

LIBERTY NATIONAL LIFE INSURANCE COMPANY

McKinney, Texas

POLICY FORM LCANLS-2

A CANCER POLICY

**Proposed Annual Premium Rates
Per \$10,000 Lump Sum Amount
For Policies Issued with Issue Age Rates**

Issue Age	Male	Female
Individuals		
00 - 17	55.00	55.00
18 - 25	55.00	63.25
26 - 30	55.00	71.50
31 - 35	60.50	79.75
36 - 40	71.50	90.75
41 - 45	104.50	118.25
46 - 50	151.25	148.50
51 - 55	225.50	192.50
56 - 60	327.25	244.75
61 - 65	470.25	310.75
66 - 69	569.25	335.50
Two Parent Families (Issue Age Based on Age of Older Spouse)		
00 - 17	82.50	82.50
18 - 25	90.75	90.75
26 - 30	99.00	99.00
31 - 35	107.25	107.25
36 - 40	121.00	121.00
41 - 45	167.75	167.75
46 - 50	225.50	225.50
51 - 55	313.50	313.50
56 - 60	429.00	429.00
61 - 65	577.50	577.50
66 - 69	682.00	682.00
Single Parent Families (Issue Age Based on Age of Parent)		
00 - 17	66.00	66.00
18 - 25	66.00	74.25
26 - 30	66.00	82.50
31 - 35	71.50	90.75
36 - 40	82.50	101.75
41 - 45	115.50	129.25
46 - 50	162.25	159.50
51 - 55	236.50	203.50
56 - 60	338.25	255.75
61 - 65	481.25	321.75
66 - 69	580.25	346.50

Modal Premium Factors:

Semi-Annual	= Annual	* 0.520
Quarterly	= Annual	* 0.265
Monthly	= Annual	/ 11

For Company Use: Plan Codes T35, T36, T37

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/04/2009
Comments:			
Attachment:			
Flesch Score.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/04/2009
Bypass Reason:	Application is being submitted for approval under the Forms Schedule tab.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	11/04/2009
Comments:			
Attachment:			
DS-LCANLS-2(03).pdf			

CERTIFICATION

This is to certify that the attached Policy Form LCANLS-2 has achieved a Flesch Reading Ease Score of 57.80 and complies with the requirements of Arkansas Stat. Ann. SS66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Michael J. Gaisbauer, Vice President

SUPPLEMENTAL FORMS

SCORE

LCANLS-AP(03)

47.94

LIBERTY NATIONAL LIFE INSURANCE COMPANY

P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

OUTLINE OF COVERAGE FOR LUMP SUM CANCER POLICY

Policy Form LKANLS-2

(Please Keep for Your Records)

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This outline of coverage is not the insurance contract and only the actual policy provisions will control your benefits. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Therefore, it is important that you **READ YOUR POLICY CAREFULLY**.

CANCER BENEFIT

Policies of this category are designed to provide a lump sum benefit to the covered person upon First Diagnosis of Cancer. Each covered person is limited to one First Diagnosis benefit under the terms of this policy. To any one covered person, the maximum benefit available shall be the amount set forth in the listed Benefit Amount in the Policy Schedule. Coverage for such person terminates upon payment of such benefit.

LIMITATIONS AND EXCLUSIONS

1. This policy pays a benefit only for First Diagnosis of Cancer while this policy is in force. Proof of First Diagnosis of Cancer must be provided. Pathologic or clinical diagnosis proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness, disability or incapacity.
2. This policy contains a 30-day waiting period. No benefit is payable to anyone who has Cancer manifested before the policy has been in force for 30 days from the effective date shown in the Policy Schedule.
3. This policy will not pay benefits if the First Diagnosis of Cancer is made outside the United States of America.

FIRST DIAGNOSIS

“First Diagnosis” means the first time a covered person is diagnosed as having internal Cancer or malignant melanoma (this excludes all other skin cancer); provided the diagnosis is after the waiting period and while this policy is in force with respect to the covered person.

RENEWABLE

This policy is guaranteed renewable for life. We have the right to change the renewal premium for this policy in accordance with our table of premium rates applicable to all policies of this form and class. Class is based on year of issue and age at issue for policyholders of this form in your state. This policy provides a 31-day grace period.

This outline of coverage is only a brief summary and is not the contract of insurance. Please refer to the policy for further policy provisions.