

SERFF Tracking Number: MUTM-126353546 State: Arkansas
 Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43966
 Company Tracking Number: KENDRA SAYLER
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Children's Whole Life Application - D018LNA09A
 Project Name/Number: Children's Whole Life Application/D018LNA09A

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Children's Whole Life Application - D018LNA09A SERFF Tr Num: MUTM-126353546 State: Arkansas

TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- Closed State Tr Num: 43966

Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life Co Tr Num: KENDRA SAYLER State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird
 Authors: Mary Cleasby, Kim Meyerring, Kendra Sayler Disposition Date: 11/05/2009
 Date Submitted: 11/03/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Children's Whole Life Application
 Project Number: D018LNA09A
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 11/05/2009

Status of Filing in Domicile:
 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: 11/05/2009
 Created By: Mary Cleasby
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Mary Cleasby
 Filing Description:
 RE: United of Omaha Life Insurance Company
 NAIC 261-69868 FEIN 47-0322111
 Individual Whole Life Insurance
 D019LNS09A Children's Whole Life Application

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On behalf of United of Omaha Life Insurance Company, I am submitting the above captioned form in final printed format for review and approval. This form contains no unusual or controversial items according to normal company and industry standards. To the best of my knowledge, it complies with all your applicable statutes.

Application D019LNS09A is new and being filed to replace the following previously approved application A012LNA05A, which was approved by your Department on June 10, 2005.

The differences between this proposed application and the previously approved version are the addition of the Bank Service Plan authorization and the health question in Section D. We have updated the health question to read:

"Have any of the Proposed Insureds received medical care for or had:
(a) a heart or circulatory system disease, birth defect, or mental or developmental disorder including autism and Down's Syndrome?"

Additionally, D019LNS09A will be used in conjunction with policy form number A019LAR05P, which was approved by your Department on June 10, 2005.

This application is intended to be used with our agency distribution channel.

This application when combined with each policy has achieved a Flesch score of (51.9).

Enclosed are the required filing materials. Thank you for your consideration of this submission. Please feel free to contact me if you have any questions or concerns.

Sincerely,

Kendra Sayler
Product and Advertising Compliance Analyst
Regulatory Affairs
Phone: 402-351-2454
Fax: 402-351-5298
E-mail: Kendra.Sayler@mutualofomaha.com

Company and Contact

Filing Contact Information

Kendra Sayler, Senior Product & Advertising kendra.sayler@mutualofomaha.com

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Compliance Analyst

Regulatory Affairs Division 402-351-2454 [Phone]
 Mutual of Omaha 402-351-5298 [FAX]
 Mutual of Omaha Plaza
 Omaha, NE 68175

Filing Company Information

United of Omaha Life Insurance Company	CoCode: 69868	State of Domicile: Nebraska
Mutual of Omaha Plaza	Group Code: 261	Company Type: Life Insurance
Omaha, NE 68175	Group Name:	State ID Number:
(402) 351-6420 ext. [Phone]	FEIN Number: 47-0322111	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$20.00	11/03/2009	31748003

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/05/2009	11/05/2009

SERFF Tracking Number: MUTM-126353546 *State:* Arkansas
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Disposition

Disposition Date: 11/05/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Filing Fee Form		Yes
Form	Children's Whole Life Application		Yes

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Form Schedule

Lead Form Number: D019LNS09A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	D019LNS09A	Application/Enrollment Form	Children's Whole Life Initial Application			51.900	Application - D019LNS09A.pdf

Children's Whole Life Application

Application for Whole Life Insurance

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

Home Office Use
CWL



Section A Owner/Applicant

- Owner/Applicant _____
First Name Initial Last Name
- Social Security Number _____ - _____ - _____ Age _____ Male Female
- Birth Date _____ E-mail Address _____ Phone Number (____) _____
Month Day Year
- Legal Residence Address _____
Street
City State ZIP
- Are you a citizen of the United States? Yes No If "No," do you have an Alien Registration Receipt Card (also known as a "Permanent Residency Card" or "Green Card")? Yes No If "Yes," Card Number _____ Date of arrival in the United States _____
- Beneficiary:** You will be the Beneficiary unless you name someone else below.
Please Print _____
First Name Initial Last Name Relationship to Proposed Insured

Section B Proposed Insured(s) Information

	First Name	Middle Initial	Last Name	Age	Date of Birth	Sex M/F	Coverage Amount	Premium
1								\$
2								\$
3								\$
4								\$
Total premium enclosed								\$

Are all Proposed Insureds citizens of the United States? Yes No If "No," do all Proposed Insureds have an Alien Registration Receipt Card (also known as a "Permanent Residency Card" or "Green Card")? Yes No If "Yes," Card Number(s) _____ Date(s) of arrival in the United States _____

Section C Other Coverage and Replacement Information

- List below all life insurance policies and/or annuity contracts on any of the Proposed Insureds that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) If none, check the following box: None
- Have any of the Proposed Insureds had, or do they intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? Yes No If "Yes," check the appropriate box(es) below. The Producer shall comply with any additional state and/or Company replacement requirements.

Company	Proposed Insured	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced?	Assigned or Sold?
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- If this is a replacement, have you received a copy of the Notice of Replacement (if required in your state)? Yes No

Section D Health Information

Have any of the Proposed Insureds received medical care for or had:

(a) a heart or circulatory system disease, birth defect, or mental or developmental disorder including autism and Down's Syndrome? Yes No

(b) any other chronic medical condition which has required care within the past 3 years? Yes No

NOTE: Provide details for "Yes" answers. Please include Proposed Insured's name and illness or condition. (Use additional sheet if necessary.)

Section E Premium and Billing Information

1 Amount collected \$ _____ Modal Premium for Proposed Insured(s) \$ _____

2 Mode of Payment Monthly Bank Service Plan Annual Semiannual Quarterly

AUTHORIZATION TO WITHDRAW FUNDS BY UNITED OF OMAHA LIFE INSURANCE COMPANY (United of Omaha)

(If Mode of Payment is Monthly Bank Service Plan (BSP) – select one below)

- Monthly Bank Service Plan **(initial premium collected with the application)** – I/We have paid the initial premium by check to United of Omaha.
- Monthly Bank Service Plan **(initial premium paid by electronic funds transfer)**– I/We authorize the initial premium for the policy(ies) to be paid to United of Omaha, by electronic funds transfer, from the bank account identified below. The withdrawal for the initial premium payment will occur only if and when the application(s) is/are approved for issue by United of Omaha.

By signing below, I/We authorize renewal premiums to be automatically paid to United of Omaha, by electronic funds transfer, from the bank account identified below and on the date specified below. I/We understand and agree that these authorized withdrawals from the bank account for premium payments will continue until this authorization is cancelled in writing.

If Monthly Bank Service Plan, complete information below OR attach a voided check:

Routing Number and Transit Number (9-digit number) _____

Account Number _____

Name as shown on account _____
First Initial Last

Authorized Signature as shown on account

Social Security Number of Payor _____ - _____ - _____

Specify the date renewal premiums will be withdrawn (1st through the 28th of each month) _____

Section F Agreement

I am the parent, grandparent or guardian of the Proposed Insured(s) and I represent that my above answers are true and complete to the best of my knowledge and belief. I also understand that this coverage will not be in force until this application is completed in full and approved by United of Omaha Life Insurance Company, and the initial premium is received during the lifetime of the Proposed Insured(s).

I have read and understand this Agreement Section and any Receipt provided, and I approve all the answers as recorded in this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed at: _____ Date _____
City State Month Day Year

Signature of Owner/Applicant Relationship to Proposed Insured(s) Signature of Proposed Insured(s) (if age 15 or older)

Signature of Parent or Guardian (if Proposed Insured(s) under age 15)

In addition to the above Agreement, has the Applicant informed you, the Producer(s), that any Proposed Insured has one or more existing life insurance policies and/or annuity contracts in force? Yes No

Do you, the Producer(s), have reason to believe that the policy applied for has replaced or will replace any existing life insurance policy(ies) and/or annuity contract(s)? Yes No

If “Yes,” the Producer(s) shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.

Have you, the Producer(s), asked each question exactly as written and recorded the answer completely and accurately? Yes No
(If “No,” explain.) _____

Did you, the Producer(s), give the Applicant the Notice of Information Practices and the Life Insurance Buyer’s Guide? Yes No
(If “No,” explain.) _____

Signature of Producer #1 Production Number Date Month Day Year

Signature of Producer #2 Production Number Date Month Day Year

Print or Stamp Producer #1 Name Print or Stamp Producer #2 Name Agency Name

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR Read Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: The Application is attached on the Form Schedule tab.		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: Not applicable for this filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Filing Fee Form		
Comments:		
Attachment: AR Fee Schedule Cert .pdf		

CERTIFICATION

This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form</u>	<u>Description</u>	<u>Score</u>
D019LNS09A	Children's Whole Life Application	51.9*

*When scored with the policy.

United of Omaha Life Insurance Company

Date: 11/03/2009



Daniel J. Kennelly
Vice President & Chief Compliance Officer

ARKANSAS
INSURANCE
DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: United of Omaha Life Insurance Company

Company NAIC Code: 261-69868

Company Contact Person & Phone: Kendra Saylor

402-351-2454

INSURANCE DEPARTMENT USE ONLY:

ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LIFE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.

* _____ X \$50 = \$ _____

**Retaliatory \$ _____

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.

* _____ X \$50 = _____

**Retaliatory \$ _____

Life and/or Disability Policy, Contract or Annuity Forms : Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.

* 1 X \$20 = \$20

**Retaliatory \$ _____

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.

* _____ X \$25 = \$ _____

**Retaliatory \$ _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority

* _____ X \$400 = _____

Filing to amend Certificate of Authority.

*** _____ X \$100 = _____

***THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

****THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

*****THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SEC. 23-61-401.**