

SERFF Tracking Number: UNAM-126367994 State: Arkansas
 Filing Company: American Pioneer Life Insurance Company State Tracking Number: 43959
 Company Tracking Number: AP-LDBAPP (12/09) AR
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Life insurance application
 Project Name/Number: /

Filing at a Glance

Company: American Pioneer Life Insurance Company

Product Name: Life insurance application

SERFF Tr Num: UNAM-126367994 State: Arkansas

TOI: L071 Individual Life - Whole

SERFF Status: Closed-Approved- Closed State Tr Num: 43959

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

Co Tr Num: AP-LDBAPP (12/09) State Status: Approved-Closed AR

Filing Type: Form

Author: Mary Reichert

Reviewer(s): Linda Bird

Date Submitted: 11/03/2009

Disposition Date: 11/04/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: not filed in domicile

Explanation for Combination/Other:

Market Type:

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: Mary Reichert

Submitted By: Mary Reichert

Corresponding Filing Tracking Number:

Filing Description:

We are submitting this form for review and approval. It will replace form AP-LDBAPP (1/09) AR. That form was approved in SERFF filing UNAM-126297182 on September 15, 2009.

The only change to the form is on question 7 where we have corrected a typographical error. The phrase "diabetes requiring insulin or diabetic coma" was removed from the first part of the question.

A copy of the original form is included for reference, with change marked.

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Company and Contact

Filing Contact Information

Mary Reichert, mreichert@universalamerican.com
 P.O. Box 958465 407-995-8000 [Phone] 8355 [Ext]
 Lake Mary, FL 32795-8465

Filing Company Information

American Pioneer Life Insurance Company CoCode: 60763 State of Domicile: Florida
 1001 Heathrow Park Lane Group Code: 953 Company Type:
 Suite 5001 Group Name: State ID Number:
 Lake Mary, FL 32746 FEIN Number: 59-0935083
 (407) 995-8000 ext. [Phone]

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Pioneer Life Insurance Company	\$20.00	11/03/2009	31746446

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/04/2009	11/04/2009

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Disposition

Disposition Date: 11/04/2009

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		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	redlined application		Yes
Form	Life insurance application		Yes

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Form Schedule

Lead Form Number: AP-LDBAPP (12/09) AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AP-LDBAPP (12/09) AR	Application/Enrollment Form	Life insurance application	Initial		40.100	AP-LDBAPP 12-09 AR.pdf



HOME OFFICE:
 [P.O. Box 958465, Lake Mary, FL 32795-8465]
 [(800) 538-1053]

APPLICATION FOR INSURANCE

Proposed Insured _____ Address _____ City _____ State _____ Zip _____ Social Security Number _____ Birth Date _____ Age _____ Birth State _____ Sex _____ Marital Status _____ Occupation _____ Height _____ Weight _____ Phone: Day (____) _____ Evening (____) _____	Complete only if Owner is not Proposed Insured Owner _____ <i>Relationship</i> _____ <i>Birth date</i> _____ Address _____ City _____ State _____ Zip _____ Social Security/Tax ID Number _____
Secondary Addressee Information When the insured or owner is age 64 or older, a copy of any notification of possible lapse will be sent to this person. Name & Address: _____	
Send premium notices to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Give name/address in Special Requests)	
Face Amount \$ _____ Plan _____ Accidental Death <input type="checkbox"/> Yes <input type="checkbox"/> No	Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC <input type="checkbox"/> Credit Card <input type="checkbox"/> Visa <input type="checkbox"/> MC (Check one) Modal Premium Amount \$ _____ Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No
Beneficiary of the Proposed Insured (If split, please indicate percentages) Primary _____ Birth Date _____ Relationship _____ Contingent _____ Birth Date _____ Relationship _____	
Does the applicant own existing, in-force policies or contracts on the Proposed Insured? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete the required replacement form.	
Do you now or have you within the last year used tobacco products in any form? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," please explain: _____	
Section 1 - No Coverage Available If the applicant answers "Yes" to any question in this section, the Proposed Insured is not eligible for coverage.	
1. Is the Proposed Insured currently: a) hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, confined to a wheel chair or awaiting an organ transplant? Yes <input type="checkbox"/> No <input type="checkbox"/> b) diagnosed with or being treated for a terminal illness? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for: a) Alzheimer's Disease or other Dementia? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes <input type="checkbox"/> No <input type="checkbox"/> 4. In the past 5 years, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for: a) Congestive Heart Failure? Yes <input type="checkbox"/> No <input type="checkbox"/> b) Internal Cancer, Malignant Melanoma, or Leukemia? Yes <input type="checkbox"/> No <input type="checkbox"/> 5. Has the Proposed Insured had an application for life insurance declined in the past 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Special Requests _____	Administrative Office Use Only: _____

6. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for:
- a) Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Chronic Asthma, Chronic Bronchitis or any other Chronic Respiratory Disorder? Yes No
- b) Parkinson's Disease, Kidney Disease, Kidney Failure, Cirrhosis, or other Liver Disease? Yes No
7. In the past 2 years, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for:
- a) Heart Attack, Angina (chest pain), Stroke, Aneurysm or other Heart or Circulatory disorder? Yes No
- b) Alcohol or Drug Dependency? Yes No
- c) Diabetes requiring insulin or Diabetic Coma? Yes No
8. Is the Proposed Insured currently Paralyzed or has the Proposed Insured had an Amputation due to disease or disorder? Yes No
9. In the past 12 months has the Proposed Insured used Oxygen Therapy to assist in breathing? Yes No

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on the application are true to the best of my knowledge and belief. I understand that my policy will be effective on the date it is issued by the company except as stated in the conditional receipt. I personally completed the questions in Section 1 & 2 above.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the MIB, Inc., a pharmaceutical database or any other organization, institution, or person that has any records or knowledge of me or my health or that of any member of my family to give to American Pioneer Life Insurance Company or its reinsurers any such information. A photographic copy of the authorization shall be valid as the original. This authorization is valid for 24 months from the date of signature. It may be revoked at any time by sending written request to the Home Office of American Pioneer Life Insurance Company. Revocation is subject to the rights of any person that acted in reliance on the authorization prior to receiving the revocation. **I the undersigned applicant acknowledge that I have read, or had read to me, the completed application. I realize that any false statement or misrepresentation made therein, that is material to the risk or hazard assumed, may result in loss of coverage under this policy.**

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.

Cash paid with application \$ _____.

Dated at _____, this _____ day of _____, _____.

X _____ X _____
 Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

Instructions to agents - This statement must be completed with application.

1. Submit all applications and business transmittals within 7 days of application date.
2. Do not solicit business on any individual currently hospitalized or confined to a nursing home.
3. Do not solicit business on any individual you have reason to believe is suffering from a terminal illness.
4. All premium checks must be made payable to American Pioneer Life Insurance Company.
5. The full initial premium must be submitted with application.

Agent's Statement

By signing below, I the agent, hereby certify that all the information contained on this application has been truly and accurately recorded as supplied by the Proposed Insured. To the best of my knowledge all the answers are complete and true, and the applicant is not currently hospitalized or confined to a nursing home, nor do I have reason to believe the applicant is suffering from a terminal illness. The applicant has read or had read to him/her the entire application. To the best of my knowledge and belief the applicant does does not own existing, in-force policies or contracts on the Proposed Insured. I personally did see did not see the applicant at the time of the application.

Agent Printed Name _____ Agent Signature _____

Agent Number: _____ Agent State ID Number: _____

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Supporting Document Schedules

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

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: being filed for approval		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: only the application is being filed		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: redlined application		
Comments:		
Attachment: ap app.pdf		

We certify that these forms comply with the provision of 19 ss 10 b and all applicable requirements of the Department.

We also certify that both the Life and Health Guaranty Association Notice and agent contact information will be delivered with the policy in compliance with Regulation 49 and Arkansas Insurance Code 23-79-138.

In addition, we certify that the form submitted has a Flesch Reading Ease score of 40.1.

November 2, 2009



HOME OFFICE:
 [P.O. Box 958465, Lake Mary, FL 32795-8465]
 [(800) 538-1053]

APPLICATION FOR INSURANCE

Proposed Insured _____ Address _____ City _____ State _____ Zip _____ Social Security Number _____ Birth Date _____ Age _____ Birth State _____ Sex _____ Marital Status _____ Occupation _____ Height _____ Weight _____ Phone: Day (____) _____ Evening (____) _____	Complete only if Owner is not Proposed Insured Owner _____ Relationship _____ Birth date _____ Address _____ City _____ State _____ Zip _____ Social Security/Tax ID Number _____
Secondary Addressee Information When the insured or owner is age 64 or older, a copy of any notification of possible lapse will be sent to this person. Name & Address: _____	
Send premium notices to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Give name/address in Special Requests)	
Face Amount \$ _____ Plan _____ Accidental Death <input type="checkbox"/> Yes <input type="checkbox"/> No	Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC <input type="checkbox"/> Credit Card <input type="checkbox"/> Visa <input type="checkbox"/> MC (Check one) Modal Premium Amount \$ _____ Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No
Beneficiary of the Proposed Insured (If split, please indicate percentages) Primary _____ Birth Date _____ Relationship _____ Contingent _____ Birth Date _____ Relationship _____	
Does the applicant own existing, in-force policies or contracts on the Proposed Insured? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete the required replacement form.	
Do you now or have you within the last year used tobacco products in any form? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," please explain: _____	
Section 1 - No Coverage Available If the applicant answers "Yes" to any question in this section, the Proposed Insured is not eligible for coverage.	
1. Is the Proposed Insured currently: a) hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, confined to a wheel chair or awaiting an organ transplant? Yes <input type="checkbox"/> No <input type="checkbox"/> b) diagnosed with or being treated for a terminal illness? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for: a) Alzheimer's Disease or other Dementia? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes <input type="checkbox"/> No <input type="checkbox"/> 4. In the past 5 years, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for: a) Congestive Heart Failure? Yes <input type="checkbox"/> No <input type="checkbox"/> b) Internal Cancer, Malignant Melanoma, or Leukemia? Yes <input type="checkbox"/> No <input type="checkbox"/> 5. Has the Proposed Insured had an application for life insurance declined in the past 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Special Requests _____	Administrative Office Use Only: _____

AP-LDBAPP (1/09) AR

(Please complete reverse side)

AP-LDBAPP (12/09) AR

6. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for:
- a) Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Chronic Asthma, Chronic Bronchitis or any other Chronic Respiratory Disorder? Yes No
 - b) Parkinson's Disease, Kidney Disease, Kidney Failure, Cirrhosis, or other Liver Disease? Yes No
7. In the past 2 years, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for ~~Diabetes requiring insulin or Diabetic Coma?~~ ~~Diabetes requiring insulin or Diabetic Coma?~~
- a) Heart Attack, Angina (chest pain), Stroke, Aneurysm or other Heart or Circulatory disorder? Yes No
 - b) Alcohol or Drug Dependency? Yes No
 - c) Diabetes requiring insulin or Diabetic Coma? Yes No
8. Is the Proposed Insured currently Paralyzed or has the Proposed Insured had an Amputation due to disease or disorder? Yes No
9. In the past 12 months has the Proposed Insured used Oxygen Therapy to assist in breathing? Yes No

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I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the MIB, Inc., a pharmaceutical database or any other organization, institution, or person that has any records or knowledge of me or my health or that of any member of my family to give to American Pioneer Life Insurance Company or its reinsurers any such information. A photographic copy of the authorization shall be valid as the original. This authorization is valid for 24 months from the date of signature. It may be revoked at any time by sending written request to the Home Office of American Pioneer Life Insurance Company. Revocation is subject to the rights of any person that acted in reliance on the authorization prior to receiving the revocation. **I the undersigned applicant acknowledge that I have read, or had read to me, the completed application. I realize that any false statement or misrepresentation made therein, that is material to the risk or hazard assumed, may result in loss of coverage under this policy.**

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.

Cash paid with application \$ _____.

Dated at _____, this _____ day of _____, _____.

X _____ X _____
 Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

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Agent Printed Name _____ Agent Signature _____

Agent Number: _____ Agent State ID Number: _____