

SERFF Tracking Number: USHG-126391845 State: Arkansas  
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 44141  
Company Tracking Number: LIFE APP-09-NOARB-FLIC  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Critical Illness Application  
Project Name/Number: /

## Filing at a Glance

Company: Freedom Life Insurance Company of America

Product Name: Critical Illness Application

TOI: L04G Group Life - Term

Sub-TOI: L04G.500 Other

Filing Type: Form

SERFF Tr Num: USHG-126391845 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44141

Co Tr Num: LIFE APP-09-NOARB-  
FLIC State Status: Approved-Closed

Author: Shari McBride

Date Submitted: 11/19/2009

Reviewer(s): Linda Bird

Disposition Date: 11/23/2009

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Overall Rate Impact:

Filing Status Changed: 11/23/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 11/23/2009

Created By: Shari McBride

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Shari McBride

Filing Description:

Please see cover letter.

## Company and Contact

### Filing Contact Information

Shari McBride, Product Analyst

801 Cherry Street, Unit 33

Fort Worth, TX 76102

mcbrides@ushealthgroup.com

800-221-9039 [Phone] 422 [Ext]

817-878-3422 [FAX]

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### Filing Company Information

Freedom Life Insurance Company of America CoCode: 62324 State of Domicile: Texas  
3100 Burnett Plaza Group Code: 839 Company Type: Accident, Life and Health  
801 Cherry Street, Unit 33 Group Name: State ID Number:  
Fort Worth, TX 76102 FEIN Number: 61-1096685  
(817) 878-3328 ext. [Phone]

### Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation: 1 form.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Freedom Life Insurance Company of America	\$50.00	11/19/2009	32175029

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/23/2009	11/23/2009

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## **Disposition**

Disposition Date: 11/23/2009

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		No
Supporting Document	Application		Yes
Supporting Document	Cover Letter		Yes
Form	LIFE APP-09-NOARB-FLIC		Yes

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## Form Schedule

**Lead Form Number: LIFE APP-09-NOARB-FLIC**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LIFE APP-09-NOARB-FLIC	Application/ Enrollment Form	Initial		0.000	LIFE APP-09-NOARB-FLIC.pdf

**AGENT INFORMATION**

Agent Name (print name): \_\_\_\_\_ Agent Number: \_\_\_\_\_

**APPLICANT INFORMATION**

	First	Name M.I.	Last	Sex	Age	Birth date (MM/DD/YY)	Birthplace	Height	Weight	Social Security Number
1. Primary										
2. Spouse										
3a. Dependent(s)										
3b.										
3c.										
3d.										

**RESIDENT ADDRESS**

4a. Address:		4c. Home Phone:	( )
City:		4d. Business Phone:	( )
State:		Zip Code:	
4b. Email:		4e. Cell Phone:	( )
		4f. Best time to call:	

May we send you communications via this email address?  Yes  No

**OCCUPATION INFORMATION**

5a. Primary Applicant's Employer:		Occupation/Duties:	
5b. Spouse's Employer:		Occupation/Duties:	

**BENEFICIARY DESIGNATION**

6a. Primary's Beneficiary:		6b. Spouse's Beneficiary:	
Relationship to Primary		Relationship to Spouse's	

**REQUESTED EFFECTIVE DATE**

This effective date request does not guarantee that the application will be approved before the requested date, and thus may not be honored.		
Specific Date / /	On the next _____ (except 29 <sup>th</sup> , 30 <sup>th</sup> , or 31 <sup>st</sup> of the month after underwriting decision.)	Date of Application Approval

**PREMIUM PAYMENT SELECTION**

<b>Method of Payment:</b>	<input type="checkbox"/> Bank Draft	<input type="checkbox"/> Direct Billing <i>(must submit payment)</i>	<input type="checkbox"/> Credit Card <i>(initial payment only)</i>	
<b>Mode of Payment:</b>	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Annual

**PLAN SELECTION**

**MedGuard – Critical Illness**

<input type="checkbox"/> Primary Applicant - Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50	<input type="checkbox"/> \$60	<input type="checkbox"/> \$80
<input type="checkbox"/> Spouse- Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50	<input type="checkbox"/> \$60	<input type="checkbox"/> \$80
<input type="checkbox"/> Child Benefit	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	Amount: \$ _____	<b>Total MedGuard Premium</b>	\$ _____

**ASSOCIATION INFORMATION**

Name of Association \_\_\_\_\_ Monthly Membership Dues \$ \_\_\_\_\_

**PAYMENTS**

Monthly Payment	\$ _____
Association One Time Initiation Fee	\$ _____
<b>Total with Application</b>	<b>\$ _____</b>

\*\*\*\*THIS AREA IS INTENDED FOR EXPANSION OF PLAN SELECTION IF NEEDED\*\*\*\*

**CURRENT AND PRIOR COVERAGE**

7. Existing Life Insurance  Yes  No  
 8. Is this insurance intended to replace any existing policy with this company or any other company?  Yes  No  
 9. If Yes: have you submitted the appropriate replacement forms?  Yes  No

Name of Company	Date of Issue	Life Amount	Purpose Business/Personal	Accidental Death Benefit Amount	Replacement	
					YES	NO

(If there is additional insurance beyond those listed, please list on a separate sheet.)

**MEDICAL HISTORY**

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.

10. Has any proposed applicant(s) listed, now or during the past 12 months, used any form of tobacco, including cigarettes, cigars, chewing tobacco or snuff?  Yes  No  
 If yes, which applicant(s) \_\_\_\_\_
11. **Have you or any applicant listed ever had, been treated or diagnosed for any of the following:** (Circle conditions for question answered "YES")
- a. Cancer in any form, including skin cancer, cancer-in-situ, leukemia, Hodgkin's disease, melanoma, or had any abnormal growth, pre-malignant condition or malignant potential, lumps, tumors, or cyst?  Yes  No
  - b. Abnormal results for a cancer test such as pap smear, mammogram, CEA (carcinoembryonic antigen) PSA (prostate specific antigen), colonoscopy, or chest x-ray?  Yes  No
  - c. Heart attack, stroke, myocardial infarction (MI), congestive heart failure, hypertension, angina pectoris, transient ischemic attack(TIA), coronary artery disease, or any disease or disorder of the heart or circulatory system?  Yes  No
  - d. Heart surgery, coronary artery surgery, angioplasty, pacemaker installed, or had an abnormal test such as an electrocardiogram (EKG), echocardiography, or cardiac catheterization?  Yes  No
  - e. Chronic Obstructive Pulmonary Disease (COPD), emphysema, severe asthma, bronchiectasis, or require the use of oxygen?  Yes  No
  - f. Parkinson's Disease, Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig's Disease, or any other Degenerative Neuromuscular Disease, or any other neurological disease or disorder that would include numbness of any extremity or loss of use of any limb(s) or permanent paralysis?  Yes  No
  - g. Senility Disorder, Organic Brain Disease, Alzheimer's Disease, or any other form of Dementia?  Yes  No
  - h. Diabetes, or sugar intolerance, Pancreatitis, Cystic Fibrosis, or any disease or disorder of the Pancreas?  Yes  No
  - i. Glaucoma, Cataract, Blindness, or any Disease or Disorder of the Eyes?  Yes  No
  - j. Recurrent kidney stones, urinary obstruction, kidney failure, or disease or disorder of the kidney?  Yes  No
  - k. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for the antibodies to the HIV virus?  Yes  No

**ADDITIONAL MEDICAL DETAILS**

12. Please provide details to any "Yes" answers in the Medical History section. Attach a separate sheet if additional space is needed. Date and sign any additional sheets.

Applicant:	Question #:	Condition:	Treatment Dates:	Dr/Hospital/Address/Phone:	Details:

**ADDITIONAL QUESTIONS**

13. Have you or any applicant listed been advised to have any surgical operation, diagnostic test, consultation, or observation or treatment that was not performed, or gone to a doctor, or any health care professional for diagnosis, advice, treatment, checkup or consultation, or been confined to a hospital, clinic, sanitarium, or other facility?  Yes  No

If "Yes", provide details: \_\_\_\_\_

14. Have you or any applicant listed had a mother, father, brother, sister, who had cancer, stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness?  Yes  No

If, "Yes", provide age of onset and details: \_\_\_\_\_

15. Have you or any applicant listed been declined, restricted, rated-up or postponed for any kind of personal insurance, or ever filed a claim for disability, or have you received or are you receiving benefits from Social Security or Workers' Compensation?  Yes  No

If "Yes", provide details: \_\_\_\_\_

Please give Name, Address, and Phone No. for any doctor with current medical records, if not listed above. Include the date last seen and reason.

**FRAUD NOTICE**

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**RELEASE OF INFORMATION NOTICE:**

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Brain Tree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurers, may also release information from its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim of benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**CONSUMER REPORT NOTICE:**

This is to inform you as part of our procedure for processing your application an investigative report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation.

**APPLICANT'S ACKNOWLEDGMENTS AND AUTHORIZATIONS**

By signing below I understand, certify and agree that:

- I am applying as an individual and the company will individually evaluate and underwrite my application.
- Freedom Life Insurance Company of America may confirm the information provided on this application for insurance with a verification telephone call. This verification call is a routine process for those applying for coverage with Freedom Life Insurance Company of America and that this telephone call will be recorded. I also understand that my application will not be considered if verification is not completed. I (or my spouse, if applicable) may be contacted at the telephone numbers listed on the first page. If I cannot be contacted, I will call Freedom Life Insurance Company of America at 1-800-387-9027.
- I hereby apply to Freedom Life Insurance Company of America for insurance coverage to be issued in reliance upon the answers made to the best of my knowledge and belief and agree that the answers are full, true and complete in their entirety. I agree that the information and answers given shall form the basis for and be a part of any insurance under which coverage is issued. The coverage shall not be effective until a Certificate/Policy has been actually issued and delivered to the Insured, with first premium paid while the health of all persons named in this Application remains as stated therein.
- The agent is not an officer of the Company and cannot change, alter or amend the Group Policy, the application, the Certificate, Individual Policy or any information requirement of the Company. I further understand that the agent has no authority to make any representations about the conditions under which the Company will issue a Certificate/Policy or make coverage under the Certificate/Policy effective.
- If coverage is offered that it shall be subject to the timely payment by me and receipt by the Company of the Initial Premium amount and Certificate/Policy administration fees. Should payment of such Initial Premium and fees not be timely made and received or returned for insufficiency of funds or in any other way insufficient or not honored, I understand, acknowledge and agree that the corresponding offer of coverage is withdrawn, void and of no effect.
- I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has records or knowledge of me, or any member of my family who is to be insured, to give to Freedom Life Insurance Company of America or its reinsurer any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give all such records or knowledge to any agency employed by Freedom Life Insurance Company of America to collect and transmit such information. I authorize Freedom Life Insurance Company of America to use such information to make determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to the consumer as a prospective insured or as an insured with Freedom Life Insurance Company of America. A photographic or electronic copy of this authorization shall be as valid as the original. This authorization shall be valid for two years from the date signed. I hereby acknowledge receipt of the Medical Information Bureau (MIB), the Notice of Information Practices and Privacy Policy, and the Fair Credit Reporting Act (FCRA) notice.
- My/our answers to the questions and the information provided in application are complete, accurate and true to the best of my/our knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to Certificate/Policy provisions, unless otherwise provided.

**Attention Applicant:** I hereby certify and affirm that my/our responses to the questions contained on this application are complete, accurate and true to the best of my/our knowledge and belief, I understand and acknowledge that any fraudulent statement of material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to the Certificate/Policy provisions, unless otherwise provided. If your electronic signature cannot be provided, your verbal electronic signature will be obtained during a recorded telephone interview before coverage will be considered.

Dated at \_\_\_\_\_  
(City) (State) (Month) (Day) (Year)

✕ \_\_\_\_\_  
Signature of Applicant

✕ \_\_\_\_\_  
Signature of Spouse, if Applicable

I certify that I have truly and accurately recorded on the application form the information supplied by the applicant and that I am not aware of any other information that might have an adverse effect on the insurability of any person here proposed for insurance.

I certify that I have reviewed this application, and that it has been completed in full for submission to Freedom Life Insurance Company of America.

Agent's Signature \_\_\_\_\_ Agent # \_\_\_\_\_ Date: \_\_\_\_\_

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Flesch Certification <b>Bypass Reason:</b> Application. <b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application <b>Comments:</b> The application is under the Form Schedule tab.		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Cover Letter <b>Comments:</b> <b>Attachment:</b> Cover LTR FLIC.pdf		

# FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza ♦ 801 Cherry Street, Unit 33, ♦ Fort Worth, Texas 76102 ♦1-800-387-9027

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November 19, 2009

Honorable Joy Bradford  
Commissioner of Insurance  
Insurance Division  
1200 W. Third Street  
Little Rock, AR 72201

RE: **Freedom Life Insurance Company of America**  
**NAIC 62324                      FEIN #61-1096685**  
**New Submission**

Forms

LIFE APP-09-NOARB-FLIC

Term Life Critical Illness Application

Dear Commissioner Bradford:

Enclosed is the referenced form filed for your review and approval. This form is new and is not intended to replace any forms previously approved or filed with your Department.

This form comprises an enrollment application to be used during the marketing of a critical illness product on a term life chassis. It also may be used with products previously approved, or that shall be approved in the future, by your Department. Please notice that the coverage selection pages of the application are bracketed to allow the insertion of product specific options as needed. We may also use this application electronically or via telephone.

We also reserve the right to amend the referenced form to correct any minor typographical errors we may have neglected to find prior to submitting for approval, and to amend the language in order to clarify the intent within the confines of the law.

Your consideration of this filing is greatly appreciated. Should you have any questions, please contact me via [mcbrides@ushealthgroup.com](mailto:mcbrides@ushealthgroup.com) by telephone at (800) 387-9027, ext.422, or fax (817) 878-3810.

Sincerely,



Shari McBride, FLMI  
Product Analyst  
Product Development