

SERFF Tracking Number: SEFL-126036705 State: Arkansas
Filing Company: Assurity Life Insurance Company State Tracking Number: 41589
Company Tracking Number: REINST
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: REINST
Project Name/Number: REINST/REINST

Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: REINST

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: SEFL-126036705

SERFF Status: Closed

Co Tr Num: REINST

Co Status: Sent to State

Author: Kristi Hendrickson

Date Submitted: 02/18/2009

State: ArkansasLH

State Tr Num: 41589

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 02/20/2009

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: REINST

Project Number: REINST

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/20/2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 02/18/2009

Domicile Status Comments: Approved

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 02/20/2009

Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

Form Numbers Form Title

75-851-05055 Application for Reinstatement

75-852-01052 Application for Reinstatement

75-853-01102 Reinstatement Request

Dear Sir or Madam:

SERFF Tracking Number: SEFL-126036705 State: Arkansas
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Assurity Life Insurance Company submits the above captioned forms for review and approval. When approved, the following forms will be utilized as an application for reinstatement of Assurity life and health products.

75-853-01102 is the application which will be used for reinstatement of Direct mail guaranteed issued products.

75-852-01052 is the application which will be used for the reinstatement of Direct mail life or health insurance product.

75-851-05055 is the application which will be used for reinstatement of all other life and health products.

When approved, these forms will replace AAW-403 (3/01) and A-DI/A 31. These forms were approved on April 25, 2001 and August 2, 2001, respectively.

Please note that the Fraud Notices for specific states are bracketed as those states have not been approved and we reserve the right to change them in accordance with their state regulations.

I was not sure which TOI to choose since these forms are used for both life and health products. Although I indicated that the marketing type is Individual, there is a very small block of group business that may utilize form 75-851-05055.

Should you have any questions or concerns regarding this submission, please contact me at 1-800-276-7619 ext.3452. I may also be reached via email at policyfiling@assurity.com.

Best regards,

Kristi Hendrickson
Policy Filing Specialist
New Business Services

Company and Contact

Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist policyfiling@assurity.com
1526 K Street (402) 437-3452 [Phone]

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Lincoln, NE 68508

(402) 437-3802[FAX]

Filing Company Information

Assurity Life Insurance Company

CoCode: 71439

State of Domicile: Nebraska

1526 K Street

Group Code: -99

Company Type: Life/Health

P.O. Box 82533

Lincoln, NE 68501-2533

Group Name:

State ID Number:

(800) 276-7619 ext. [Phone]

FEIN Number: 38-1843471

SERFF Tracking Number: SEFL-126036705 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$60.00
Retaliatory? No
Fee Explanation: \$20.00 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	\$60.00	02/18/2009	25806156

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/20/2009	02/20/2009

SERFF Tracking Number: SEFL-126036705 *State:* Arkansas
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TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
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Disposition

Disposition Date: 02/20/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SEFL-126036705 *State:* Arkansas
Filing Company: Assurity Life Insurance Company *State Tracking Number:* 41589
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Item Type	Item Name	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
Supporting Document	Certificate of Compliance	Approved-Closed	Yes
Form	Application for Reinstatement	Approved-Closed	Yes
Form	Application for Reinstatement	Approved-Closed	Yes
Form	Reinstatement Request	Approved-Closed	Yes

SERFF Tracking Number: SEFL-126036705

State: Arkansas

Filing Company: Assurity Life Insurance Company

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TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: REINST

Project Name/Number: REINST/REINST

Form Schedule

Lead Form Number: 75-851-05055

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	75-851-05055	Application/ Enrollment Reinstatement Form	Initial		50	75-851-05055.pdf
Approved-Closed	75-852-01052	Application/ Enrollment Reinstatement Form	Initial		51	75-852-01052__02-06_.pdf
Approved-Closed	75-853-01102	Application/ Enrollment Request Form	Initial		47	75-853-01102.pdf



PROPOSED INSURED

<i>First</i>	<i>Middle</i>	<i>Last</i>	Policy No.	
Legal Name		Home Address		
<i>Street Address</i>		<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Policyowner's Social Security No.		Personal Phone No. ()		
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number _____				
Is the Proposed Insured currently working at least 30 hours per week in primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of employment _____ Yrs. / Mos.				
Occupation _____		Duties _____		

STATEMENT OF HEALTH

Complete the following questions for all persons covered under this policy. Provide details to any YES answers in Supplemental Section on page 2.

1. Has any Proposed Insured **ever** consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
 - a. Chest pain, heart attack, irregular heartbeat, coronary heart disease, stroke, transient ischemic attack (*TIA or mini-stroke*), aneurysm, any disease or disorder of the circulatory system or elevated cholesterol? Yes No
 - b. Any disease or disorder of the thyroid, pancreas, liver, kidney (*other than kidney stones*), stomach, gall bladder, bladder or prostate, genitourinary system, intestinal or digestive tract, ulcerative colitis, lupus, anemia or any other blood disorder? Yes No
 - c. Polyp, mole, lump or other growth, breast disorder or abnormal mammogram, biopsy or abnormal prostate specific antigen (*PSA*) test, cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? Yes No
 - d. Alzheimer's disease, dementia, memory loss, seizures, multiple sclerosis (*MS*), muscular dystrophy (*MD*), Parkinson's disease, amyotrophic lateral sclerosis (*ALS*), any brain or nervous system disorder, cerebral palsy (*CP*) or any form of muscular atrophy?..... Yes No
 - e. Chronic obstructive pulmonary disease (*COPD*), emphysema, shortness of breath, asthma, sleep apnea or other respiratory disorder? Yes No
 - f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder?..... Yes No
 - g. Rheumatoid or osteoarthritis, or any disease or disorder of the back, spine, bones, joints or muscles? Yes No
 - h. Been advised to have surgery, treatments or testing which have not been completed, or been aware of any symptoms or complaints regarding their health for which they have not yet consulted a physician? Yes No
 - i. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related*) or urine tests? Yes No
 - j. Been admitted to any hospital or psychiatric facility, received home health care, or been unable to complete the activities of daily living: bathing, dressing, grooming, toileting, transferring, mobility, eating, etc.? Yes No
 - k. Used marijuana or any illegal or addictive drugs, or been advised to seek treatment or sought treatment for alcoholism, drug addiction, drug abuse or other substance abuse? Yes No

2. Has any Proposed Insured during the past **5 years** participated in, or is any Proposed Insured planning within the next **12 months** to participate in, any hazardous sport or activities? If YES to any of the following, please complete and return the Avocation Questionnaire. Yes No

If YES, check all that apply:

<input type="checkbox"/> Skin/Scuba Diving	<input type="checkbox"/> Bungee Jumping	<input type="checkbox"/> Skydiving/Parachuting/Hang Gliding
<input type="checkbox"/> Motor-powered Racing	<input type="checkbox"/> Boxing	<input type="checkbox"/> Rodeo
<input type="checkbox"/> Professional, Semi-professional or Club Sports	<input type="checkbox"/> Cave Exploration	<input type="checkbox"/> Mountain/Rock/Ice Climbing
<input type="checkbox"/> Hot Air Ballooning		

3. In the past **12 months**, has any person used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? Yes No

If YES, please list type _____ and last date of use (*MM/DD/YYYY*) _____ / _____ / _____

4. During the past **5 years**, has any Proposed Insured had their driver's license suspended or revoked, been convicted of or pleaded "guilty" or "no contest" to driving under the influence (*DUI/DWI*), or had more than 3 moving violations? Yes No

5. Has any Proposed Insured been convicted of a felony, or is any Proposed Insured currently on probation?..... Yes No

6. Is any Proposed Insured currently pregnant? If YES, please give due date: _____ Yes No

7. Has any Proposed Insured **ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*); or had a positive test for human immunodeficiency virus (*HIV*) antibodies? ... Yes No

8. Within the past **12 months**, has any Proposed Insured been prescribed medication? Yes No



SUPPLEMENTAL INFORMATION

Enter complete details to questions 1-7 (if answered YES). In addition, please list all medications prescribed for any Proposed Insured in the last 12 months and why they were prescribed. If more space is needed, attach additional sheet.

Table with 8 columns: Question #/Letter, Name (First, Middle, Last), Onset Date (MM/DD/YYYY), Duration (Days, Months, Years), Health Condition and Details, Name of Medication, Dosage and Frequency, Date Last Taken (MM/DD/YYYY), Medical Care Provider's Name/Address/Phone. The table contains five rows with placeholder slashes in the Onset Date and Date Last Taken columns.

REPRESENTATION

I represent that these statements are true and complete to the best of my knowledge and belief. I understand and agree that the Company shall not incur any liability under this application until reinstatement is approved by the Company. I hereby acknowledge that I have read and understand the applicable state fraud information given below.

Signature lines for Date (MM/DD/YYYY), Signature of Proposed Insured, Signature of Owner (if other than Insured), and Signature of Proposed Joint Insured.

FRAUD NOTICES

Unless specific state language is provided below, the following general fraud notice applies.

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 shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

CO RESIDENTS: Knowingly providing false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud is unlawful. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or its agent that knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant regarding amounts payable from insurance proceeds for the purpose of defrauding or attempting to defraud shall be reported to the Colorado Department of Regulatory Agencies, Division of Insurance.

FL RESIDENTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony in the third degree.

KY RESIDENTS: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance 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.

MD RESIDENTS: Any person who knowingly and willfully presents a fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN RESIDENTS: Any solicitor, agent, examining physician or other person who knowingly and willfully makes a fake or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

NC RESIDENTS: 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 may be subject to a substantial civil penalty where and to the extent allowed by state law.

NJ RESIDENTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OK RESIDENTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA RESIDENTS: 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.

VA, WA RESIDENTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]





PLEASE PRINT WITH BLACK INK

PROPOSED INSURED

	<i>First</i>	<i>Middle</i>	<i>Last</i>	
Legal Name				Policy No.
<i>Street Address</i>		<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Home Address				
Owner's Social Security No.			Personal Phone No. ()	
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number				

STATEMENT OF HEALTH

Please complete the following questions for all persons covered under this policy.

1. In the past **12 months**, has any person used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? Yes No
 If YES, please list type _____ and last date of use (MM/DD/YYYY) ____ / ____ / ____
2. During the past **5 years**, has any person had any driving violations, including driving while intoxicated, or received or been advised to receive treatment for any drug or alcohol abuse? Yes No
3. Has any person **ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*); or had a positive test for human immunodeficiency virus (*HIV*) antibodies? Yes No
4. During the past **5 years**, has any person received or been advised to have any test (*except HIV tests*), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received? Yes No
5. During the past **5 years**, has any person been diagnosed or treated by a medical professional for heart disease, chronic obstructive pulmonary disease (*COPD*), cancer, diabetes, kidney disease, stroke or liver disease including hepatitis? Yes No
6. During the past **5 years**, has any person been: 1) diagnosed or treated for any mental or nervous disorder, 2) admitted to a hospital or psychiatric facility or 3) received home health care? Yes No
7. Please list **any** prescription medications any person covered under this policy has taken in the **past 12 months** and why they were prescribed.

8. Enter complete details to question nos.2-7 above (*if answered YES*). If more space is needed, attach additional sheet.

PRIMARY CARE PHYSICIAN

Name	Phone No. ()
<i>Street Address</i>	<i>Suite No.</i>
<i>City</i>	<i>State</i>
<i>ZIP+4</i>	
Address	
Date Last Consulted	Reason(s) for Consultation
/ /	Results



<i>SERFF Tracking Number:</i>	<i>SEFL-126036705</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Assurity Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41589</i>
<i>Company Tracking Number:</i>	<i>REINST</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>REINST</i>		
<i>Project Name/Number:</i>	<i>REINST/REINST</i>		

Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>SEFL-126036705</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Assurity Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41589</i>
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<i>Project Name/Number:</i>	<i>REINST/REINST</i>		

Supporting Document Schedules

Satisfied -Name:	Flesch Certification	Review Status:	Approved-Closed	02/20/2009
Comments:				
Attachment:				
	AR READ CERT.pdf			
Bypassed -Name:	Application	Review Status:	Approved-Closed	02/20/2009
Bypass Reason:	These are reinstatement applications			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	02/20/2009
Bypass Reason:	N/A			
Comments:				
Satisfied -Name:	Certificate of Compliance	Review Status:	Approved-Closed	02/20/2009
Comments:				
Attachment:				
	AR Cert of Compliance.pdf			

READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word 2007 program and achieved the following test results:

Company Name: Assurity Life Insurance Company

Form Number(s):

Type of Form: Reinstatement Application

Form No.	Description	Flesch Score
75-851-05055	Application for Reinstatement	50.1
75-852-05055	Application for Reinstatement	50.7
75-853-05055	Reinstatement Request	47.0



Signature

February 18, 2009

Date

Carol Watson
Vice President, General Counsel
Secretary



STATE OF ARKANSAS

CERTIFICATE OF COMPLIANCE

Company Name: Assurity Life Insurance Company.

Form Title(s) and Numbers:

75-851-05055	Application for Reinstatement
75-852-01052	Application for Reinstatement
75-853-01102	Reinstatement Request

I hereby certify that to the best of my knowledge and belief, the above forms and submission complies with the following:

- Regulation 19, as well as the other laws and regulations of the State of Arkansas.
- The company's policy issue procedure includes the notice required by Ark. Code Ann. 23-79-138 as addressed in Bulletins 6-87 and 11-88.
- The company's policy issue procedure includes the Life and Health Guaranty Association Notice as set form in Regulation 49.

A handwritten signature in cursive script that reads "Carol S. Watson".

Carol S. Watson
Vice President, Corporate Secretary

February 18, 2009 _____