

SERFF Tracking Number:	UNFG-126016166	State:	Arkansas
Filing Company:	United Life Insurance Company	State Tracking Number:	41447
Company Tracking Number:	LIU-113 (4-09)		
TOI:	L071 Individual Life - Whole	Sub-TOI:	L071.111 Single Premium - Single Life
Product Name:	LIU-113 (4-09)		
Project Name/Number:	/		

Filing at a Glance

Company: United Life Insurance Company

Product Name: LIU-113 (4-09)

TOI: L071 Individual Life - Whole

Sub-TOI: L071.111 Single Premium - Single Life Co Tr Num: LIU-113 (4-09)

Filing Type: Form

SERFF Tr Num: UNFG-126016166 State: ArkansasLH

SERFF Status: Closed

Co Status:

Author: Joanne Young

Date Submitted: 02/03/2009

State Tr Num: 41447

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 02/09/2009

Disposition Status: Approved-Closed

Implementation Date Requested: 04/01/2009

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: 02/09/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed in Iowa.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 02/09/2009

Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

LIU-113 (4-09) Application for Life Insurance

We are filing this updated application to be used with our life products. This will replace LIU-113 (1-09) that was recently approved by your office. It is virtually the same as the previous version; we have a new rider to begin marketing and this new app includes that rider on the first page. It is 20-Year Additional Term Insurance.

This filing to the best of our knowledge contains no unusual or possibly controversial items from normal company or

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industry standrads.

Thank you for your consideration.

Company and Contact

Filing Contact Information

Joanne Young, Analyst jyoung@unitedfiregroup.com
 118 2nd Ave SE (319) 286-2620 [Phone]
 Cedar Rapids, IA 52407-3909 (319) 286-2570[FAX]

Filing Company Information

United Life Insurance Company CoCode: 69973 State of Domicile: Iowa
 118 2nd Ave SE Group Code: 248 Company Type: Life
 PO Box 73909
 Cedar Rapids, IA 52407-3909 Group Name: United Fire Group State ID Number:
 (319) 399-5700 ext. [Phone] FEIN Number: 42-6061188

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Life Insurance Company	\$20.00	02/03/2009	25464728

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/09/2009	02/09/2009

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Disposition

Disposition Date: 02/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Application for Life Insurance		Yes

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Form Schedule

Lead Form Number: LIU-113 (4-09)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LIU-113 (4-09)	Application/Enrollment Form	Application for Life Insurance	Initial		0	LIU-113 (4-09).pdf

STATEMENT OF EARNINGS & OTHER INSURANCE (Complete if applying for over \$500 Disability Income Benefits.)

Earnings last year	(A) \$ _____	Other disability insurance in force? (A) <input type="checkbox"/> Yes	<input type="checkbox"/> No
	(B) \$ _____	(B) <input type="checkbox"/> Yes	<input type="checkbox"/> No
Earnings for prior year	(A) \$ _____	If yes, please provide details and identify by A or B.	
	(B) \$ _____	Monthly Benefit	Benefit Period
		_____	_____
		_____	Company
		_____	_____

APPLICATION FOR CHILDREN'S COVERAGE

Children of the proposed insured who have not reached their 19th birthday.

Name	DOB	Injury, illness or history of medical problems within the past 5 yrs.?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have any of these children applied or been examined for life, accident or health insurance that was declined or modified as to rate or amount? Yes___ No___ If yes, give details.
 Provide doctor's name and address. _____

BENEFICIARY DESIGNATION (will be Revocable and Per Stirpes if not indicated.)

PER STIRPES—if a named beneficiary dies before the insured, proceeds will be paid to the surviving direct descendants of that beneficiary.

PER CAPITA—if named beneficiary dies before the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

PROPOSED INSURED A	PROPOSED INSURED B (OTHER INSURED RIDER)
Primary <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ Contingent <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____	Primary <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ Contingent <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____

IRS Taxpayer Certification

Under penalties of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

Medical Authorization

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, employer, or the Medical Information Bureau, Inc., to give United Life Insurance Company all information from the past 10 years that it holds, that pertains to medical consultations, treatments, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. United Life Insurance Company or its reinsurers may release information to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This Authorization shall be in force for 24 months following the date of my signature, except in Arizona, where the authorization to disclose HIV related information shall be in force for 180 days. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at 118 Second Avenue SE, Cedar Rapids, Iowa 52407. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

I acknowledge that I have received a copy of this Authorization and I agree that a photocopy of this Authorization shall be as valid as the original.

Acknowledgement

I (we) have read this application in its entirety. I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.

City and State where signed _____ Date _____

X _____ **X** _____
SIGNATURE OF PROPOSED INSURED A (or parent if Proposed Insured is a minor) SIGNATURE OF PROPOSED INSURED B (or parent if Proposed Insured is a minor)

X _____ **X** _____
SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED A

I the agent, certify that to the best of my knowledge, the proposed insured does or does not have existing life policies or annuity contracts and that replacement is or is not involved in this transaction.

I the agent, certify that I have 1) used only insurer-approved or provided sales material, 2) left a copy of all sales material, 3) verified the identity of the owner/applicant.

X _____
SIGNATURE OF AGENT AGENT'S PRINTED NAME

_____ % _____ %
AGENCY NAME AGENCY NUMBER AGENCY NAME AGENCY NUMBER



United Life Insurance Company

P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

CONDITIONAL RECEIPT

AGENT: VALID ONLY WHEN ONE MONTH PREMIUM HAS BEEN COLLECTED

Unless every condition specified in Paragraph "First" below is fulfilled exactly, no insurance will become effective prior to Policy Delivery. No agent of the Company may alter or waive any conditions.

Received from _____ this _____ day of _____, 20 _____

the sum of \$ _____ in connection with this application for life insurance to United Life Insurance Company. The application bears the same date as this receipt. (Checks must be payable to United Life Insurance Company.)

Type of Policy applied for: _____ (Generic Name)

FIRST. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery.

- (a) the amount of premium taken with the application must be at least equal to the amount of one full monthly premium for the amount of insurance which may become effective prior to policy delivery; and
- (b) all medical examinations, tests, electrocardiograms required by the Company must be completed within 60 days from the date of the application; and
- (c) the Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards for the plan and for the amount applied for without modification and at the rate of premium paid; and
- (d) with respect to any life insurance applied for the Proposed Insureds must be in good health on the Effective Date.

Then the insurance as applied for in an amount not exceeding \$100,000 will become effective as of the latest of: (a) the date of the application, or (b) the date of completion of all medical examinations, tests, and electrocardiograms required by the Company or (c) the Date of Issue, if any, requested on the application.

SECOND. Limits Provision:

The maximum amount of insurance which may become effective prior to policy delivery shall not exceed a total of \$100,000 for this and any other applications pending with this Company.

THIRD. Return of Premiums Paid.

If one or more of the conditions in paragraph "FIRST" have not been fulfilled exactly, there shall be no liability on the part of the Company except to return Premiums paid.

(Signature of Agent)



United Life Insurance Company
P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

NOTICES TO APPLICANTS

AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United Life Insurance 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 or 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 in its file.

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

United Life Insurance Company or its reinsurers may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at www.mib.com.

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Rate Information

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Supporting Document Schedules

Satisfied -Name: Flesch Certification

Comments:

Attachment:

AR Cert.pdf

Review Status:

01/30/2009

CERTIFICATE OF COMPLIANCE

UNITED LIFE INSURANCE COMPANY

Form number: LIU-113 (4-09) Application for Life Insurance

I hereby certify to the best of my knowledge and belief that this filing is in compliance with Arkansas Regulations 19 and 49 and Bulletin 11-88.

Certified by:



Jean Newlin Schnake, Secretary
United Life Insurance Company

2/3/2009
Date