

SERFF Tracking Number: AEGX-126074861 State: Arkansas  
Filing Company: Monumental Life Insurance Company State Tracking Number: 41825  
Company Tracking Number: TL AR0005255F02  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Term Life  
Project Name/Number: Term Life/TL AR0005255F02

## Filing at a Glance

Company: Monumental Life Insurance Company

Product Name: Term Life

TOI: L04G Group Life - Term

Sub-TOI: L04G.500 Other

Filing Type: Form

SERFF Tr Num: AEGX-126074861 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 41825

Co Tr Num: TL AR0005255F02

State Status: Approved-Closed

Author: SPI ADMSLH

Reviewer(s): Linda Bird

Date Submitted: 03/13/2009

Disposition Date: 03/18/2009

Disposition Status: Approved-  
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Term Life

Project Number: TL AR0005255F02

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/18/2009

Deemer Date:

Submitted By: SPI ADMSLH

Filing Description:

Monumental Life Insurance Company

NAIC #66281 FEIN #52-0419790

Form Filing

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Association, Other,  
Discretionary

Explanation for Other Group Market Type:  
Credit Union

State Status Changed: 03/18/2009

Created By: SPI ADMSLH

Corresponding Filing Tracking Number:

RE: TL1099GAM (Rev. 02-09) - Group Term Life Application

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The above-captioned application form is being filed for your review and approval to be used with our Group Term Life Policy form TL1000GPM, approved by your department on 08/07/91. The form will be used for marketing our group term life product on a direct mail, direct response basis.

This form is new and does not replace any existing forms.

Our domicilliary state of Iowa does not charge a filing fee. A filing fee of \$20.00 has been submitted via EFT.

Should you have any questions or need any additional information, please feel free to contact me.

## Company and Contact

### Filing Contact Information

Cathy Wynn, Filing Specialist cwynn@aegonusa.com  
 400 Galleria Parkway 678-402-2085 [Phone]  
 Suite 1000 678-402-2105 [FAX]  
 Atlanta, GA 30339

### Filing Company Information

Monumental Life Insurance Company CoCode: 66281 State of Domicile: Iowa  
 4333 Edgewood Road, N.E. Group Code: 468 Company Type: Life and Health  
 Cedar Rapids, IA 52499 Group Name: State ID Number:  
 (800) 553-5957 ext. [Phone] FEIN Number: 52-0419790

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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monumental Life Insurance Company	\$20.00	03/13/2009	26419621

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/18/2009	03/18/2009

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## Disposition

Disposition Date: 03/18/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-126074861 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application		No
Supporting Document	EOV Variability for TL1099GAM (Rev. 02-09)		Yes
Supporting Document	Flesch Certification		Yes
Supporting Document	AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT		Yes
Form	Group Term Life Application		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	TL1099GA	Application/Group Term Life M (Rev. 02-Enrollment Application Form)	Revised	Replaced Form #: Previous Filing #:	0.000	TL1099GAM (Rev_ 02-09).PDF



# Group Term Life Application

underwritten by Monumental Life Insurance Company

Please complete the entire application. Please print clearly in dark ink and mail in the envelope provided to: **[GEA, 6110 Parkland Boulevard, Cleveland, OH 44124-4187]**.

**1**

**[ABC ORGANIZATION]**

**Policy No. [MZ12345]**

Your name ( <i>last, first, middle</i> )		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced
Date of Birth / /	Height ( <i>feet, inches</i> )	Weight ( <i>pounds</i> )	Social Security Number - -
Address			
City		State	Zip
Preferred E-mail Address			
Home Phone ( ) -		Work Phone ( ) -	

**[For Spouse, only if applying]**

Spouse Name ( <i>last, first, middle</i> )		
Date of Birth / /	Height ( <i>feet, inches</i> )	Weight ( <i>pounds</i> )

**2**

**[1. Have you used tobacco products of any kind in the last 12 months?]**

Member:  Yes  No

**[Spouse:  Yes  No (only if applying)]**

**[2. If you are a new applicant, indicate desired amount of coverage:]**

Member \$ \_\_\_\_\_ **[Spouse \$ \_\_\_\_\_ ]**

**[• 1 Unit]    [• 2 Units]    [• 3 Units]    [• 4 Units]    [• 5 Units]**

**[• Dependent's insurance: \$ \_\_\_\_\_ per child]**

**[Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_]**

**[Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_]**

**[Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_]**

**[3. If you are increasing coverage, indicate amount of additional coverage:]**

Member \$ \_\_\_\_\_ **[Spouse \$ \_\_\_\_\_ ]**

**[• 1 Unit]    [• 2 Units]    [• 3 Units]    [• 4 Units]    [• 5 Units]**

**[• Dependent's insurance: \$ \_\_\_\_\_ per child]**

**[Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_]**

[Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_]  
 [Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_]

4. Is this insurance intended, in whole or in part, to replace, discontinue, or change any existing life insurance or annuity now in effect with this or any other company?  
 Member: • Yes • No  
 [Spouse: • Yes • No (only if applying)]

**Beneficiary Information**

List one or more beneficiaries below. Beneficiaries may include your spouse, children, parents, charities or anyone you wish.

Member's Beneficiary	Address	Relationship
Spouse's Beneficiary	Address	Relationship

**3 Statement of Health**

Each Applicant Please Answer All [9] Questions.

**Member Spouse**

1. Have you ever had [chest pains] disease or disorder of the [heart], [liver] [kidneys] or [lungs], [high blood pressure], [albumin or sugar in your urine], [diabetes], [cancer], [tumors], or [ulcers?]  
 [• Yes • No] [• Yes • No]
2. Have you ever had or been treated for [heart trouble], [stroke], [Hepatitis B or C], [high blood pressure], [ulcerative colitis], [kidney] or [liver disorder], [blood or circulatory disorder], [diabetes], any mental [or nervous] disorder, [drug abuse] or [alcoholism], [lung disorder], [cancer] or [tumors?]  
 [• Yes • No] [• Yes • No]
3. Have you, during the past [24] months, consulted a physician or other Practitioner, received treatment for any disease, ailment or injury or been confined or treated in any hospital or similar Institution?  
 [• Yes • No] [• Yes • No]
4. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?  
 [• Yes • No] [• Yes • No]
5. Have you had any condition for which hospitalization or surgery has been advised, or is contemplated, within the next year?  
 [• Yes • No] [• Yes • No]
6. Are you involved in the operation of an aircraft [or] [car racing] [water racing,] or involved in sports [such as] [bungee jumping,] [scuba diving,] [amateur or interscholastic athletics,] [hang gliding,] [ballooning,] [parasailing,] [mountain climbing,] [or hunting].  
 [• Yes • No] [• Yes • No]



misrepresentation or omission, or failed to update the Company on any health status change prior to the effective date of this coverage.

To determine my insurability or for claims purposes, I authorize any medical practitioner, institution, VA Hospital, insurance company or person having knowledge of my health, or the Medical Information Bureau to give any information about my physical or mental health to Monumental Life Insurance Company, Baltimore, MD 21201, or its authorized representatives. This authorization, original or copy, is valid for two years from the effective date of coverage. I acknowledge receiving the "NOTIFICATION" regarding the Medical Information Bureau.

I understand that the coverage will take effect on the Effective Date shown on the Certificate of Insurance, provided the first premium has been paid and there has been no change in my insurability since the date of the application. I understand that I am obligated to notify Monumental Life Insurance Company in writing if my health status changes to the extent it would change or otherwise alter one or more of my answers to these application questions.

I acknowledge that I have read the Fraud Warning Statement on the reverse side of this form where applicable.

Member signature	Date signed / /
Spouse signature (only if applying)	Date signed / /

**NOTICE TO APPLICANT – PLEASE READ**

Insurance regulations require that we send you this statement using the following wording:

Information regarding your insurability will be treated as confidential. Monumental Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon receipt, will supply such company with the information in its file."

"Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660."

"Monumental Life Insurance Company or its reinsurer(s) may also release information in its file to any other life insurance company to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted."

Public Law 91-508 requires that we advise you that a routine inquiry may be made which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

## **SUMMARY NOTICE OF INFORMATION PRACTICES**

As part of the underwriting and processing of your application for insurance coverage, this Company will rely heavily on information provided by you. The Insurance Company also seeks information about you, from others, such as physicians who have treated you or family members.

In some situations, and in compliance with applicable laws, we may disclose certain of the information to third parties without your specific authorization.

You have a right of access and correction with respect to all personal information collected about you which is contained in our files. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of Monumental Life's information practices. If you would like to receive a more detailed explanation of those practices, please contact our Underwriting Department, Monumental Life Insurance Company, c/o FSG, 520 Park Ave. Baltimore, Maryland 21201.

## **FRAUD WARNING STATEMENT**

**[LA Residents:** 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.]

**[Maryland Residents:** Any person who knowingly and willfully presents a false or 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.]

**[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.]

**[AR, CO, DC, FL, KY, ME, NJ, NM, OH, TN and WA Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.]

<i>SERFF Tracking Number:</i>	<i>AEGX-126074861</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Monumental Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41825</i>
<i>Company Tracking Number:</i>	<i>TL AR0005255F02</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.500 Other</i>
<i>Product Name:</i>	<i>Term Life</i>		
<i>Project Name/Number:</i>	<i>Term Life/TL AR0005255F02</i>		

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application		
<b>Bypass Reason:</b>	See Forms Tab		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	EOV Variability for TL1099GAM (Rev. 02-09)		
<b>Comments:</b>			
<b>Attachment:</b>			
	EOV Variability for TL1099GAM (Rev_ 02-09).PDF		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification		
<b>Comments:</b>			
<b>Attachment:</b>			
	AR - READABILITY CERTIFICATION.PDF		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT		
<b>Comments:</b>			
<b>Attachments:</b>			
	AR - NAIC TRANSMITTAL DOC.PDF		
	AR - NAIC FORM FILING ATTACHMENT.PDF		

## **EXPLANATION OF VARIABILITY FOR APPLICATION FORM TL1099GAM (Rev. 02-09)**

### **Top of Page**

- The organization's logo, name, address and policy number will vary on a case by case basis.

### **Section 1**

- The spouse information section will be included or excluded in its entirety based on whether or not spousal dependent coverage is being offered.

### **Section 2**

- Questions 1 through 4 will be included or excluded in its entirety.
- The spouse and dependent child sections will be included or excluded in its entirety based on whether or not dependent coverage is being offered.
- The number of units offered will vary.

### **Section 3**

- Questions 1 through 7 will be included or excluded in its entirety.
- The references to answering all questions will reflect the number of questions included or excluded on the application.
- In questions 1 and 2, the named conditions will be included or excluded on a case by case basis depending on the group.
- In question 3, the number of months will vary on a case by case basis depending on the group.
- In question 6, the named activities will be included or excluded on a case by case basis depending on the group.
- In question 9, either the word occupation or profession will be used.

### **Section 4**

- The various payment options will be included or excluded in its entirety depending on the group.

### **Fraud Warning Statement Section**

- The appropriate/required fraud statements will be included or excluded in its entirety depending on the states in which the application will be used.

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** Monumental Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
TL1099GAM (Rev. 02-09)	40.2

Signed: \_\_\_\_\_



Name: Cathy L. Wynn  
Title: Filing Specialist

Date: 03/12/2009

**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Monumental Life Insurance Company 4333 Edgewood Road, N.E. Cedar Rapids IA 52499	IA	L&H	468	66281	52-0419790	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Cathy L. Wynn, HIA, FLMI, ACS, ALHC 400 Galleria Parkway, Suite 1000 Atlanta GA 30339	800-521-1670	678-402-2105	cwynn@aegonusa.com

<b>5. Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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<b>6. Company Tracking Number</b>	TL AR0005255F02
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<b>7. <input checked="" type="checkbox"/> New Submission</b>	<input type="checkbox"/> Resubmission	Previous file # _____
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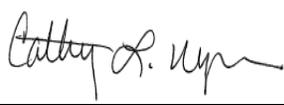
<b>8. Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input checked="" type="checkbox"/> Association <input type="checkbox"/> Blanket <input checked="" type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

<b>9. Type of Insurance</b>	
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<b>10. Product Coding Matrix Filing Code</b>	
--	--

<b>11. Submitted Documents</b>	<input checked="" type="checkbox"/> <b>FORMS</b> <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____  <input type="checkbox"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input checked="" type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	<b>Filing Submission Date</b>	03/09/2009
13.	<b>Filing Fee (If required)</b>	Amount <u>\$20.00</u> Check Date _____ Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number _____
14.	<b>Date of Domiciliary Approval</b>	
15.	<b>Filing Description:</b>	
<p>Monumental Life Insurance Company NAIC #66281 FEIN #52-0419790 Form Filing</p> <p>The above-captioned application form is being filed for your review and approval to be used with our Group Term Life Policy form TL1000GPM, approved by your department on 08/07/91. The form will be used for marketing our group term life product on a direct mail, direct response basis.</p> <p>This form is new and does not replace any existing forms.</p> <p>Our domiciliary state of Iowa does not charge a filing fee, therefore, a filing fee of \$20.00 was submitted via EFT.</p> <p>Should you have any questions or need any additional information, please feel free to contact me.</p>		

16.	<b>Certification (If required)</b>	
<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
<p>Print Name <u>Cathy L. Wynn, HIA, FLMI, ACS, ALHC</u> Title <u>Filing Specialist</u></p>		
<p>Signature <u></u> Date <u>03/12/2009</u></p>		

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>	TL AR0005255F02	
<b>This filing corresponds to rate filing company tracking number</b>		

	<b>Document Name</b>	<b>Form Number</b>		<b>Replaced Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	Group Term Life Application	TL1099GAM (Rev. 02-09)	<input type="checkbox"/> Initial <input checked="" type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	