

SERFF Tracking Number: GBAC-126094152 State: Arkansas
Filing Company: Degree of Honor Protective Association State Tracking Number: 42057
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: DOH APP INS-09
Project Name/Number: DOH APP INS-09/

Filing at a Glance

Company: Degree of Honor Protective Association

Product Name: DOH APP INS-09

SERFF Tr Num: GBAC-126094152 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 42057

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Mary Gardner

Disposition Date: 04/07/2009

Date Submitted: 04/06/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: DOH APP INS-09

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/07/2009

Explanation for Other Group Market Type:

State Status Changed: 04/07/2009

Deemer Date:

Created By: Mary Gardner

Submitted By: Mary Gardner

Corresponding Filing Tracking Number:

Filing Description:

Re: DEGREE OF HONOR PROTECTIVE ASSOCIATION - NAIC #57088 - FEIN #41-0216310

APP INSURANCE-09F Application for Membership and Life Insurance

On behalf of Degree of Honor Protective Association, a fraternal benefit society incorporated under laws of the State of Minnesota, we are submitting the above-referenced individual life application.

APP INSURANCE-09F will replace both adult application APP ADULTF-06(AR) Rev. 6/06 (approved 7/12/2006) and junior application APP JRF-06(AR) (approved 9/5/2006). The following are the basic changes made to the replaced application:

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- Added a citizenship question for both the primary and spouse insureds.
- Added driver's license and Employer/income information for the spouse rider applicant.
- Benefits applied for were updated to reflect our current products available.
- Reduced number of questions required for child rider applicant; same medical questions for all ages of primary insureds.
- Requesting signatures of juveniles age 15 and over, if primary insured.
- Combined fraud warnings onto generic application.
- Updated the MIB address.

APP INSURANCE-09F will be used with the following insurance forms:

UL NLF-07 Flexible Premium Adjustable Death Benefit Life Insurance approved 3/6/2007
ULIVZF(AR) Flexible Premium Adjustable Death Benefit Life Insurance approved 12/4/2008
RCTF-08 Level Term Insurance (renewable to age 70) approved 9/25/2007

Company and Contact

Filing Contact Information

Mary Gardner, mgardner@lifebase.com
100 First Avenue N.E. 319-896-5970 [Phone]
Suite 117 319-896-5979 [FAX]
Cedar Rapids, IA 52401

Filing Company Information

(This filing was made by a third party - griffithballardandco)

Degree of Honor Protective Association CoCode: 57088 State of Domicile: Minnesota
400 Robert Street N Group Code: Company Type: Fraternal
Suite 1600 Group Name: State ID Number:
St. Paul, MN 55101-2029 FEIN Number: 41-0216310
(651) 228-7600 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$75.00
Retaliatory? Yes
Fee Explanation: 1 form @ \$75.00

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Degree of Honor Protective Association	\$75.00	04/06/2009	26976379

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/07/2009	04/07/2009

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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: DOH APP INS-09
Project Name/Number: DOH APP INS-09/

Disposition

Disposition Date: 04/07/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GBAC-126094152 *State:* Arkansas
Filing Company: Degree of Honor Protective Association *State Tracking Number:* 42057
Company Tracking Number:
TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: DOH APP INS-09
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Authorization Letter		Yes
Form	Application for Membership and Life Insurance		Yes

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Form Schedule

Lead Form Number: APP INSURANCE-09F

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	APP INSURANCE-09F	Application/Enrollment Form	Application for Membership and Life Insurance	Initial		45.800	John Doe F.pdf



*Degree of Honor
Protective Association*

A Fraternal Benefit Society

*Application for Membership
and Life Insurance*

400 Robert Street North, Suite 1600
Saint Paul, Minnesota 55101
Telephone: 651.228.7600, 800.947.5812
degreeofhonor.org

PLEASE PRINT WITH BLACK INK (medium point)

Identification Verification for Proposed Insured and Owner. The identification must be an unexpired government-issued identification card or document that includes a photograph and one or more of the following: driver's license number, taxpayer identification number, passport number and country of issuance, permanent resident identification number, or number and country of issuance of any other government-issued document evidencing nationality or residence.

A. PROPOSED INSURED Please print Mail policy to [X] Agent [] Owner [] Other

1. John Doe Date of Birth: 1-1-1974
123 Maple
Anywhere 22 00000
2. Social Security Number 123-45-6789 3. U.S. State or Country of Birth MN 4. Age 35
5. Sex [X] Male [] Female 6. Marital Status Married 7. Former Last Name
8. E-mail address 9. Driver's License # 0000000
10. Daytime Phone # 000-000-0000 Evening Phone #
Best time to call: 5:00 PM
11. Citizenship: [X] U.S. [] Other Date of arrival in U.S.
U.S. Permanent Resident card? (green card) [] Yes [] No If no, list Visa type:
12. Employer Name and address: Acme Inc, 123 Main St Anywhere XX 00000
Duration(yrs): 5 Occupation/Duties: General
13. Individual Income \$ 40,000 Net Worth \$ 100,000 Household Income \$ 40,000
14. Type of ID(s) Dr. License ; SSN ID #(s) 0000000

B. PROPOSED SPOUSE RIDER INSURED If being applied for:

1. Date of Birth:
2. Social Security Number 3. U.S. State or Country of Birth 4. Age
5. Sex [] Male [] Female 6. Former Last Name
7. E-mail address 8. Driver's License #
9. Daytime Phone # Evening Phone #
10. Citizenship: [] U.S. [] Other Date of arrival in U.S.
U.S. Permanent Resident card? (green card) [] Yes [] No If no, list Visa type:
11. Employer Name and address:
Duration(yrs): Occupation/Duties:
12. Individual Income \$
13. Type of ID(s) ID #(s)

C. OWNERSHIP (Required if Proposed Insured is Under Age 18) Must comply with Fraternal Code

Owner (if other than Proposed Insured)
First Name Middle Name Last Name
Street Address - RFD - Box Number City State Zip Code
Relationship to Proposed Insured Home Telephone # E-mail Address Social Security # Date of Birth
Type of ID(s) ID #(s)

D. CONTINGENT OWNER (Optional) Must comply with Fraternal Code

Owner
First Name Middle Name Last Name
Street Address - RFD - Box Number City State Zip Code
Relationship to Proposed Insured Home Telephone # E-mail Address Social Security # Date of Birth
Type of ID(s) ID #(s)

E. INSURANCE AND BENEFITS APPLIED FOR: New Policy Change to Existing Policy # _____

1. Plan of Insurance Universal Life 2. Amount of Basic Plan \$ 50,000
 a. For Universal Life Plans, is application for No Lapse Guarantee? Yes No
 b. If No, Death Benefit Option A - Level B - Increasing

3. Additional Benefit Riders

- Spouse Term (U.L. only) \$ _____ Primary Insured Term \$ _____
 Children's Term (U.L. only) \$ _____ Accidental Death Benefit \$ _____
 Monthly Disability Benefit (U.L. only) \$ _____ Disability Waiver (Traditional only) Yes No
 Guaranteed Insurability Option (U.L.) \$ _____ Guaranteed Insurability Option (Traditional) \$ _____
 Accelerated Death Benefit Rider Yes No

F. PREMIUM INFORMATION

1. Planned annual premium \$ 474.00 2. Amount paid per Conditional Receipt \$ 474.00
 3. Method of payment Monthly (EFT only) Quarterly Semi-annual Annual Single Premium
 List Bill Government Allotment
 4. Premium paid by Check Cash Other _____

G. DIVIDEND OPTION (Traditional Only) Paid in Cash Paid-Up Additions Accumulate at Interest

H. AUTOMATIC PREMIUM LOAN (Traditional Only) Yes No

I. EXISTING AND PROPOSED INSURANCE

- Is there existing life insurance or annuities? Proposed Insured Yes No
 Proposed Spouse Rider Yes No

Is the policy applied for intended to replace, change or borrow on any existing life insurance or annuity in this or any other company? Yes No If "Yes", complete Replacement Forms and attach any required transfer forms.

If replacing, please list current policy information,:

Company Name/Address	Policy #	Amount	Insured Name(s)

NOTE: The replacement form(s) must be presented to applicant if the answer to the above question is Yes.
List Life Insurance In Force and/or Currently Applied For

1. _____
 Company _____
 Year Issued Life Insurance Plan Life Insurance Amount Name of Insured on the Policy
2. _____
 Company _____
 Year Issued Life Insurance Plan Life Insurance Amount Name of Insured on the Policy

J. SPECIAL REQUESTS For example: special issue date. _____

K. COMPLETE IF PROPOSED INSURED IS UNDER AGE 18 (Primary Insured only)

- Is there similar insurance in force or applied for on all siblings? Yes No
 If not, why? _____
 Please list amount of life insurance already in force on parent(s)/guardian(s) \$ _____

L. PRIMARY INSURED BENEFICIARY DESIGNATION *If more space is needed, use page 2.*

Must comply with Fraternal Code.

Primary Beneficiary(ies) SSN % Date of Birth Relationship to Proposed Insured Home Telephone #
Jane Doe 987-65-4321 100% 1-1-1974 Spouse 000-00-0000

Contingent Beneficiary(ies) SSN % Date of Birth Relationship to Proposed Insured Home Telephone #

If there is no surviving Beneficiary designated, the proceeds shall be paid to the Owner or the Owner's estate. Should the Owner or the Owner's estate fail to claim the funds within three years of the Insured's death, the funds shall be paid to the Degree of Honor Foundation.

Beneficiary Designation if Spouse and/or Children's Riders are applied for: The Beneficiary Designation on the Spouse and/or Children's Rider shall be the Primary Insured if living; otherwise the estate of the person insured by the Rider. The above shall apply unless otherwise indicated by a Beneficiary Designation form.

M. CHILDREN'S INSURANCE RIDER INFORMATION (if applied for)

For Identification Verification: the identification must be an unexpired government-issued identification card, student identification card or document that includes a **photograph** and one or more of the following: driver's license number, taxpayer identification number, passport number and country of issuance, permanent resident identification number, or number and country of issuance of any other government-issued document evidencing nationality or residence.

Please list the type of ID(s) for the children listed below: _____

1. Name(s) of children to be covered by rider (must be under the age of 18 and unmarried)						Physical/Mental Abnormalities at Birth? (If yes, explain below)
Name (First, Middle, Last)	ID Number	Sex	Birthdate	Height	Weight	
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Has any child listed above:
 a. Had a weight change during the last year? Yes No
 b. Received treatment for any disease, physical or mental condition, including ADD/ADHD in the past five years?..... Yes No
 If yes to 1., 2a. or 2b. above, explain here: _____

3. Are there any children under the age of 18 and unmarried not listed above? Yes No
 If yes, List Name _____ Birthdate: _____
 Reason for Exclusion: _____

N. WITHIN THE PAST 10 YEARS, HAS ANY PROPOSED INSURED HAD (including Spouse if Rider applied for. List details on page 7):

	YES	NO
1. A disorder of the blood, heart, or circulatory system; chest pain, heart murmur, heart attack, rheumatic fever, irregular heart beat, high blood pressure, PVD (peripheral vascular disease), varicose veins, stroke, memory loss, dementia, aneurysm, anemia or any other disorder of the heart, blood vessels or circulatory system?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Cancer, tumor, cyst, growth, or enlargement of the lymph glands?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. A disorder of the respiratory system; asthma, bronchitis, COPD, emphysema, tuberculosis, sleep apnea, shortness of breath or other lung disorders?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. A disorder of the digestive system; ulcer, colitis, rectal bleeding, diarrhea, hepatitis or other disorders of the stomach, esophagus, intestines, liver or gallbladder?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Diabetes, thyroid, adrenal, pituitary or other glandular disorder?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Albumin, blood, sugar or pus in the urine; any disorder of the kidney or bladder?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Epilepsy, convulsions, loss of consciousness, dizziness, paralysis, headaches, depression, anxiety, mental, emotional or nervous disorder, mental retardation or cerebral palsy?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. A disorder of the muscles, skin, or bone; arthritis, gout, connective tissue disorder or disorders of the back, joints, or extremities?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. A disorder of the reproductive system including prostate, testes, breast(s), ovaries or uterus, sexually transmitted disease, HPV, or current pregnancy?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. A disorder of the eyes, ears, nose, throat, or mouth?(other than glasses or contacts).....	<input type="checkbox"/>	<input checked="" type="checkbox"/>

O. WITHIN THE PAST 5 YEARS HAS ANY PROPOSED INSURED (including Spouse if Rider if applied for. List details on page 7):

	YES	NO
11. Had a medical checkup, sought or received medical advice or been advised to restrict normal activities because of illness or injury (including x-rays, ECGs, other tests or medication)?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Been treated or evaluated at a hospital, clinic or other facility by a medical professional or been advised by a medical professional to have any test or surgery not yet completed?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Consulted a hospital, clinic, psychiatrist, psychologist, or counselor for any reason?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Been refused a motor vehicle driver's license, had a license suspended, a moving traffic violation, or been cited for a DUI/DWI? (If "yes", give date, type of violation, and state).....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15. Used marijuana, cocaine, heroin, amphetamines or any other controlled or prohibited substances?..... If Yes, give date last used: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16. Been treated for, received counseling, or been advised to seek counseling by a medical professional because of alcohol or drug usage?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>

P. HAS ANY PROPOSED INSURED (including Spouse if Rider applied for. List details on page 7):

	YES	NO
17. Ever been diagnosed by a member of the medical profession or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an AIDS-related condition; or tested positive for the Human Immunodeficiency Virus (HIV)?....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
18. Received any medical advice, treatment, or surgery or presently have a physical impairment or illness not already listed?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
19. Ever had a life or health insurance application declined, postponed, rated, modified or withdrawn? (If "yes", give name of company(ies), date, and reason).....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
20. Within the past two years flown as a pilot, co-pilot, student pilot, or crew member?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
21. Within the past two years participated in any of the following: scuba diving, skydiving, ultra-light flying, hang-gliding, or auto, boat, motorcycle or snowmobile racing?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
22. Used nicotine in any form within the past year?..... If "yes", <input type="checkbox"/> Pipe or Cigars <input type="checkbox"/> Smokeless <input type="checkbox"/> Cigarettes <input type="checkbox"/> Nicotine patch, gum, spray How often? _____ How many? _____ Date last used: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>

ACKNOWLEDGEMENT

I understand and agree that:

1. I have read and received the Notice of Insurance Information Practices and the MIB, Inc. Pre-Notice.
2. I have read the previous statements and answers and to the best of my knowledge they are true and complete.
3. This application shall become part of the insurance contract together with our Articles of Incorporation and Bylaws, as amended from time to time.
4. No change in this application shall be made without my written consent.
5. No agent of Degree of Honor Protective Association is authorized to make or alter any contract or waive any Degree of Honor Protective Association rights or requirements.
6. No insurance shall take effect (unless otherwise provided in a completed Conditional Receipt) until:
 - a) the Policy is delivered and you accept it;
 - b) the first full premium is paid by check, money order or cashiers check made payable only to Degree of Honor Protective Association during the lifetime of the Insured; and
 - c) the insurability of the Proposed Insured remains as described in this application and all representations are true and correct.

Signed at Anywhere, ZZ, this 1 day of April, 2009
City, State Month Year

John Doe
Signature of Proposed Insured, age 15 or older (primary Insured only)

Signature of Spouse if Spouse Rider Applied For

Signature of Parent/Guardian, if under age 18

Any Agent
Authorized Agent

Signature of Owner if different than Proposed Insured

ARKANSAS and West Virginia Fraud Warning: 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.

COLORADO Fraud Warning: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

OHIO Fraud Warning: 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 civil and criminal penalties.

TENNESSEE AND WASHINGTON Fraud Warning: 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.

TEXAS Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

ILLUSTRATION CERTIFICATION

I have received an illustration with this application. Yes No (If "no", complete acknowledgement below)

Owner Acknowledgement

I did not receive an illustration at the time I applied for my Degree of Honor Protective Association life insurance policy. I understand that an illustration conforming to the policy issued shall be provided no later than at the time of policy delivery.

Signature of Owner _____ Date _____

Authorized Agent Acknowledgement

I certify that I did not present an illustration to the above-named Owner at the time of application.

Signature of Authorized Agent _____ Date _____

LODGE/SERVICE CLUB MEMBERSHIP Must be signed. Not applicable for Proposed Insureds age 17 or less.

Is(Are) Proposed Insured(s) now a member of the Association? Yes Lodge/Service Club # _____ State _____
 No (If "no", complete membership application below)

APPLICATION FOR MEMBERSHIP TO DEGREE OF HONOR PROTECTIVE ASSOCIATION

I **hereby apply** for membership in the Association and its local Lodge/Service Club # _____ State of _____
 I **understand** that unless I select a specific Lodge/Service Club, the Association will select the Lodge/Service Club to which I will be assigned membership.

I **agree** if accepted, to abide by the Articles of Incorporation and Bylaws of the Association and the Bylaws of said Lodge/Service Club, all as the same now exist or are hereafter amended.

I **hereby affirm** my belief in: [Christian beliefs and values and demonstration of high moral character. The protection and support of family members and their dependents through fraternal insurance products. Promotion of the family unit and the seeking of ways to strengthen it. Assistance to members, their dependents and others in times of adversity. The desire to help others in need through community service and adherence to the principals of volunteerism. Maintenance of a representative form of government by providing members with the opportunity to become involved in structured events, club meetings and programs. Respect for and allegiance to the United States of America and its flag by promoting patriotism. Adherence to the Golden Rule "Do unto others as you would have them do unto you."]

Signature of Proposed Member _____ Date _____

Signature of Proposed Member _____ Date _____

DEGREE OF HONOR PROTECTIVE ASSOCIATION
 BANK INFORMATION FOR ELECTRONIC FUNDS TRANSFER

I(We) hereby authorize the above-named Association to initiate automatic premium payments to be charged to my(our) account indicated below and the financial institution named below to charge these premiums to such account.

Financial Institution _____

EFT WITHDRAWAL METHOD Checking Account* Savings Account**
 EFT WITHDRAWAL BUSINESS DAY OF THE MONTH 1st Day 8th Day 16th Day 23rd Day

* If choosing EFT from **Checking Account**, attach a voided check for account and transit numbers.
 ** If choosing EFT from **Savings Account**, attach a voided withdrawal or deposit slip with the preprinted account and transit numbers.

NOTICE TO POLICYHOLDERS: This authority is to remain in full force and effect until the Financial Institution has received written notification from you of its termination in such time and in such manner as to afford the Financial Institution a reasonable opportunity to act on it. You have the right to stop payment of a premium by notification to the Financial Institution prior to charging the account. After the account has been charged, a customer has the right to have the amount of an erroneous payment immediately credited to his(her) account by the Financial Institution up to 15 days following notification.

List Name and Policy Number for those policies to be paid under this Agreement

NAME	POLICY #	NAME	POLICY #
_____	_____	_____	_____
_____	_____	_____	_____

Account Holder(s) (Please print) _____

Signature _____ **Both Signatures Required if This is a Joint Account** _____ 2nd Signature if Joint Account

AGENT'S CONFIDENTIAL REPORT

1. Did you personally see the Proposed Insured and ask each question? Yes No
2. Did the Proposed Insured contact you for this insurance? Yes No
3. Purpose for insurance? Estate liquidity (estate taxes, clearance costs) Business insurance (Give details. Must comply with Fraternal Code.) Family income (survivor, retirement, etc) Other personal needs (personal loan) Other _____
4. How well do you know the Proposed Insured? Very well Casually Just met Relative
If a relative, please explain relationship; _____
5. Are any other family members who are not on this application applying for insurance at this time? Yes No

Name(s) & Date	Relationship to Proposed Insured	Company	Plan/Amount

6. Indicate type of arrangements made:

	Nonmedical	Basic Paramed	H.O. Urine specimen	Blood chemistry profile	ECG	Other (explain below)
Proposed Insured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proposed Spouse Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (indicate) _____

Name of paramedical facility or medical doctor being used _____

Scheduled date of completion _____ Telephone # _____

7. Was the premium paid with this application? Yes No
8. Who paid the premium? Owner Proposed Insured Other (explain below)
9. Additional information and explanations: _____

To the best of my knowledge and belief:

1. I have asked all questions and recorded all answers as they were given to me by the Proposed Insured and/or Owner.
2. I know nothing about Proposed Insured's health, habits, avocations or life style affecting insurability which has not been stated in this application.
3. The Proposed Insured does does not have existing life insurance policies or annuity contracts.
4. The insurance applied for on this application is is not intended to replace or change any life insurance or annuity with this or any other organization, except as indicated. Section I must be completed.
5. The Notice of Insurance Information Practices and MIB, Inc. Pre-Notice and disclosure or outline(s) of coverage, if required, were left with the Proposed Insured and Owner.
6. I have explained the anti-money laundering/terrorist financing information collecting requirements to the Owner and Proposed Insured.
7. I have seen have not seen the Owner's photo ID and verified such identity.
I have seen have not seen the Proposed Insured's photo ID (as applicable) and verified such identity(ies).

DATED 4-1-2009 SIGNED Any Agent
Authorized Agent

AGENT PERSISTENCY NUMBER IS REQUIRED. PLEASE FULLY COMPLETE THIS SECTION.

<u>000000</u> Persistency Number	Persistency Number
<u>Any Agent</u> Print Agent's Name	Print Agent's Name
<u>Any Agent</u> Agent's Signature	Agent's Signature
Agent's E-mail Address	Agent's Telephone Number
<u>100%</u> Percent (%)	Agent's E-mail Address
Agent's Telephone Number	Percent (%)

CONDITIONAL RECEIPT

Detach and deliver to applicant only if first premium is received.

- A. **WHEN INSURANCE IS EFFECTIVE.** It is mutually agreed that the insurance applied for will take effect prior to delivery of a policy as of the latest of the date hereof or the date of any required medical examination only if: (1) the application is fully and truthfully completed; (2) all medical examinations required by our published underwriting rules have been completed; (3) the Proposed Insured(s) is(are) eligible as of the Policy Date for the plan and amount of insurance applied for; (4) the Proposed Insured(s) is(are) approved as an insurable risk at standard rates under Association rules after receipt of required information; and (5) the required first full premium is paid by check, money order or cashiers check made payable to Degree of Honor Protective Association.
- B. **WHEN RECEIPT IS VOID.** This receipt shall be void and no insurance shall be in force hereunder if: (1) any of the required conditions in A above are not fulfilled; or (2) if any plan or amount applied for is declined or is not approved for issuance within 60 days of the date of the application; or (3) if a check in payment of premium is not honored on first presentation; or (4) if death occurs as a result of suicide or attempted suicide.

NO AGENT OR REPRESENTATIVE OF THE ASSOCIATION IS AUTHORIZED TO WAIVE ANY OF THE FOREGOING CONDITIONS

Received from _____ the sum of _____ as first premium for application
Please print

Dated _____ relating to _____
Proposed Insured(s)

subject to the foregoing terms and conditions.

Degree of Honor Protective Association
400 Robert Street North, Suite 1600
Saint Paul, Minnesota 55101-2029
Telephone: 651.228.7600, 800.947.5812
degreeofhonor.org

Authorized Agent



NOTICE OF INSURANCE INFORMATION PRACTICES and MIB, INC. PRE-NOTICE
Always detach and give to the Proposed Insured or Parent or Guardian

Degree of Honor Protective Association appreciates your application and the confidence you have shown in us. Information regarding insurability is necessary to equitably evaluate your application. All information will be treated as confidential. Sources for this information include statements made on the application or possibly in a telephone interview from the Home Office, examination results, medical studies, and reports we receive from doctors, practitioners, medical facilities, the MIB, Inc., or from investigative consumer reports.

Degree of Honor and its reinsurers may 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, 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. If you question the accuracy of the 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 the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734; telephone number 866-692-6901 (TTY 866-346-3642). Degree of Honor, or its reinsurers, may also release information from its file to other insurance companies to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

In addition, we may get an investigative report from a consumer reporting agency. This report may include personal interviews with your neighbors, friends or other acquaintances for information as to your general reputation, personal characteristics and mode of living. Upon written request, you will be informed if such a report was obtained and, if so, the name and address of the consumer reporting agency to whom such a request was made. You may contact that agency and ask for a copy of this report.

Upon request, Degree of Honor will furnish details on how to obtain and correct personal information in its file.

Application for Membership and Life Insurance



***Degree of Honor
Protective Association***

A Fraternal Benefit Society

**400 Robert Street North, Suite 1600
Saint Paul, Minnesota 55101
Telephone: 651.228.7600, 800.947.5812
degreeofhonor.org**

SERFF Tracking Number: GBAC-126094152 State: Arkansas
Filing Company: Degree of Honor Protective Association State Tracking Number: 42057
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: DOH APP INS-09
Project Name/Number: DOH APP INS-09/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR Cert Comp 19.pdf AR Cert Comp 34.pdf AR Flesch.pdf		
Bypassed - Item: Application Bypass Reason: N/A Comments:		
Satisfied - Item: Authorization Letter Comments: Attachment: Authorization APP INS-09F.pdf		

STATE OF ARKANSAS

1200 West Third Street
Little Rock, AR 72201

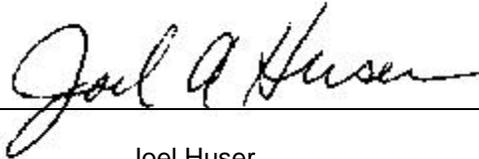
***Certification of Compliance
Rule and Regulation 19***

Carrier: **DEGREE OF HONOR PROTECTIVE ASSOCIATION**

Form Number and Title: **APP INSURANCE-09F Application for Membership and Life Insurance**

We hereby certify that to the best of our knowledge and belief the above submission complies with the Arkansas Rule and Regulation 19.

Signature of Officer: _____



Name (typed or printed): _____

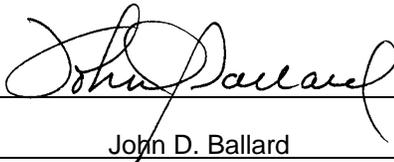
Joel Huser

Title or business affiliation: _____

Chief Executive Secretary

Date: April 1, 2009

Signature of Actuary : _____



Name (typed or printed): _____

John D. Ballard

Title or business affiliation: _____

Consulting Actuary, Griffith, Ballard and Company

Date: April 2, 2009

STATE OF ARKANSAS

1200 West Third Street
Little Rock, AR 72201

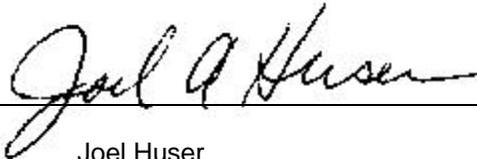
*Certification of Compliance
Rule and Regulation 34*

Carrier: **Degree of Honor Protective Association**

Form Number and Title: **APP INSURANCE-09F Application for Membership and Life Insurance**

We hereby certify that to the best of our knowledge and belief the above submission complies with the Arkansas Rule and Regulation 34.

Signature of Officer: _____



Name (typed or printed): _____

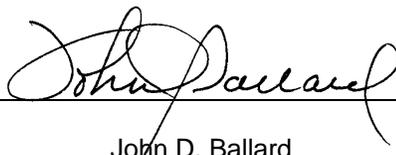
Joel Huser

Title or business affiliation: _____

Chief Executive Secretary

Date: April 1, 2009

Signature of Actuary : _____



Name (typed or printed): _____

John D. Ballard

Title or business affiliation: _____

Consulting Actuary, Griffith, Ballard and Company

Date: April 2, 2009

STATE OF ARKANSAS

DEPARTMENT OF INSURANCE

1200 West Third Street
Little Rock, AR 72201

CERTIFICATION

Readability Requirement

DEGREE OF HONOR PROTECTIVE ASSOCIATION hereby certifies that this filing complies with Ark. Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and achieves a Flesch reading ease test score as follows:

<u>Form #</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables/ Characters</u>	<u>Flesch Score</u>
APP INSURNACE-09F	146	4,168	35,359	45.8



Signature

Joel A. Huser

Name (Signed by Officer of Company)

Chief Executive Officer

Title



Degree of Honor Protective Association

400 Robert Street N., Suite 1600
Saint Paul, Minnesota 55101-2029
1-800-947-5812 • (651) 228-7600 • FAX: (651) 224-7446
degreedhonor.com

April 1, 2009

Re: DEGREE OF HONOR PROTECTIVE ASSOCIATION – NAIC #57088

APP INSURANCE-09F Application for Membership and Life Insurance

To Whom it May Concern:

I HEREBY CERTIFY that Griffith, Ballard and Company has supervised the development of the application included in this submission, and that they are authorized to submit these forms on behalf of DEGREE OF HONOR PROTECTIVE ASSOCIATION.

Any questions regarding this submission should be directed to John D. Ballard of Griffith, Ballard and Company, as the individual responsible for this filing.

Joel Huser
Chief Financial Officer