

SERFF Tracking Number: SHLI-126096047 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 42016
 Company Tracking Number: 03L10409
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Reinstatement Application
 Project Name/Number: Reinst App2/10409

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: Reinstatement Application

TOI: L071 Individual Life - Whole

SERFF Tr Num: SHLI-126096047

State: Arkansas

SERFF Status: Closed-Approved-Closed

State Tr Num: 42016

Sub-TOI: L071.101 Fixed/Indeterminate

Co Tr Num: 03L10409

State Status: Approved-Closed

Premium - Single Life

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Dina Krofta, Berdetta Moore

Disposition Date: 04/02/2009

Date Submitted: 03/31/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Reinst App2

Project Number: 10409

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/02/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 04/02/2009

Created By: Berdetta Moore

Corresponding Filing Tracking Number: 0310409

Filing Description:

Form L-68.16 is an application for reinstatement of life insurance. It will be used with any previously approved form numbers where business is still in force. This is filed as a whole life application, but could also be used for with term and universal life.

Shelter Life Insurance Company

SERFF Tracking Number: SHLI-126096047 State: Arkansas
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 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Reinstatement Application
 Project Name/Number: Reinst App2/10409
 1817 W. Broadway, Columbia, MO 65203
 Group Number 123
 NAIC Number 65757
 Filing Number 03L10409

Contact Person: Berdetta Moore
 Toll Free Number 800-shelter

Company and Contact

Filing Contact Information

Berdetta Moore, Actuarial Administrative Assistant
 1817 W. Broadway
 Columbia, MO 65203
 blmoore@shelterinsurance.com
 573-214-4832 [Phone]
 573-214-6942 [FAX]

Filing Company Information

Shelter Life Insurance Company
 1817 W. Broadway Street
 Columbia, MO 65203
 (800) 743-5837 ext. [Phone]
 CoCode: 65757
 Group Code: 123
 Group Name:
 FEIN Number: 43-0740882
 State of Domicile: Missouri
 Company Type: Life and Health
 State ID Number:

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	\$0.00	03/31/2009	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
1565396	\$50.00	03/27/2009

SERFF Tracking Number: SHLI-126096047 State: Arkansas
Filing Company: Shelter Life Insurance Company State Tracking Number: 42016
Company Tracking Number: 03LI0409
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Reinstatement Application
Project Name/Number: Reinst App2/10409

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/02/2009	04/02/2009

SERFF Tracking Number: *SHLI-126096047* *State:* *Arkansas*
Filing Company: *Shelter Life Insurance Company* *State Tracking Number:* *42016*
Company Tracking Number: *03LI0409*
TOI: *L071 Individual Life - Whole* *Sub-TOI:* *L071.101 Fixed/Indeterminate Premium - Single*
Product Name: *Reinstatement Application*
Project Name/Number: *Reinst App2/10409*

Disposition

Disposition Date: 04/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SHLI-126096047 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 42016
 Company Tracking Number: 03LI0409
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Reinstatement Application
 Project Name/Number: Reinst App2/10409

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

SERFF Tracking Number: SHLI-126096047 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 42016
 Company Tracking Number: 03L10409
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Reinstatement Application
 Project Name/Number: Reinst App2/10409

Form Schedule

Lead Form Number: L-68.16

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-68.16	Application/ Enrollment Form	Application for Reinstatement of Life Insurance	Initial		44.500	L-68.16.pdf



SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

APPLICATION FOR REINSTATEMENT OF LIFE INSURANCE



1. Name of Insured	(Last)	(First)	(MI)	Policy Number
2. Address	(Street)	(City)	(State)	(Zip) Phone
3. Name of Joint Insured (If Joint Policy)				

THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON INSURED UNDER THE POLICY INCLUDING THE INSURED, SPOUSE, CHILDREN, PAYOR & JOINT INSURED.

4. To the best of your knowledge and belief, since the effective date of this policy, have you or any other person insured under this policy:	Yes	No
a. consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any physical or mental disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
c. sought or received treatment or counseling for alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
d. been charged with driving while intoxicated or under the influence from alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
e. changed occupations? (If yes, list current business or industry and duties.)	<input type="checkbox"/>	<input type="checkbox"/>
f. engaged in or anticipate engaging in aviation activities including ultralight flying, hang gliding or parachute jumping?	<input type="checkbox"/>	<input type="checkbox"/>
g. engaged in or anticipate engaging in rodeo riding, underwater diving, racing of any motor powered vehicle or any other sport or hobby?	<input type="checkbox"/>	<input type="checkbox"/>
h. used tobacco in any form? (If yes, list date last used in Question 5.)	<input type="checkbox"/>	<input type="checkbox"/>

5. FOR ALL YES ANSWERS TO QUESTION 4 (a thru h), GIVE FULL DETAILS BELOW.

Question No.	Name of Covered Person	Date	Details (Condition, operation performed, hospitalization, medications, names & addresses of doctors, hospitals or clinics involved, other details)

This application is a legal document and is part of the policy. Reinstatement is based on statements in this application and those in the original application, and is contingent on approval at the Company's Home Office and payment of premium and interest. Any misrepresentations, omissions, or incorrect statements that are material to the acceptance of the risk, shall, for two years from the date of reinstatement, bar right to recover under the policy. If not approved, any premium paid with this application will be refunded.

THE INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

ANY PERSON WHO KNOWINGLY PRESENTS 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.

Signature of Insured (Parent or legal guardian must sign if Insured is under the age of 18) _____ Soc. Sec. No. _____ Date _____

Signature of Joint Insured (If Joint Policy) _____ Soc. Sec. No. _____ Date _____

Signature of Spouse (If policy includes Spouse Term Rider) _____ Soc. Sec. No. _____ Date _____

Signature of Owner (If other than Insured) _____ Soc. Sec. No. _____ Date _____

Agent _____ Agent No. _____ Date _____

**Authorization for Use or Disclosure
Of Protected Health Information**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.
2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.
3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

Print Name and Date of Birth of Insured

Signature of Insured (Parent or legal guardian must sign if Insured is under age 18)

Date

Print Name and Date of Birth of Spouse (If policy includes Spouse Term Rider)

Signature of Spouse (If policy includes Spouse Term Rider)

Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

MEDICAL TEST AUTHORIZATION

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, test for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

Date

Signature of Insured (Parent or legal guardian must sign if Insured is under the age of 18)

Date

Signature of Joint Insured (If Joint Policy)

Date

Signature of Spouse (If policy includes Spouse Term Rider)



⤵ Please read, detach and save for your records. ⤴

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter 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, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of 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 MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's Home Office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.



**SHELTER
INSURANCE
COMPANIES**

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

This is to certify that the following forms have achieved the indicated Flesch Reading Ease Scores and comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form No.</u>	<u>Name</u>	<u>Score</u>
L-68.16	Application for Reinstatement of Life Insurance	44.8

Signed _____
Dina Krofta, FSA, MAAA
Senior Life Actuary
Shelter Life Insurance Company



SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

APPLICATION FOR REINSTATEMENT OF LIFE INSURANCE



1. Name of Insured	(Last)	(First)	(MI)	Policy Number
2. Address	(Street)	(City)	(State)	(Zip) Phone
3. Name of Joint Insured (If Joint Policy)				

THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON INSURED UNDER THE POLICY INCLUDING THE INSURED, SPOUSE, CHILDREN, PAYOR & JOINT INSURED.

4. To the best of your knowledge and belief, since the effective date of this policy, have you or any other person insured under this policy:	Yes	No
a. consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any physical or mental disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
c. sought or received treatment or counseling for alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
d. been charged with driving while intoxicated or under the influence from alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
e. changed occupations? (If yes, list current business or industry and duties.)	<input type="checkbox"/>	<input type="checkbox"/>
f. engaged in or anticipate engaging in aviation activities including ultralight flying, hang gliding or parachute jumping?	<input type="checkbox"/>	<input type="checkbox"/>
g. engaged in or anticipate engaging in rodeo riding, underwater diving, racing of any motor powered vehicle or any other sport or hobby?	<input type="checkbox"/>	<input type="checkbox"/>
h. used tobacco in any form? (If yes, list date last used in Question 5.)	<input type="checkbox"/>	<input type="checkbox"/>

5. FOR ALL YES ANSWERS TO QUESTION 4 (a thru h), GIVE FULL DETAILS BELOW.

Question No.	Name of Covered Person	Date	Details (Condition, operation performed, hospitalization, medications, names & addresses of doctors, hospitals or clinics involved, other details)

This application is a legal document and is part of the policy. Reinstatement is based on statements in this application and those in the original application, and is contingent on approval at the Company's Home Office and payment of premium and interest. Any misrepresentations, omissions, or incorrect statements that are material to the acceptance of the risk, shall, for two years from the date of reinstatement, bar right to recover under the policy. If not approved, any premium paid with this application will be refunded.

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Signature of Insured (Parent or legal guardian must sign if Insured is under the age of 18) _____ Soc. Sec. No. _____ Date _____

Signature of Joint Insured (If Joint Policy) _____ Soc. Sec. No. _____ Date _____

Signature of Spouse (If policy includes Spouse Term Rider) _____ Soc. Sec. No. _____ Date _____

Signature of Owner (If other than Insured) _____ Soc. Sec. No. _____ Date _____

Agent _____ Agent No. _____ Date _____

**Authorization for Use or Disclosure
Of Protected Health Information**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.
2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.
3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

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Date

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Signature of Spouse (If policy includes Spouse Term Rider)

Date

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I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, test for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

Date

Signature of Insured (Parent or legal guardian must sign if Insured is under the age of 18)

Date

Signature of Joint Insured (If Joint Policy)

Date

Signature of Spouse (If policy includes Spouse Term Rider)



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NOTICE OF CONSUMER REPORT

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