

SERFF Tracking Number: LBLI-126149231 State: Arkansas
 Filing Company: Liberty Life Insurance Company State Tracking Number: 42418
 Company Tracking Number: 048-874 ET AL
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: NAIC Model Replacement update for Group apps
 Project Name/Number: /

Filing at a Glance

Company: Liberty Life Insurance Company

Product Name: NAIC Model Replacement
 update for Group apps

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: LBLI-126149231 State: Arkansas

SERFF Status: Closed-Approved-
 Closed State Tr Num: 42418

Co Tr Num: 048-874 ET AL

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Julie Duncan, Dianne
 Harris

Disposition Date: 05/20/2009

Date Submitted: 05/15/2009

Disposition Status: Approved-
 Closed

Implementation Date Requested: 06/18/2009

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Franchise

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/20/2009

Explanation for Other Group Market Type:

State Status Changed: 05/20/2009

Deemer Date:

Created By: Dianne Harris

Submitted By: Dianne Harris

Corresponding Filing Tracking Number: 048-
 874 (06-09)AR et al

Filing Description:

Submission of Application Forms for Informational Purposes

Form Numbers:

048-874 (06-09)AR

UNL (06-09)AR

UNLS (06-09)AR

SERFF Tracking Number: LBLI-126149231 State: Arkansas
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NAIC Model Replacement update for Group apps
Project Name/Number: /

Dear Sir or Madam:

Liberty Life Insurance Company has prepared the above-referenced filing for your information. The referenced applications will replace the previously approved applications, listed below, as they contain the same content and questions. We request that all other material, including original bracketed material, remain as is currently on file in your department. The only changes to the forms are the replacement question and form number. The changes are the result of your adoption of the Life Insurance and Annuities Replacement Model Regulation of the National Association of Insurance Commissioners.

Form Number Approval Date
084-874(5-94) 8-21-01
UNL(02-02) 7-16-02
UNLS(01-06) 1-19-06

All changes are highlighted.

To the best of my knowledge and belief, these forms comply with the statutory and regulatory requirements of your state. These forms contain no unusual or possible controversial items from normal company or industry standards. If you have any questions, please contact me at 864-609-8350 or by email at libertydoiresponses@rbc.com Attn: Dianne Harris. We will begin using these forms upon receiving your acknowledgement of this filing.

Company and Contact

Filing Contact Information

Dianne Harris, Compliance Analyst dianne.k.harris@rbc.com
2000 Wade Hampton Blvd 864-609-1198 [Phone]
Greenville, SC 29615 864-609-1039 [FAX]

Filing Company Information

Liberty Life Insurance Company CoCode: 61492 State of Domicile: South Carolina
2000 Wade Hampton Blvd Group Code: Company Type:
Greenville, SC 29602 Group Name: State ID Number:
(864) 609-4815 ext. [Phone] FEIN Number: 44-0188050

Filing Fees

SERFF Tracking Number: LBLI-126149231 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 42418
Company Tracking Number: 048-874 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
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Project Name/Number: /

Fee Required? Yes
Fee Amount: \$60.00
Retaliatory? No
Fee Explanation: 3 apps. x \$20.00 = \$60.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty Life Insurance Company	\$60.00	05/15/2009	27925915

SERFF Tracking Number: LBLI-126149231 State: Arkansas
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/20/2009	05/20/2009

SERFF Tracking Number: LBLI-126149231 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 42418
Company Tracking Number: 048-874 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NAIC Model Replacement update for Group apps
Project Name/Number: /

Disposition

Disposition Date: 05/20/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *LBLI-126149231* State: *Arkansas*
 Filing Company: *Liberty Life Insurance Company* State Tracking Number: *42418*
 Company Tracking Number: *048-874 ET AL*
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
 Product Name: *NAIC Model Replacement update for Group apps*
 Project Name/Number: */*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Form	Application		Yes
Form	Application		Yes
Form	Application		Yes

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 Filing Company: Liberty Life Insurance Company State Tracking Number: 42418
 Company Tracking Number: 048-874 ET AL
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: NAIC Model Replacement update for Group apps
 Project Name/Number: /

Form Schedule

Lead Form Number: 048-874 multi group apps

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	048-874 (06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update of NAIC Model Replacement Reg		048-874(06-09)AR.pdf
	UNL (06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update of NAIC Model Replacement Reg		UNL (06-09)AR.pdf
	UNLS (06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update of NAIC Model Replacement Reg		UNLS (06-09)AR.pdf

APPLICATION/ENROLLMENT For Life Insurance

Liberty Life Insurance Company
 P.O. Box 789
 Greenville, SC 29602-0789

Initial Amount of Insurance

STANDARD MONTHLY PREMIUM (Current age - Older Applicant's Current Age, if joint coverage.
 To qualify for non-smoking joint rates, both applicants must be non-smokers).

Full Coverage Partial Coverage
 If partial coverage, see reverse side to calculate premium. Coverage is subject to a \$15,000 minimum.

AGE	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Single Non-Smoker								
Single-Smoker								
Joint Non-Smoker								
Joint-Smoker								

NAME AND ADDRESS

BENEFICIARY (Name and Address)

Are you planning to replace, discontinue, or change an existing Policy or Contract? Yes No
 If Yes, give Company and amount.

I. APPLICANT INFORMATION														
FIRST APPLICANT					JOINT APPLICANT									
Last			First		MI			Last			First		MI	
Date of Birth	State of Birth	SS#	Height	Weight	Date of Birth	State of Birth	SS#	Height	Weight	M/ D / Y				lbs
Occupation		<input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Telephone ()		Occupation		<input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Telephone ()						

II HEALTH INFORMATION

1. During the past 3 years, have you consulted a doctor, or other health care provider or been hospitalized?
FIRST APPLICANT Yes* No **JOINT APPLICANT** Yes* No

2. Have you ever been treated for or advised by a licensed physician that you had any of the following: heart, lung, nervous, kidney or liver disorder; high blood pressure; stroke; drug abuse, including alcohol; cancer or tumor; AIDS; diabetes?
FIRST APPLICANT Yes* No **JOINT APPLICANT** Yes* No

* If "Yes," indicate reason, dates, names and addresses of doctors, in space below:

FIRST APPLICANT	JOINT APPLICANT

3. During the last 12 months, have you smoked or used tobacco in any form?
FIRST APPLICANT Yes** No **JOINT APPLICANT** Yes** No

** If "Yes," give form and frequency of use.

III ACKNOWLEDGEMENT

The information offered in this application/enrollment is made individually by each applicant in order to obtain insurance and is true and complete to the best of my/our knowledge. It is understood that the Company will incur no liability unless and until this application/enrollment is approved by the Company. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records on me or my health to give to Liberty Life Insurance Company and its reinsurers any such information at any time during the next 24 months. A photographic copy of this authorization will be as valid as the original. I have read this authorization and the notices on the back of this application/enrollment. I understand that I may request and receive copies.

I acknowledge receipt from the Company of consumer protection disclosures required by federal law.

SIGNATURE(S)

First Applicant _____ Date / /	Joint Applicant _____ Date / /
--------------------------------	--------------------------------

Present Balance	Customer Number	Remaining Term Yrs.	Account Number	Plan ABMS
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AGENT: To the best of your knowledge, will this insurance replace any other insurance or annuity? Yes NO

Signature _____

LIFE INSURANCE APPLICATION

Liberty Life Insurance Company

PO Box 789 Greenville, SC 29602-0789

Questions? Contact us at: 1 800-813-4412

This application is for decreasing mortgage term life insurance in the initial amount of:

Customer number:
Beneficiary:

This is the monthly cost to protect your family's home:

The cost does not increase because you grow older. The rates are based on age of older insured. To qualify for non-tobacco rates both applicants must not use tobacco.

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Non-Tobacco Rates	One Insured							
	Two Insureds							
Tobacco Rates	One Insured							
	Two Insureds							

APPLICANT (Please Print)

First		Middle		Last Name	
Date of Birth	State of Birth	Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	
Social Security #		Height	Weight		
Residence Telephone Number		Business Telephone Number			
Email Address					

SECOND APPLICANT (Please Print)

First		Middle		Last Name	
Date of Birth	State of Birth	Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	
Social Security #		Height	Weight		
Residence Telephone Number		Business Telephone Number			
Email Address					

- | | Applicant | | Second Applicant | |
|---|----------------------------|--------------------------|----------------------------|--------------------------|
| | Yes | No | Yes | No |
| 1) During the past 3 years, have you consulted a doctor, or other health care provider, or been hospitalized? | * <input type="checkbox"/> | <input type="checkbox"/> | * <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Have you, in the last 10 years, been treated for or advised by a licensed physician that you had any of the following: heart, lung, nervous, kidney, or liver disorder; high blood pressure; stroke; drug abuse, including alcohol; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS); diabetes? | * <input type="checkbox"/> | <input type="checkbox"/> | * <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you tested positive for Human Immunodeficiency Virus (HIV)? | * <input type="checkbox"/> | <input type="checkbox"/> | * <input type="checkbox"/> | <input type="checkbox"/> |
| 4) During the past 12 months, have you smoked or used tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*** If you answered "yes" to questions 1, 2 or 3, please circle condition and provide details on the back of the application in the space provided. Include name and address of attending physician.**

The information offered in this application is made individually by each applicant in order to obtain insurance and is true and complete to the best of my/our knowledge. It is understood that the Company will incur no liability unless and until this application is approved by the Company. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, pharmacy, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records on me or my health to give to Liberty Life Insurance Company and its reinsurers any such information at any time during the next 24 months. A photographic copy of this authorization will be as valid as the original. I have read this authorization and the notices on the back of this application. I understand that I may request and receive copies.

I authorize my lending institution to add the premium to my mortgage payment for the amount of insurance as indicated. If I have authorized my lending institution to automatically/electronically debit from my account, I hereby request this insurance premium to be added to this authorization. This authority is to remain in effect until I cancel it in writing and until the Company or my lending institution actually receives such notice.

By signing this form, I acknowledge receipt of the enclosed consumer protection and privacy disclosures.

Are you planning to replace, discontinue or change an existing policy or contract? Yes No

If "yes," give company and amount:

APPLICANT'S SIGNATURE	DATE
X	/ /

SECOND APPLICANT'S SIGNATURE	DATE
X	/ /

	Ques. #	Date	Name of Doctor	Address of Doctor	Reason for Consultation	Diagnosis & Treatment
Applicant (Please Print Name)						
Second Applicant (Please Print Name)						

Consumer Report Notice

In compliance with the Fair Credit Reporting Act, (the "Act"), we are informing you that as part of our routine procedures an investigative consumer report including information as to character, general reputation, personal characteristics and mode of living may be made. Under the Act you have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation. However, to avoid the necessity of your making further inquiry, we are informing you that the investigation (which may include personal interviews) concerns residence verification, marital status, number of children, economic status, employment, occupation, general health, habits, reputation and mode of living (except as related directly or indirectly to your sexual orientation). You may request from the consumer reporting agency a written summary of your rights under the Fair Credit Reporting Act.

Notice of Insurance Information Practices

The following is a brief description of the Information Practices of Liberty Life Insurance Company. We are providing you with this information in accordance with the requirements of the Insurance Information and Privacy Protection Act which may be in effect in your state of residence.

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
2. Such information, as well as other personal or privileged information subsequently collected, may be disclosed to third parties in certain circumstances, without authorization.
3. A right of access and correction exists with respect to all personal information collected.
4. The company will make such other disclosures as are permitted by law.

We hope that you will find this description of our information practices to be helpful. We take our responsibilities, and your rights very seriously. If you have any questions about the above procedures, please send them to: Liberty Life Insurance Company, New Business Department, PO Box 19075, Greenville, SC 29602-9075.

NOTICE: 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.

UNL (06-09) AR

Medical Information Bureau (MIB), Inc. Notice

Information regarding your insurability will be treated as confidential. Liberty Life Insurance Company, its third-party administrators, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life 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 you, the MIB will arrange disclosure of any information it may have in your file. 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
Suite 400
Braintree, MA 02184-8734
www.mib.com
Telephone: (866) 692-6901, TTY: (866) 346-3642

For information about your file, you may write to:

Underwriting Department
Liberty Life Insurance Company
PO Box 789
Greenville, SC 29602-0789

Not FDIC (Federal Deposit Insurance Corporation) Insured. Not insured by any federal government agency. Not a deposit or guaranteed by the financial institution or its affiliates.

Liberty Life Insurance Company, P.O. Box 789, Greenville, SC 29602-0789

LIFE INSURANCE APPLICATION

Liberty Life Insurance Company

PO Box 789 Greenville, SC 29602-0789

Name
Address 1
Address 2
City, State, Zip

Mail ID 9999 DM1 60000
CIDN: 12345678910

Questions? Contact us at: 1 800-813-4412

This application is for decreasing mortgage term life insurance in the initial amount of:
\$250,000

This is the monthly cost to protect your family's home:

The cost does not increase because you grow older. The rates are based on age of older insured. To qualify for non-tobacco rates both applicants must not use tobacco.

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Non-Tobacco Rates	One Insured Two Insureds							
Tobacco Rates	One Insured Two Insureds							

APPLICANT (Please Print)

First MI Last Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth	State of Birth	Marital Status	Height ft in Weight lbs
SSN	Daytime Phone ()	Evening Phone ()	
Beneficiary			

SECOND APPLICANT (Please Print)

First MI Last Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth	State of Birth	Marital Status	Height ft in Weight lbs
SSN	Daytime Phone ()	Evening Phone ()	
Beneficiary			

	Applicant		Second Applicant	
	Yes	No	Yes	No
1) Are you employed? (If No, please explain below. If Yes, insert your occupation below.) Applicant _____ Second Applicant _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) In the past 12 months, have you used any nicotine or tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) In the past 2 years, have you consulted a doctor or other health care provider or been hospitalized for any chronic illness requiring ongoing treatment?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
4) In the past 10 years, have you received any treatment, medical advice, or consultation for OR been diagnosed with OR had any known indication of: diabetes; cancer; stroke; mental disorder; drug or alcohol abuse; or any disease or disorder of the brain, heart, blood vessels, lung, kidney, liver, or pancreas?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
5) Have you been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

* If you answered "YES" to questions 3, 4, or 5, please **CIRCLE CONDITION** and provide details on the back of the application in the space provided. Include name and address of attending physician.

UNLS (06-09) AR

(Continued on Back)

	Ques. #	Date	Name of Doctor	Address of Doctor	Reason for Consultation	Diagnosis & Treatment
Applicant (Please Print Name)						
Second Applicant (Please Print Name)						

Each applicant represents that the information provided in this application is true and complete and is provided to obtain insurance. **No coverage will take effect under this application unless Liberty Life Insurance Company ("Liberty") issues the policy/certificate applied for and the full initial premium has been paid. In that event, coverage will take effect on the effective date stated in the policy/certificate if on that date the information provided in this application is still accurate and complete.** Each applicant authorizes any physician, medical practitioner, hospital, clinic or other medical or medically related facility, pharmacy benefit manager, insurance company, consumer reporting agency, and the Medical Information Bureau to give Liberty the following information about the applicant: past and present physical, mental, drug, and alcohol conditions; other insurance coverage; prescribed drugs; employment; avocations; and other personal characteristics. Liberty is collecting this information to determine eligibility for insurance. This authorization is effective for 24 months. A photographic copy of this authorization is as valid as the original. Each applicant may request and receive copies of this authorization. Each applicant may revoke his or her authorization by sending a written request for revocation to Liberty at PO Box 19075, Greenville, SC 29602, subject to the rights of anyone who has relied on this authorization. Each applicant acknowledges receipt of the consumer protection disclosures accompanying this application.

I authorize my lending institution to collect the premium with my mortgage payment for the amount of insurance as indicated. If I have authorized my lending institution to automatically/electronically debit from my account, I hereby request this insurance premium to be added to this authorization. This authority is to remain in effect until I cancel it in writing and until Liberty or my lending institution actually receives such notice.

Are you planning to replace, discontinue or change an existing policy or contract? Yes No

If "yes," give company and amount: _____

APPLICANT'S SIGNATURE	DATE
X	/ /

SECOND APPLICANT'S SIGNATURE	DATE
X	/ /

Agent's Signature Date

Agent: to the best of your knowledge, will this insurance replace any other life insurance or annuity? Yes No

Not FDIC (Federal Depositors Insurance Corporation) Insured. Not insured by any federal government agency. Not a deposit or guaranteed by the financial institution or its affiliates.

NOTICE: 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.

UNLS (06-09) AR

SERFF Tracking Number: LBLI-126149231 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 42418
Company Tracking Number: 048-874 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NAIC Model Replacement update for Group apps
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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification		
Bypass Reason: Not applicable. Filing to update replacement question due to your state's adoption of the NAIC Model replacement regulation.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Not applicable. Filing to update replacement question due to your state's adoption of the NAIC Model replacement regulation.		
Comments:		