

SERFF Tracking Number: NGLI-126189910 State: Arkansas  
Filing Company: National Guardian Life Insurance Company State Tracking Number: 42663  
Company Tracking Number: NPNCERTMP2002-GDB - 7 PAY  
TOI: L07G Group Life - Whole Sub-TOI: L07G.202 Early Duration Reduced Benefit -  
Level Premium - Any Policy Design - Funeral  
Expense  
Product Name: 7-PAY NPNCERTMP2002  
Project Name/Number: 7-PAY NPNCERTMP2002-GDB/

## Filing at a Glance

Company: National Guardian Life Insurance Company

Product Name: 7-PAY NPNCERTMP2002 SERFF Tr Num: NGLI-126189910 State: Arkansas  
TOI: L07G Group Life - Whole SERFF Status: Closed-Approved- State Tr Num: 42663  
Closed

Sub-TOI: L07G.202 Early Duration Reduced Co Tr Num: NPNCERTMP2002- State Status: Approved-Closed  
Benefit - Level Premium - Any Policy Design - GDB - 7 PAY  
Funeral Expense

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Peggy Kratz, Kim Bolinder Disposition Date: 06/16/2009

Date Submitted: 06/15/2009 Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: 7-PAY NPNCERTMP2002-GDB

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Association

Filing Status Changed: 06/16/2009

Explanation for Other Group Market Type:

State Status Changed: 06/16/2009

Deemer Date:

Created By: Peggy Kratz

Submitted By: Peggy Kratz

Corresponding Filing Tracking Number:

Filing Description:

I have enclosed an additional certificate schedule page, intended for use with Certificate form NPNCERTMP2002-GDB-AR. This group Certificate was previously approved for use by your department on November 21, 2002 in accordance with group policies issued outside your state (Missouri) which extend coverage to residents of Arkansas.

Certificate NPNCERTMP2002-GDB-AR was initially filed with premium payment options of 3 years, 5 years and 10

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years. We would like to offer a seven year payment option.

The attached schedule page represents a 7-year payment option. Premiums are paid modally over a period of 7 years. At the end of seven years the Certificate is fully paid up. Note that this is a Preneed policy, therefore, the schedule continues to reference the 1980 CSO.

The following application forms are also attached for your approval:

2735PN-AR 07/09

2800PN-AR 07/09

These enrollment forms are substantially similar to and will replace the following previously approved enrollment forms:

2735PN-AR 05/08 (prior approval date: October 30, 2008)

2800PN-AR 05/09 (prior approval date: August 27, 2008)

The only difference between the enclosed application forms and the previously approved forms are:

1. We have added the option for the 7 year plan.
2. Under the Statement of Health, we changed the reference to "3, 5, or 10 Pay Life plan" to "Multi Pay Life plan."

Please note we have bracketed several areas of the application for variability.

1. The Mail Policy to field has been bracketed so that we may add or delete a mailing option.
2. The Payment Options field is bracketed so that we may add a new plan or delete a plan or payment mode that we are no longer offering.
3. The Statement of Health field is bracketed so that if we delete a plan, we may delete a portion of that text that would no longer be applicable.
4. The Applicant Signatures field is bracketed so that we may change, delete, or update the statement to comply with all Insurable Interest statement requirements.
5. The field containing blanks for listing the Insured and Agent names is bracketed to offer this as an optional field to our marketers.
6. The Irrevocable Assignment field is bracketed so that we may remove it or print it on a separate page..
7. The Automatic Payment Authorization field is bracketed so that we may remove it or print it on a separate page.
8. The Acknowledgement of Payment field is bracketed so that we may remove it or print it on a separate page.
9. The Fraud Warning Statement field is bracketed, so that we may change, delete, or update the statements and comply with all fraud statement requirements (without needing to re-file the form).

Your review and approval of these forms would be greatly appreciated; if you have any questions or comments, please contact me via the email address or phone number provided.

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## Company and Contact

### Filing Contact Information

Peggy Kratz, Senior Policy Forms Specialist plkratz@nglic.com  
 P.O. Box 1191 608-443-5325 [Phone]  
 Madison, WI 53701-1191 608-443-5365 [FAX]

### Filing Company Information

National Guardian Life Insurance Company CoCode: 66583 State of Domicile: Wisconsin  
 P.O. Box 1191 Group Code: Company Type: LAH  
 Madison, WI 53701-1191 Group Name: State ID Number:  
 (800) 626-7931 ext. 5790[Phone] FEIN Number: 39-0493780

## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Guardian Life Insurance Company	\$50.00	06/15/2009	28584373

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	06/16/2009	06/16/2009

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## **Disposition**

Disposition Date: 06/16/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Schedule of Benefits and Premiums		Yes
Form	Enrollment Form for Group Insurance		Yes
Form	Enrollment for for Group Insurance		Yes

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## Form Schedule

**Lead Form Number: NPNCERTMP2002-GDB**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	NPNCERTMP2002-GDB 1/06	Schedule Pages	Schedule of Benefits and Premiums	Initial			NPNCERTMP2002-GDB-3 (7 Pay).pdf
	2735PN-AR 07/09	Application/Enrollment Form	Enrollment Group Insurance Form	Initial		49.100	2735PN-AR 07-09.pdf
	2800PN-AR 07/09	Application/Enrollment Form	Enrollment Group Insurance Form	Initial		50.000	2800PN-AR 07-09.pdf

SCHEDULE OF BENEFITS AND PREMIUMS  
 CERTIFICATE NUMBER [123456] ISSUED [JANUARY 15, 2006]  
 Group Policy Number [78910]

Plan	Certificate Year	Certificate Amount	Annual Premium	Years Payable	Maturity/Expiry Date
Graded Benefit Whole Life	1	[1,500]*	[\$935.00]	[7]	Life
	2	[3,500]*	[\$935.00]	[7]	Life
	3 & Later	[5,000]	[\$935.00]	[7]	Life

\*Benefit will be reduced during the first two years. See Page 8 for a detailed explanation.

Payment Mode:	Annually	Semi-annually	Quarterly	Monthly	Monthly EFT
Premium Payable:	935.00	486.20	247.78	86.02	82.28
**Total Annual Cost:	935.00	972.40	991.12	1,032.24	987.36
**Total Extra Annual Cost:	0.00	37.40	56.12	97.24	52.36

\* \*\*Note: Total Extra Annual Cost is the additional cost each year for your certificate if you pay your premium other than annually.

Guaranteed Values

Figures based on above Certificate Amount not including future growth.

End of Certificate Year	Cash or Loan Value	Paid-Up Insurance
1	[0.00]	[0.00]
2	[143.00]	[688.06]
3	[346.35]	[1,601.91]
4	[559.50]	[2,488.10]
5	[782.90]	[3,348.30]
6	[1,017.10]	[4,184.91]
7	[1,262.75]	[5,000.00]
8	[1,311.70]	[5,000.00]
9	[1,362.15]	[5,000.00]
10	[1,414.05]	[5,000.00]
11	[1,467.40]	[5,000.00]
12	[1,522.35]	[5,000.00]
13	[1,578.85]	[5,000.00]
14	[1,637.00]	[5,000.00]
15	[1,696.70]	[5,000.00]
16	[1,757.95]	[5,000.00]
17	[1,820.65]	[5,000.00]
18	[1,884.70]	[5,000.00]
19	[1,949.95]	[5,000.00]
20	[2,016.30]	[5,000.00]

Initial Certificate Amount                    \$[5,000]  
 Declared Annual Growth Rate:            [3.00]% Non-Guaranteed  
 Certificate Loan Interest Rate:            [8.00]% Annually In Arrears  
 Guaranteed Basis Of Values and Paid-Up Insurance:  
   Mortality Table:                            1980 CSO Sex Distinct Age Last Birthday  
   Interest Rate:                              5.00%  
 Method:                                        1980 CSO Standard Nonforfeiture Law Minimum

Insured:                                        [John Doe]  
 Age:    [35 Male]  
 Beneficiary:                                 As Stated In The Enrollment Form Or Last Recorded Endorsement  
 Certificate Owner:                            [John Doe]

**ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY - (PLEASE PRINT)**

2735PN-AR 07/09 Series 4

 National Guardian Life Insurance Company (NGL) • Phone 800.988.0826 • Fax 866.228.9927  
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191

MAIL POLICY TO:

- AGENT  
 FUNERAL HOME  
 OWNER

PROPOSED INSURED/ANNUITANT  Male  Female

\_\_\_\_\_  
First Name MI Last Name Phone Number Social Security Number Age Date of Birth  
**OWNER - Complete only if other than Insured/Annuitant**

\_\_\_\_\_  
First Name MI Last Name Social Security Number Relationship to Insured  
MAILING ADDRESS  INSURED/ANNUITANT  OWNER (Where to send information about this Policy)

\_\_\_\_\_  
Street Address City State Zip

PAYMENT PLAN		PLAN	PAYMENT MODE (Do not complete for Single Pay)	
Funeral Price \$	Face Amount \$	<input type="checkbox"/> A	<input type="checkbox"/> Annual (Not available on 1 Pay)	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Single Pay Life	<input type="checkbox"/> Flexible Annuity \$ _____	<input type="checkbox"/> B	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> EFT
Multi Pay Life: <input type="checkbox"/> 1 Year <input type="checkbox"/> 3 Year <input type="checkbox"/> 5 Year <input type="checkbox"/> 7 Year <input type="checkbox"/> 10 Year		<input type="checkbox"/> C	<input type="checkbox"/> MC/MSA - Use Monthly Direct Factor	<input type="checkbox"/> Monthly Direct
Initial Premium + Multi Pay Premium = Total Premium Amount (with app)		<input type="checkbox"/> D		
\$ _____	\$ _____	<input type="checkbox"/> E		
		<input type="checkbox"/> F		

**STATEMENT OF HEALTH (To be completed by Proposed Insured - Do not complete for Annuity)**

Are you currently on oxygen, hospitalized, or confined to a nursing home or long term care facility; or during the past two years have you been advised by a medical professional to have any surgical procedure that has not been performed or have you been treated or are you being treated by a medical professional for any of the following diseases or disorders:  YES  NO

- |                          |                                     |  |                                |
|--------------------------|-------------------------------------|--|--------------------------------|
| Congestive Heart Failure | Immune System Disorder              | Chronic Obstructive Pulmonary (lung) Disease | Amputation (caused by disease) |
| Heart Disease            | Cirrhosis of the Liver              | Emphysema                                    |                                |
| Stroke                   | Drug or Alcohol Dependency          | Alzheimer's/Dementia                         |                                |
| Cancer (other than skin) | Kidney failure (including dialysis) | Diabetic Coma/Insulin Shock                  |                                |

If the health question is not answered or answered "Yes" the 1 pay Life Plan is not available and any Multi Pay Life Plan will have limited death benefits during the first two Policy years.

**DIRECTION FOR PAYMENT OF PROCEEDS (These directions may be changed any time before the funeral is provided by giving written notice to the Insurer.)**

NGL is directed to pay an amount not to exceed the death benefit of the Policy to the Funeral Provider named below, if any, upon receipt of proof that funeral merchandise and services have been provided. In the event that NGL rescinds or declines to issue the Policy, I also assign to the Funeral Provider (1) the right to receive the premium paid upon receipt of proof that funeral merchandise and services have been provided, (2) the right to compromise claims and (3) the right to agree to rescission.

\_\_\_\_\_  
Name of Funeral Provider Street Address City State Zip  
\_\_\_\_\_  
Name of Primary Beneficiary Street Address City State Zip Relationship to Insured

**APPLICANT SIGNATURES**

To the best of my knowledge and belief, the above information is true and complete. I understand that no insurance will be effective until this form is approved and the Policy is issued while the Insured is living. I authorize NGL to share my nonpublic personal information with any Funeral Provider with whom I have a Prefunded Funeral Agreement. If I am the Owner for insurance on the life of the Proposed Insured, I certify that I have an insurable interest in his or her life.

**I acknowledge that I have read the fraud warning statement on the last page of this form.**

Signed at \_\_\_\_\_ State \_\_\_\_\_

Signature of Proposed Insured/Annuitant \_\_\_\_\_ Date \_\_\_\_\_ Signature of Owner (Required if other than Insured) \_\_\_\_\_ Date \_\_\_\_\_

**AGENT'S STATEMENT**

I certify that any information recorded by me on this form is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Agent(s) Signature Agent Name(s) Printed NGL Agent # Agent State License# %  
\_\_\_\_\_  
Agent(s) Signature Agent Name(s) Printed NGL Agent # Agent State License# %

Insured: \_\_\_\_\_  
 Agent: \_\_\_\_\_

**IRREVOCABLE ASSIGNMENT OF POLICY**

Assignment of Ownership, Death Benefit and Rescission Rights: The Owner hereby irrevocably assigns to the Funeral Provider named in the Direction for Payment of Proceeds all incidents of ownership of the Policy, the right to receive all or part of the death benefit payable under the Policy upon receipt of proof that the funeral merchandise and services have been provided, and, if the Insurer, for any reason either rescinds or declines to issue a Policy, all rights, including the following: (1) the right to receive the premium paid (upon receipt of proof that the funeral merchandise and services have been provided), (2) the right to compromise claims and (3) the right to agree to rescission.

The Owner acknowledges that by making the assignment irrevocable it cannot be canceled. This assignment does not affect the right of the Owner to cancel the Policy under the Right to Cancel provision. By making this assignment irrevocable, the Owner also acknowledges the following:

1. The assignment of death benefit proceeds is permanent and cannot be changed by the Owner.
2. The Owner has waived all rights under the Policy to surrender for cash, to obtain a loan, to change the Owner or beneficiary, or to receive a refund for any premium paid.
3. The Owner remains responsible for the payment of all insurance premiums when due.

It is understood and agreed that this irrevocable assignment in no way inhibits the Owner or the next of kin of the Insured from hereafter selecting another Funeral Provider to perform funeral services and provide funeral merchandise in connection with the funeral of the Insured. The Insurer is not a party to this assignment and the sole responsibility of the Insurer is to pay the death benefit proceeds pursuant to the terms of the Policy as amended by this assignment.

**Immediate Transfer (For purposes of Medicaid Eligibility ONLY)** - I hereby elect to make this irrevocable assignment effective immediately. I understand that by making this election I give up all rights to cancel the Policy and receive a return of premium under the Right to Cancel provision of the Policy. To make an immediate transfer election please initial here \_\_\_\_\_.

\_\_\_\_\_  
*Signature of Owner* Date

**AUTOMATIC PAYMENT AUTHORIZATION (Select One)**

**Monthly Electronic Funds Transfer**  
 I request and authorize NGL to make monthly withdrawals against the financial institution account specified at right or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them, for the purpose of collecting premiums under this plan. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank.

Date of month to initiate payment (dates available are 1st through 28th) – select one: \_\_\_\_\_  
 Bank Name \_\_\_\_\_  
 Bank Routing/ABA # \_\_\_\_\_  
 Account # \_\_\_\_\_  
 Checking  Savings

If using a checking account, please include a void check. For savings account, please contact the bank to verify EFT is allowed and verify correct routing and account number.

\_\_\_\_\_  
 (Signature as it appears on bank records)  
 \_\_\_\_\_  
 (Date)

**Monthly Credit Card Authorization (Not on Annuity)**  
 I authorize the premiums due to be remitted monthly to NGL through my credit card account indicated at right. This authority will remain in full force and effect until I revoke this authorization by written notification to NGL.

\_\_\_\_\_  
 (Account Number)  
 \_\_\_\_\_  
 (Exp. Date)  
 \_\_\_\_\_  
 (Cardholder Signature)  
 \_\_\_\_\_  
 (Cardholder Address)  
 \_\_\_\_\_  
 (Printed Name) (Date)

Select one only:  VISA  MasterCard

**ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY**



National Guardian Life Insurance Company (NGL) • Phone 800.988.0826 • Fax 866.228.9927  
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191

**ACKNOWLEDGMENT OF PAYMENT**

This acknowledges payment from \_\_\_\_\_ in the amount of \$ \_\_\_\_\_ in connection with the Policy applied for from NGL. If all of the conditions of the application are met and the application is accepted, a Policy will be issued. If the application is not accepted, the Insurer's only responsibility will be to refund the amount for which this Acknowledgment of Payment was given.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution. For inquiries please call 1-800-988-0826.

\_\_\_\_\_  
*Agent Signature*

\_\_\_\_\_  
*Date*

**FRAUD WARNING STATEMENT**

**For Residents of Arkansas**

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.

"Policy" is defined as the insurance policy, certificate or annuity contract for which I am applying.

**ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY - (PLEASE PRINT)**

2800PN-AR 07/09 (7P) Series 7

 National Guardian Life Insurance Company (NGL) • Phone 800.988.0826 • Fax 866.228.9927  
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191

MAIL POLICY TO:  AGENT  
 FUNERAL HOME  
 OWNER

PROPOSED INSURED/ANNUITANT  Male  Female

\_\_\_\_\_  
First Name MI Last Name Phone Number Social Security Number Age Date of Birth

**OWNER - Complete only if other than Insured/Annuitant**

\_\_\_\_\_  
First Name MI Last Name Social Security Number Relationship to Insured

MAILING ADDRESS  INSURED/ANNUITANT  OWNER (Where to send information about this Policy)

\_\_\_\_\_  
Street Address City State Zip

**PAYMENT PLAN**

**PAYMENT MODE** (Do not complete for Single Pay)

Funeral Price \$ Face Amount \$

Annual  Quarterly

Single Pay Life  Flexible Annuity \$ \_\_\_\_\_

Semi-Annual  Monthly EFT

Multi Pay Life:  3 Year  5 Year  7 Year  10 Year

MC/VISA - Use Monthly Direct Factor  Monthly Direct

Initial Premium + Multi Pay Premium = Total Premium Amount (with app)

\$ \$ \$

**STATEMENT OF HEALTH (To be completed by Proposed Insured - If enrolling in a Multi Pay Life Plan)**

Are you currently on oxygen, hospitalized, or confined to a nursing home or long term care facility; or during the past two years have you been advised by a medical professional to have any surgical procedure that has not been performed or have you been treated or are you being treated by a medical professional for any of the following diseases or disorders:  YES  NO

- |                          |                                     |  |                                |
|--------------------------|-------------------------------------|--|--------------------------------|
| Congestive Heart Failure | Immune System Disorder              | Chronic Obstructive Pulmonary (lung) Disease | Amputation (caused by disease) |
| Heart Disease            | Cirrhosis of the Liver              | Emphysema                                    |                                |
| Stroke                   | Drug or Alcohol Dependency          | Alzheimer's/Dementia                         |                                |
| Cancer (other than skin) | Kidney failure (including dialysis) | Diabetic Coma/Insulin Shock                  |                                |

If the health question is not answered or answered "Yes" and you are applying for a Multi Pay Life plan, a Policy with limited death benefits during the first 2 Policy years will be issued.

**DIRECTION FOR PAYMENT OF PROCEEDS** (These directions may be changed any time before the funeral is provided by giving written notice to the insurer.)

NGL is directed to pay an amount not to exceed the death benefit of the Policy to the Funeral Provider named below, if any, upon receipt of proof that funeral merchandise and services have been provided. In the event that NGL rescinds or declines to issue the Policy, I also assign to the Funeral Provider (1) the right to receive the premium paid upon receipt of proof that funeral merchandise and services have been provided, (2) the right to compromise claims and (3) the right to agree to rescission.

\_\_\_\_\_  
Name of Funeral Provider Street Address City State Zip

\_\_\_\_\_  
Name of Primary Beneficiary Street Address City State Zip Relationship to Insured

**APPLICANT SIGNATURES**

To the best of my knowledge and belief, the above information is true and complete. I understand that no insurance will be effective until this form is approved and the Policy is issued while the Insured is living. I authorize NGL to share my nonpublic personal information with any Funeral Provider with whom I have a Prefunded Funeral Agreement. If I am the Owner for insurance on the life of the Proposed Insured, I certify that I have an insurable interest in his or her life.

**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 is guilty of a crime and may be subject to fines and confinement in prison.**

Signed at \_\_\_\_\_ State \_\_\_\_\_

Signature of Proposed Insured/Annuitant Date Signature of Owner (Required if other than Insured) Date

**AGENT'S STATEMENT**

I certify that any information recorded by me on this form is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Agent(s) Signature Agent Name(s) Printed NGL Agent # Agent State License# %

\_\_\_\_\_  
Agent(s) Signature Agent Name(s) Printed NGL Agent # Agent State License# %

**ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY**



National Guardian Life Insurance Company (NGL) • Phone 800.988.0826 • Fax 866.228.9927  
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191

Insured: \_\_\_\_\_

Agent: \_\_\_\_\_

**IRREVOCABLE ASSIGNMENT OF POLICY**

Assignment of Ownership, Death Benefit and Rescission Rights: The Owner hereby irrevocably assigns to the Funeral Provider named in the Direction for Payment of Proceeds all incidents of ownership of the Policy, the right to receive all or part of the death benefit payable under the Policy upon receipt of proof that the funeral merchandise and services have been provided, and, if the Insurer, for any reason either rescinds or declines to issue a Policy, all rights, including the following: (1) the right to receive the premium paid (upon receipt of proof that the funeral merchandise and services have been provided), (2) the right to compromise claims and (3) the right to agree to rescission.

The Owner acknowledges that by making the assignment irrevocable it cannot be canceled. This assignment does not affect the right of the Owner to cancel the Policy under the Right to Cancel provision. By making this assignment irrevocable, the Owner also acknowledges the following:

1. The assignment of death benefit proceeds is permanent and cannot be changed by the Owner.
2. The Owner has waived all rights under the Policy to surrender for cash, to obtain a loan, to change the Owner or beneficiary, or to receive a refund for any premium paid.
3. The Owner remains responsible for the payment of all insurance premiums when due.

It is understood and agreed that this irrevocable assignment in no way inhibits the Owner or the next of kin of the Insured from hereafter selecting another Funeral Provider to perform funeral services and provide funeral merchandise in connection with the funeral of the Insured. The Insurer is not a party to this assignment and the sole responsibility of the Insurer is to pay the death benefit proceeds pursuant to the terms of the Policy as amended by this assignment.

**Immediate Transfer (For purposes of Medicaid Eligibility ONLY)** - I hereby elect to make this irrevocable assignment effective immediately. I understand that by making this election I give up all rights to cancel the Policy and receive a return of premium under the Right to Cancel provision of the Policy. To make an immediate transfer election please initial here \_\_\_\_\_.

Signature of Owner \_\_\_\_\_

Date \_\_\_\_\_

**AUTOMATIC PAYMENT AUTHORIZATION (Select One)**

**Monthly Electronic Funds Transfer**

I request and authorize NGL to make monthly withdrawals against the financial institution account specified at right or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them, for the purpose of collecting premiums under this plan. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank.

If using a checking account, please include a void check. For savings account, please contact the bank to verify EFT is allowed and verify correct routing and account number.

Date of month to initiate payment (dates available are 1st through 28th) – select one: \_\_\_\_\_

Bank Name \_\_\_\_\_

Bank Routing/ABA # \_\_\_\_\_

Account # \_\_\_\_\_

Checking  Savings

\_\_\_\_\_  
(Signature as it appears on bank records)

\_\_\_\_\_  
(Date)

**Monthly Credit Card Authorization (Not on Annuity)**

I authorize the premiums due to be remitted monthly to NGL through my credit card account indicated at right. This authority will remain in full force and effect until I revoke this authorization by written notification to NGL.

\_\_\_\_\_  
(Account Number)

\_\_\_\_\_  
(Exp. Date)

\_\_\_\_\_  
(Cardholder Signature)

\_\_\_\_\_  
(Cardholder Address)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Date)

Select one only:  VISA  MasterCard

**ENROLLMENT FORM FOR GROUP INSURANCE/ANNUITY - (PLEASE PRINT)**



National Guardian Life Insurance Company (NGL) • Phone 800.988.0826 • Fax 866.228.9927  
Two East Gilman Street • PO Box 1191 • Madison WI 53701-1191

**ACKNOWLEDGMENT OF PAYMENT**

This acknowledges payment from \_\_\_\_\_ in the amount of \$ \_\_\_\_\_ in connection with the Policy applied for from NGL. If all of the conditions of the application are met and the application is accepted, a Policy will be issued. If the application is not accepted, the Insurer's only responsibility will be to refund the amount for which this Acknowledgment of Payment was given.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution. For inquiries please call 1-800-988-0826.

Agent Signature

Date

"Policy" is defined as the insurance policy, certificate or annuity contract for which I am applying.

SERFF Tracking Number: NGLI-126189910 State: Arkansas  
 Filing Company: National Guardian Life Insurance Company State Tracking Number: 42663  
 Company Tracking Number: NPNCERTMP2002-GDB - 7 PAY  
 TOI: L07G Group Life - Whole Sub-TOI: L07G.202 Early Duration Reduced Benefit -  
 Level Premium - Any Policy Design - Funeral  
 Expense  
 Product Name: 7-PAY NPNCERTMP2002  
 Project Name/Number: 7-PAY NPNCERTMP2002-GDB/

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Satisfied - Item:</b> Flesch Certification</p> <p><b>Comments:</b></p> <p><b>Attachments:</b></p> <p>AR - Required Certification 2 - Title 19.pdf</p> <p>CERTIFICATION OF READABILITY-MCN.pdf</p> <p>AR - Required Certification - Life.pdf</p>		

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Satisfied - Item:</b> Application</p> <p><b>Comments:</b></p> <p>Applications attached to form schedule tab.</p>		



**STATE OF ARKANSAS  
CERTIFICATION OF COMPLIANCE**

I, **Mark C. Neidinger**, an officer of **National Guardian Life Insurance Company**, hereby certify that, to the best of my information, knowledge and belief the attached filing is in compliance with Rule and Regulation 19 regarding Unfair Sex Discrimination in the Sale of Insurance.

June 15, 2009

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*Signature*

*Date*

**Mark C. Neidinger**

Associate General Counsel – Company Officer

Individual responsible for this filing:

Name: Kim Bolinder

Title: Form Filing Specialist

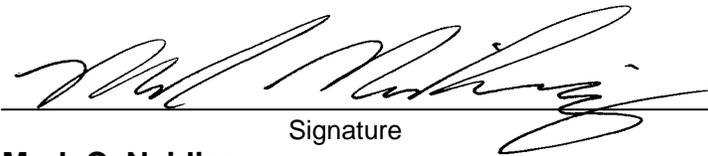
Phone #: (608) 443-5335

Email: kabolinder@nglic.com

## CERTIFICATION OF READABILITY

I, Mark C. Neidinger, an officer of National Guardian Life Insurance Company,  
certify that the Flesch scores for the submitted forms are listed below:

Forms	Flesch Scores
2735PN-AR 07/09	49.1
2800PN-AR 07/09	50



Signature

June 15, 2009

Date

**Mark C. Neidinger**  
Associate General Counsel and Company Officer



**STATE OF ARKANSAS  
CERTIFICATION OF COMPLIANCE**

I, **Mark Neidinger**, an officer of ***National Guardian Life Insurance Company***, hereby certify the following:

- Our company is in compliance with Arkansas Code Ann. 23-79-138. Our policy issue system is set up so that the required notice providing information on the Arkansas Department of Insurance is automatically included with each policy issued in the state of Arkansas.
- In compliance with Regulation 49, our policy issue system automatically generates the required Life and Health Guaranty Association Notice with each policy issued in Arkansas.
- To the best of my information, knowledge and belief the attached filing is in compliance with Rule and Regulation 19 regarding Unfair Sex Discrimination in the Sale of Insurance.

June 15, 2009

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*Signature*

*Date*

***Mark Neidinger***

Associate General Counsel – Company Officer

Individual responsible for this filing:

Name: Kim Bolinder

Title: Policy Forms Specialist

Phone #: (608) 443-5335

Email: [kabolinder@nglic.com](mailto:kabolinder@nglic.com)