

SERFF Tracking Number: AAMC-126234458 State: Arkansas  
Filing Company: Pioneer American Insurance Company State Tracking Number: 43040  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Insurance Application - 9466(Rev.7/09)  
Project Name/Number: /

## Filing at a Glance

Company: Pioneer American Insurance Company

Product Name: Life Insurance Application - 9466(Rev.7/09) SERFF Tr Num: AAMC-126234458 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 43040

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Traci Baty

Disposition Date: 07/29/2009

Date Submitted: 07/24/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

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: 07/29/2009

Explanation for Other Group Market Type:

State Status Changed: 07/29/2009

Deemer Date:

Created By: Traci Baty

Submitted By: Traci Baty

Corresponding Filing Tracking Number:

Filing Description:

Cover letter under Supporting Documentations.

## Company and Contact

### Filing Contact Information

Clara Keel, Product Filing Manager and

ckeel@aatx.com

Assistant Secretary

425 Austin Avenue

254-297-2794 [Phone]

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 Waco, TX 76701 254-297-2138 [FAX]

**Filing Company Information**

Pioneer American Insurance Company CoCode: 67873 State of Domicile: Texas  
 425 Austin Avenue Group Code: 1327 Company Type: LAH  
 Waco, TX 76701 Group Name: State ID Number:  
 (254) 297-2777 ext. [Phone] FEIN Number: 75-0914374

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**Filing Fees**

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pioneer American Insurance Company	\$50.00	07/24/2009	29429351

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/29/2009	07/29/2009

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## Disposition

Disposition Date: 07/29/2009

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
Supporting Document	Letter		Yes
Form	Life Insurance Application		Yes

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## Form Schedule

**Lead Form Number: 9466(Rev.7/09)**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form No. PA9466-AR(Rev.7/09)	Application/ Enrollment	Life Insurance Application Form	Initial		42.600	AR PA9466(Rev. 7-09) Life Insurance Application.pdf

**PIONEER AMERICAN INSURANCE COMPANY**  
P.O. BOX 240, WACO, TX 76703-0240 • (254) 297-2776

**LIFE INSURANCE APPLICATION (Please print in black ink)**

Telephone Case No: \_\_\_\_\_

Proposed Insured _____ <small>(First) (Middle) (Last)</small>			Telephone interview completed <input type="checkbox"/> Yes <input type="checkbox"/> No			
Address (No. & Street) _____			_____ <input type="checkbox"/> am <input type="checkbox"/> pm			
City _____		State _____		Zip Code _____		
E-mail Address _____			Phone _____ Best time to call _____			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Age	State of Birth	Social Security Number / /	Height ft in	Weight lbs
Owner: Name _____			Relationship _____		SS# _____ / _____ / _____	
Address _____			City/State/Zip _____			
Primary Beneficiary _____		Relationship _____	Contingent Beneficiary _____		Relationship _____	
Plan: <input type="checkbox"/> Immediate Death Benefit <input type="checkbox"/> Graded Death Benefit (Percentage of Face Amount)						
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>Face Amount of Insurance \$</b>						
Rider: <input type="checkbox"/> Grandchild/Great Grandchild Coverage (Indicate Number of Children Applying) _____				Automatic Premium Loan Elected? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Child Rider _____ Units <input type="checkbox"/> ADB Amt \$ _____						
Mode: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Draft 1st Prem on Req. Date		CWA: <input type="checkbox"/> E-Check Immediate 1st Prem		Mail Policy To: <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Owner		
<input type="checkbox"/> Other Modal Prem \$ _____		<input type="checkbox"/> Collected \$ _____		Requested Policy Date: / /		
A. Do you have existing life insurance or an annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No			Company _____			
B. Will you replace an existing life insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No			Policy # _____		Amount of Coverage \$ _____	
Physician Name: _____		City/State: _____		Phone: _____		

**HEALTH INFORMATION**

1. Are you currently hospitalized, confined to a bed or nursing facility, confined to a wheelchair due to chronic illness or disease, or using oxygen equipment to assist in breathing, or receiving Hospice Care? .....  Yes  No
  2. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having metastatic cancer, Alzheimer's, dementia, mental incapacity, or have you been diagnosed, treated (including dialysis) or taken medication for renal insufficiency, kidney failure, liver failure, or respiratory failure? .....  Yes  No
  3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? .....  Yes  No
  4. Have you been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, TIA, heart disease, heart attack, coronary artery bypass, angioplasty, circulatory disease, or peripheral vascular disease? .....  Yes  No
  5. Have you taken insulin shots prior to age 50 or been treated for insulin shock or diabetic coma? .....  Yes  No
  6. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, Huntington's disease, had an amputation caused by disease, or more than one occurrence of cancer (excluding basal or squamous cell skin cancer) in your lifetime? .....  Yes  No
  7. Within the past 12 months have you:
    - a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? .....  Yes  No
    - b. had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant or had or been medically advised to have surgery for brain or heart disorders (including, but not limited to catheterization, a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? .....  Yes  No
    - c. been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? .....  Yes  No
    - d. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? .....  Yes  No
    - e. used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug use, or been convicted of any felony or driving under the influence of alcohol or drugs? .....  Yes  No
- If any answer to questions 1 through 7 is answered "Yes" the Proposed Insured is not eligible for any coverage.***
8. Within the past 24 months have you been medically diagnosed or treated, or hospitalized for:
    - a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ...  Yes  No
    - b. or taken medication for internal cancer, leukemia, melanoma, emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, liver disease? .....  Yes  No
    - c. paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? .....  Yes  No
- If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.***
- If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.***

Form No. PA9466-AR(Rev.7/09)

**NOTICE**

**Printed in compliance with Public Law 91-508**

Thank you for considering Pioneer American Insurance Company for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

**MIB PRE-NOTICE**

Information regarding your insurability will be treated as confidential. Pioneer American Insurance Company, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another 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 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.

Pioneer American 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](http://www.mib.com).

**CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):**

Proposed Insured Name	Sex	Birthdate	Relationship	Proposed Insured Name	Sex	Birthdate	Relationship

**PROPOSED CHILDREN'S HEALTH STATEMENT**—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT.

**Children listed as an exception are excluded from the appropriate Child Rider Coverage.** Exceptions are: \_\_\_\_\_

**AGREEMENT**—I agree with Pioneer American Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

**AUTHORIZATION**—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the Medical Information Bureau or other organization that has knowledge or records of me and my health to give such information to: (a) Pioneer American Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the Medical Information Bureau, are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Pioneer American Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the Medical Information Bureau; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at \_\_\_\_\_  
CITY STATE

Date of Application \_\_\_\_\_  
MONTH DAY YEAR

SIGNATURE OF PROPOSED INSURED

SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

**AGENT'S REPORT**

Does the proposed insured have any existing life insurance or annuity contract? .....  Yes  No  
Is the proposed insurance intended to replace or change any existing life insurance or annuity?.....  Yes  No

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.

I certify that the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable. AGENT'S REMARKS: \_\_\_\_\_

AGENT'S PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_  
Agent \_\_\_\_\_ No: \_\_\_\_\_ % \_\_\_\_\_  
SIGNATURE

AGENT'S PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_  
Agent \_\_\_\_\_ No: \_\_\_\_\_ % \_\_\_\_\_  
SIGNATURE

**PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN**

Insured \_\_\_\_\_ Account Holder \_\_\_\_\_  
Financial Institution \_\_\_\_\_ Address \_\_\_\_\_  
Transit/ABA Number \_\_\_\_\_ Account Number \_\_\_\_\_  Checking  Savings Requested Draft Day (1st-28th) \_\_\_\_\_

**ATTACH VOIDED CHECK OR DEPOSIT SLIP**

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of Pioneer American Insurance Company, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS)

DATE

Form No. PA9466-AR(Rev.7/09)

**PIONEER AMERICAN INSURANCE COMPANY**  
P.O. BOX 240, WACO, TX 76703-0240

**CONDITIONAL RECEIPT**

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY  
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of \_\_\_\_\_ the sum of \$ \_\_\_\_\_ as first payment on this application.

Date \_\_\_\_\_ Agent \_\_\_\_\_

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED \$30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR PA9466 Readability Certification.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application <b>Comments:</b> Form Schedule		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Letter <b>Comments:</b> <b>Attachment:</b> AR PA9466 Cover Letter.pdf		

ARKANSAS

PIONEER AMERICAN INSURANCE COMPANY

CERTIFICATION

This is to certify that the attached Life Insurance Application, Form Number PA9466-AR(Rev.7/09), has achieved a Flesch Reading Ease Score of 42.6 and complies with the requirements of Arkansas Statute 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Simplification Act.



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Signature

Clara Keel, FLMI  
Product Filing Manager & Assistant Secretary

July 24, 2009

# Pioneer American Insurance Company

P.O. Box 240 • Waco, Texas 76703-0240 • 254-297-2776

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July 24, 2009

NAIC No. 67873

Mr. Joe Musgrove  
Policy and Other Form Filings  
State of Arkansas  
Department of Insurance  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
Attention: Compliance - Life and Health

Re: Form No. PA9466-AR(Rev.7/09)  
Life Insurance Application

Dear Mr. Musgrove:

The above referenced application is new and will replace Application Form No. PA9466-AR(Rev.1/07) previously approved by your department on March 5, 2007.

Form No. PA9466-AR(Rev.7/09) is an application to be used when applying for whole life insurance product(s) marketed by the company. The flesch readability score is 42.6.

The above referenced submission meets the provisions of Arkansas Rule and Regulation 19 (Unfair Sex Discrimination in the Sale of Insurance) as well as all applicable requirements of the department.

If I may be of assistance in your review, please contact me at 1-800-736-7311, extension 3216, or [ckeel@aatx.com](mailto:ckeel@aatx.com).

Sincerely,



Clara Keel, FLMI  
Product Filing Manager & Assistant Secretary

CJK:tad

Enc.

