

SERFF Tracking Number: FUDL-126232360 State: Arkansas
Filing Company: Funeral Directors Life Insurance Company State Tracking Number: 42973
Company Tracking Number: APP-PAR032009AR
TOI: L071 Individual Life - Whole Sub-TOI: L071.104 Fixed/Indeterminate Premium - Single Life - Funeral Expense
Product Name: Paramount Series Application
Project Name/Number: /

Filing at a Glance

Company: Funeral Directors Life Insurance Company

Product Name: Paramount Series Application SERFF Tr Num: FUDL-126232360 State: Arkansas
TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- State Tr Num: 42973
Closed

Sub-TOI: L071.104 Fixed/Indeterminate Co Tr Num: APP-PAR032009AR State Status: Approved-Closed
Premium - Single Life - Funeral Expense
Filing Type: Form

Author: Mike Walls Reviewer(s): Linda Bird
Disposition Date: 07/22/2009
Date Submitted: 07/16/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: A similar form has been approved for use in the state of domicile.

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 07/22/2009

Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 07/22/2009

Deemer Date:
Submitted By: Mike Walls
Filing Description:

Created By: Mike Walls
Corresponding Filing Tracking Number:

The submitted form is an application for individual life insurance to fund prepaid funeral contracts. It may be used for final expense insurance where a preneed contract is not involved. This application will be used with policies previously approved for use in Arkansas.

Company and Contact

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Filing Contact Information

Mike Walls, chaselaw@camalott.com
 P.O. Box 726 325-673-3745 [Phone]
 Abilene, TX 79604

Filing Company Information

Funeral Directors Life Insurance Company CoCode: 99775 State of Domicile: Texas
 6550 Directors Parkway Group Code: 801 Company Type: Life
 Abilene, TX 79606 Group Name: DIG State ID Number:
 (325) 695-3412 ext. [Phone] FEIN Number: 74-1001040

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: The fee is based on the Texas (state of domicile) Department of Insurance filing fee schedule.
 Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--|----------|----------------|---------------|
| Funeral Directors Life Insurance Company | \$100.00 | 07/16/2009 | 29257831 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|---------------------|------------|------------|----------------|
| Approved- Closed | Linda Bird | 07/22/2009 | 07/22/2009 |

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Disposition

Disposition Date: 07/22/2009

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 | | No |
| Supporting Document | Life & Annuity - Acturial Memo | | No |
| Form | Paramount Series Application | | Yes |

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Form Schedule

Lead Form Number: APP-PAR032009AR

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|----------------------|-----------------|--|-------------|---------|----------------------|-------------|---|
| | APP-PAR032009AR | Application/Paramount Series Enrollment Form | Application | Initial | | 40.700 | Paramount Application PAR 03-2009AR.pdf |

APPLICATION FOR INSURANCE OR ANNUITY

POLICY INFORMATION

Proposed Insured/Annuitant First Name _____ Middle Initial ____ Last Name _____ Sex ____
 Soc Sec No _____ Age _____ Birth Date _____
 Street _____ City _____ State _____ Zip _____
 Owner's First Name _____ Middle Initial ____ Last Name _____ Soc Sec No _____
 Street _____ City _____ State _____ Zip _____
 Primary Beneficiary _____ Relationship _____
 Contingent Beneficiary _____ Relationship _____
 Ultimate Face Amount \$ _____ Choose One: Single Pay Graded Benefit Life Annuity or Increasing Life
 Initial Payment \$ _____ Scheduled Payment \$ _____ Will coverage fund a preneed contract? Yes No
 Billing Frequency: Annual Semi-annual Quarterly Monthly Years to Pay _____
 Billing Method: Direct Bill Coupon Book Monthly PAC Credit Card
 Send Bill To: Owner Proposed Insured/Annuitant Individual Billing Family Billing

HEALTH INFORMATION

To be answered by all applicants ("You" refers to the Proposed Insured/Annuitant.)
 I, the undersigned, represent specifically for the purpose of obtaining this coverage the following:
 1. Are you now a patient in a hospital of any kind, or receiving hospice care or within the past 12 months, have you been advised by a medical practitioner to be hospitalized, but have chosen not to follow that advice? Yes No
 2. Have you received diagnosis or treatment by a licensed member of the medical profession, consulted by you, for a terminal illness or condition, not including HIV/AIDS? Yes No
If either of the above questions is answered "Yes", only a single pay annuity policy can be issued.
Single Pay benefits in the first 12 months may be less than the Ultimate Face Amount. For Graded Benefit Life, the death benefit during the first year is less than the Ultimate Face Amount. For Annuity or Increasing Life, the death benefit is less than the Ultimate Face Amount until all Scheduled Payments have been made.

CERTIFICATION

I, the undersigned, affirm that the above information is true and complete to the best of my knowledge. I understand that false statements or misrepresentations may result in loss of coverage. **I agree that no coverage is effective until a premium has been paid and a policy or certificate is issued while the Insured/Annuitant is living.** I may return the policy within 30 days of receipt for a full refund. I hereby grant consent for any of the below listed entities to give to Funeral Directors Life Insurance Company information about my past or present physical or mental condition, and health care service provided to me. I may revoke my consent at any time by calling 1-800-234-8031. This consent shall apply to any health care or custodial facility, clinic, practitioner, hospital or medical service plan, health service plan, health maintenance organization. I understand that information disclosed pursuant to this consent shall be used for the sole purpose of insurance rating, investigating a claim or other insurance activities. I understand the authorization is valid for no longer than 30 months and that I or my authorized representative is entitled to receive a copy of the authorization form. **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 civil fines and criminal penalties.**
 Does the Proposed Insured/Annuitant have existing life policies or annuity contracts? Yes No
 Will the Insurance/Annuity applied for replace any existing coverage on the same Proposed Insured/Annuitant? Yes No
 If yes, provide company name and policy number (agents: complete required replacement form, if required by your state.)

 Signature & Consent of Proposed Insured/Annuitant Phone _____ City Where Signed _____ State _____ Date _____

 Signature of Owner (if other than Proposed Insured/Annuitant) Phone _____

AGENT CERTIFICATION

To the best of my knowledge, the coverage applied for replaces existing coverage. Yes No
 I certify that all information contained in this application is true to the best of my knowledge, was recorded accurately, and that this application was signed in my presence.

 Print Agent Name Agent Signature Agent No.

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Supporting Document Schedules

| | Item Status: | Status Date: |
|--|---------------------|---------------------|
| Satisfied - Item: Flesch Certification Comments: See attached. Attachment: Readability Cert.pdf | | |

| | Item Status: | Status Date: |
|---|---------------------|---------------------|
| Bypassed - Item: Application Bypass Reason: The submitted form is an application only. Comments: | | |

July 16, 2009

FLESCH READABILITY CERTIFICATION

Form APP-PAR032009AR, Paramount Series Application

I certify that this form attains a Flesch readability score of 40.7. In calculating this score, the name and address of the insurer, the title and form number of the endorsement and the signatures were excluded.



Charles M. Walls

Attorney for Funeral Directors Life Insurance Company