

SERFF Tracking Number: TAPK-126216417 State: Arkansas  
Filing Company: Leaders Life Insurance Company State Tracking Number: 42826  
Company Tracking Number:  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other  
Product Name: Disability Income  
Project Name/Number: /

## Filing at a Glance

Company: Leaders Life Insurance Company

Product Name: Disability Income

TOI: H111 Individual Health - Disability Income

Sub-TOI: H111.004 Other

Filing Type: Form

SERFF Tr Num: TAPK-126216417

SERFF Status: Closed

Co Tr Num:

Co Status:

Author: Suzanne Heasley

Date Submitted: 07/03/2009

State: ArkansasLH

State Tr Num: 42826

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 07/09/2009

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Overall Rate Impact:

Filing Status Changed: 07/09/2009

Deemer Date:

Filing Description:

See attached submission letter

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 07/09/2009

Corresponding Filing Tracking Number:

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - tallenpark)

Suzanne Heasley,

Uheas@aol.com

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2325 Havard Oak Drive (972) 398-3733 [Phone]  
Plano, TX 75074 (972) 398-3733[FAX]

**Filing Company Information**

Leaders Life Insurance Company CoCode: 94799 State of Domicile: Oklahoma  
P.O. Box 35768 Group Code: Company Type:  
Tulsa, OK 74153 Group Name: State ID Number:  
(800) 725-5433 ext. [Phone] FEIN Number: 73-1333608  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$20.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Leaders Life Insurance Company	\$20.00	07/03/2009	28970323

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/09/2009	07/09/2009

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## Disposition

Disposition Date: 07/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Authorization	Approved-Closed	Yes
<b>Supporting Document</b>	Submission letter	Approved-Closed	Yes
<b>Form</b>	Application	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-	LL-VSDI	Application/ Application	Initial			application
Closed	APP-100 (07/09)	Enrollment Form				Revised 0709.pdf

# Leaders Life Insurance Company

P.O. Box 35768, Tulsa, OK 74153  
1 800-725-5433

[Application # \_\_\_\_\_]

[LOGO]

## WAGE PROTECTOR APPLICATION

Proposed Insured (Employee) \_\_\_\_\_ SS No. \_\_\_\_\_  
(Last) (First) (MI)

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Street City State Zip

Employer/Sponsor \_\_\_\_\_ Work Phone# \_\_\_\_\_

1. Date of Hire ____/____/____	Occupation & Job Title:	<input type="checkbox"/> Male <input type="checkbox"/> Female	U. S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Please Provide Green Card/Visa No.
2. Date of Birth ____/____/____	Current Age	State of Birth	3. Height Weight ____ft ____in ____lbs	4. Monthly Salary \$ _____
[Proposed Insured is spouse of Employee <input type="checkbox"/> Yes <input type="checkbox"/> No]				

**The Policy provides benefits on a weekly basis.**

**The Monthly Benefit amount shown below is a monthly equivalent of the weekly benefits payable under the Policy.**

5. Policy Information	Elimination Period (Injury/Illness): [ <input type="checkbox"/> 0/7 <input type="checkbox"/> 7/7 <input type="checkbox"/> 0/14 <input type="checkbox"/> 14/14 <input type="checkbox"/> 0/30 <input type="checkbox"/> 30/30]	Benefit Period (Weeks): [ <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> 104]	Monthly Benefit: \$ _____	Benefit Level: _____ %	Premium Monthly	Home Office Use
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[Optional Partial Disability Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No Benefit Period (%Total Disability Benefit Period) <input type="checkbox"/> ½ <input type="checkbox"/> ¼ Monthly Benefit: \$ _____]	[Optional Survivor Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No Period of Prior Total Disability Benefits (weeks) <input type="checkbox"/> 6 <input type="checkbox"/> 12 Multiple of Total Disability Mo. Benefit <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6]
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6. Premium Mode: Payroll Deduction <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (List Bill or EFT only) <input type="checkbox"/> Bank Draft <input type="checkbox"/>	<b>Total Monthly</b>
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[7. Name of Beneficiary and Relationship]	[Contingent Beneficiary and Relationship]	HOME OFFICE USE
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[8.] MEDICAL EVIDENCE OF INSURABILITY	Yes	No
A. Have you consulted a Physician, received medical treatment of any kind or been disabled or hospitalized in the past three years?		
B. Have you ever been medically diagnosed or treated as having "AIDS" (Acquired Immune Deficiency Syndrome), AIDS Related Complex (ARC), or tested positive for antibodies to the Human Immunodeficiency Virus (HIV) or Human T-lymphotrophic Virus Type III (HTLV) prior to today?		
C. Have you ever been treated for the following:	Yes	No
1. Disorder of stomach, intestines, liver or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>
2. Disorder of kidney, bladder or genitourinary organs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Diabetes, thyroid disorder, tumor, cancer or Hernia?	<input type="checkbox"/>	<input type="checkbox"/>
4. Disorder of muscles, bones, spine, back or joints?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you currently taking medication?	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart disease, heart attack, chest pain, hypertension, high cholesterol, murmur, palpitations or any other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
7. Alcoholism, drug abuse, mental or physical disorders not listed?	<input type="checkbox"/>	<input type="checkbox"/>
D. During the past six months, have you been limited in performing normal activity in a job for 24 hours or more per week?		
E. Within the last 90 days, have you been told by your medical provider that you are pregnant?		
F. Within the past two years, have you engaged in any type of racing, parachuting or scuba diving activities?		
G. Within the past two years, have you had a driver's license suspended or revoked? If Yes, provide license # _____ State of Issue _____		

[9.] Details for Item A through C answered "YES"				
Question item	Medication, Disease & Injury	Date (Mo/Yr)	Details	Physician/Hospital/Address
[10.] Details for Item D through G answered "YES"				

LL-VSDI APP-100 (07/09)

### MEDICAL INFORMATION BUREAU NOTICE

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

Information you provide will be treated as confidential except that the Leaders Life Insurance Company, or its reinsurers, however, makes a brief report to the Medical Information Bureau, a non-profit membership organization or life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 617-426-3660.

Leaders Life Insurance Company, or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. (See NOTICE TO APPLICANT on reverse side.)

**LEADERS LIFE INSURANCE COMPANY**  
(WWW.LEADERSLIFE.COM)

**Conditions With Respect To This Application**

**AUTHORIZATION TO OBTAIN INFORMATION:** I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau, Inc., consumer reporting agency, employer or Veterans Administration, having information available as to diagnosis, treatment or care of any physical or mental condition concerning me, including information about drugs, alcoholism, or mental illness, and any other non-medical information concerning me to give the Leaders Life Insurance Company, its legal representative or its reinsurers any and all such information.

To facilitate rapid submission of such information, I authorize all said resources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

I UNDERSTAND the information obtained by the use of this Authorization will be by the Leaders Life Insurance Company to determine eligibility for insurance.

I KNOW that I may request to receive a copy of this Authorization.

I ACKNOWLEDGE having received and read the Notice Regarding Medical Information Bureau and the Notice to Applicant.

I AGREE that a copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall remain valid for two years from its date.

I UNDERSTAND that I may revoke this Authorization at any time.

I represent that all statements and answers in this application are complete, true, and correctly recorded. If I am deemed to be insurable at standard rates, the insurance shall become effective on the date hereon; otherwise, the insurance shall not take effect until a policy is issued and the first premium paid. I have read and agree that the above statements are true, to the best of my knowledge and belief and shall constitute a part of this application. I also agree that the Authorization for additional information shall be a part of this application. A photocopy of this Authorization shall be valid as the original. As the Proposed Insured (Employee), my signature authorizes payroll deduction of premium from my employer. Where required, I certify that I have received the outline of coverage.

Receipt of notice of Fair Credit Reporting Act of 1970 and Pre-Notice relating to Medical Information Bureau is hereby acknowledged.

**NOTICE: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of a crime and may be subject to fines and imprisonment.**

Applicable to AR residents: 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.

Applicable to OK residents: **WARNING:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

<b>INSURED'S STATEMENT:</b> Will the policy applied for replace or change any disability insurance in force? (If Yes, give name of company, policy number being replaced/ changed and enclose any required state replacement forms.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<hr/> <b>AGENT'S STATEMENT:</b> Does this insurance replace or change any existing disability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, and if required, is replacement form completed and attached? If NO, give details _____	

Agent's Signature  Witness (licensed Resident Agent, if required)  X # _____ Agent  X # _____ Agent	Proposed Insured (Employee)'s Signature  Signed at _____ City State  Signed on _____ Month Day Year  X _____ Signature of Proposed Insured (Employee)
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LL-VSDI APP-100 (07/09)

**NOTICE TO APPLICANT**

PLEASE DETACH AND HAND TO APPLICANT – FAIR CREDIT REPORTING ACT OF 1970 – This is to inform you that as part of this Company's procedure for processing your application for insurance, 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 reputations, personal characteristics and mode of living. 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. (See Notice on Reverse Side)

**LEADERS LIFE INSURANCE COMPANY – Tulsa, Oklahoma**

SERFF Tracking Number: TAPK-126216417 State: Arkansas  
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TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other  
Product Name: Disability Income  
Project Name/Number: /

## Rate Information

Rate data does NOT apply to filing.

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## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 07/09/2009  
**Comments:**  
**Attachment:**  
 Readability certificate.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 07/09/2009  
**Bypass Reason:** this is an application filing. The application is being submitted under the forms section  
**Comments:**

**Bypassed -Name:** Health - Actuarial Justification **Review Status:** Approved-Closed 07/09/2009  
**Bypass Reason:** This is an application only filing.  
**Comments:**

**Bypassed -Name:** Outline of Coverage **Review Status:** Approved-Closed 07/09/2009  
**Bypass Reason:** This is an application only filing.  
**Comments:**

**Satisfied -Name:** Authorization **Review Status:** Approved-Closed 07/09/2009  
**Comments:**  
**Attachment:**  
 HeasleyAuthorizationForms.pdf

**Satisfied -Name:** Submission letter **Review Status:** Approved-Closed 07/09/2009  
**Comments:**  
**Attachment:**  
 Submission letter AR for new application.pdf

**Readability Certification**

Insurance Company: Leaders Life Insurance Company

**Form Number**

LL-VSDI APP-100 (07/09)

**Description of Form**

Short Term Disability Income Application

I hereby certify that the above referenced form complies with the readability requirements of this State.

*Karen S. Carper*

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Authorized Signature

Karen S. Carper

---

Name

Secretary

---

Title

July 3, 2009

---

Date



September 12, 2008

Re: Filing Authorization  
Lewis & Ellis, Inc.  
PO Box 851857  
Richardson, TX 75085

To Whom It May Concern:

I hereby authorize Lewis & Ellis, Inc. (L&E) and any authorized representatives of L&E to submit state filings of insurance forms/rates/products on behalf of Leaders Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Leaders Life Insurance Company.

A handwritten signature in cursive script, reading 'Russell E. Angell', is written over a horizontal line.

Russell E. Angell, CPA FLMI

**Dallas**

Glenn A. Tobleman, F.S.A., F.C.A.S.  
S. Scott Gibson, F.S.A.  
Cabe W. Chadick, F.S.A.  
Steven D. Bryson, F.S.A.  
Michael A. Mayberry, F.S.A.  
Gregory S. Wilson, F.C.A.S.  
David M. Dillon, F.S.A.  
Bonnie S. Albritton, F.S.A.  
Brian D. Rankin, F.S.A.  
Robert E. Gove, A.S.A.  
Alexis M. Bash, A.S.A.  
Sarah A. Hoover, A.S.A.  
Wes R. Campbell, A.S.A.  
Jacqueline B. Horstmann, A.S.A.  
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)



**Kansas City**

Gary L. Rose, F.S.A.  
Terry M. Long, F.S.A.  
David L. Batchelder, A.S.A.  
Leon L. Langlitz, F.S.A.  
Gary R. McElwain, FLMI  
Christopher H. Davis, F.S.A.  
Thomas L. Handley, F.S.A.  
Anthony G. Proulx, F.S.A.  
Karen E. Elsom, F.S.A.  
Jill J. Humes, F.S.A.

**London**

Roger K. Annin, F.S.A.  
Timothy A. DeMars, F.S.A.  
Scott E. Morrow, F.S.A.

September 24, 2008

Re: Filing Authorization  
T. Allen Park & Associates, Inc.  
9441 LBJ Freeway, Suite 102  
Dallas, TX 75074

Re: Leaders Life Insurance Company

To Whom It May Concern:

I hereby authorize Suzanne Heasley and Vicki Rowe to submit state filings of insurance forms/rates/products on behalf of Lewis & Ellis, Inc. regarding the Leaders Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Lewis & Ellis, Inc.

A handwritten signature in cursive script that reads 'David M. Dillon'. The signature is written in dark ink and is positioned above a horizontal line.

David M. Dillon, FSA, MAAA  
Vice President & Principal  
Lewis & Ellis, Inc.



T. ALLEN PARK & ASSOCIATES, INC.

2325 Havard Oak Drive Plano, TX 75074  
(972) 398-3733 Uheas@aol.com

July 3, 2009

Arkansas Department of Insurance  
Life and Health Section  
1200 West Third Street  
Little Rock, AR 72201

ATTN: Life & Health

RE: Leaders Life Insurance Company NAIC # 74799

LL-VSDI APP-100 (07/09) Short Term Disability Income Application

Dear Sir or Madam:

This filing is being submitted on behalf of Leaders Life Insurance Company. The above referenced form is submitted for your review and approval. This form is new and is not intended to replace any previously approved forms.

Form LL-VSDI APP-100 (07/09) is an alternate application to be used with the following forms approved by your office as shown below.

Form Number	Form Description	Approval Date
LL-VSTD (09/08)	Short Term Disability Policy	11/10/08
LL-VSTD OC (09/08)	Outline of Coverage	10/28/08
LL-ARK-NOT	Required Notice	10/28/08

This application is similar to form LL-VSTD AP (09/08) approved by your office on November 10, 2008 with the exception that section 5, Policy Information has been revised to show the benefits on a monthly rather than a weekly basis.

Similar forms were filed in the Company's domiciliary State of Oklahoma on July 3, 2009.

Should you have any questions or need additional information, please do not hesitate to call me at (972) 398-3733.

Sincerely,

Suzanne Heasley, FLMI, CLU  
Legal Assistant and Compliance Specialist