Filing at a Glance

Company: United Home Life Insurance Company

Product Name: 200-642	SERFF Tr Num: UFFL-126216487	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 42978
Sub-TOI: L04I.500 Other	Co Tr Num: 200-642	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Karen Hynes	Disposition Date: 07/24/2009
	Date Submitted: 07/14/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 01/01/2010		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: Filed concurrently with IN, our state of domicile.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/24/2009	Explanation for Other Group Market Type:
	State Status Changed: 07/24/2009
Deemer Date:	Created By: Karen Hynes
Submitted By: Karen Hynes	Corresponding Filing Tracking Number:

Filing Description:

Attached please find the form referenced below for your review and approval. The requested implementation date of the form included in this submission is the later of your approval or January 1, 2010.

Form 200-642A 8-09 (AR) is a term life insurance application that will be used to apply for term life products currently on file with your department and those that may be filed at a later date. The application replaces form 200-498A 5-06 (AR) previously approved by your department June 19, 2006.

The main differences between the enclosed application and that previously approved are we: a) added additional plans

to question 6.a.; b) revised the underwriting questions; c) revised the bank authorization to allow various options for bank drafts; d) updated Medical Information Bureau references to MIB, Inc.; e) revised the street address and added the website address of MIB, Inc. in the Fair Credit Reporting Act/MIB, Inc., Notice; and f) added language regarding anti-money laundering.

We hereby certify we are in compliance with Ark. Code Ann. 23-79-138 and Regulation 49 and this submission meets the provisions of Rule 19.

We reserve the right to make any typographical corrections or make minor revisions to the appearance of the form due to printing constraints.

If you have any questions or need any additional information, please feel free to contact me at 317-692-7465 or by email at Karen.Hynes@infarmbureau.com.

Company and Contact

Filing Contact Information

Karen Hynes,	karen.hynes@infarmbureau.com
225 S East	317-692-7465 [Phone]
Indianapolis, IN 46202	

Filing Company Information

United Home Life Insurance Company	CoCode: 69922	State of Domicile: Indiana
225 S. East St.	Group Code:	Company Type: LAH
Indianapolis, IN 46202	Group Name:	State ID Number:
(317) 692-7465 ext. [Phone]	FEIN Number: 35-0841899	

Filing Fees

Fee Required?	Yes
Fee Amount:	$35.00
Retaliatory?	Yes
Fee Explanation:	IN, our state of domicile, imposes a filing fee of $35.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

United Home Life Insurance Company	$35.00	07/14/2009	29186362

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/24/2009	07/24/2009

Disposition

Disposition Date: 07/24/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UFFL-126216487*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*42978*
Company Tracking Number:	*200-642*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*200-642*		
Project Name/Number:	*/*		

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	Term Life Insurance Application		Yes

Form Schedule

Lead Form Number: 200-642A 8-09 (AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	200-642A 8-09 (AR)	Application/ Enrollment Form	Term Life Insurance Application	Initial		53.600	200-642 8-09 AR.pdf

Term Life Insurance Application

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

1. Last Name	First Name	Middle Initial	Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female

Marital Status	Height	Weight	Social Security Number	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:*

Street Address	City	State	Zip Code	Phone Number ( )

2. Employer/Occupation/Duties/How Long There

3.a. Primary Beneficiary Name	Relationship	Age
3.b. Contingent Beneficiary Name	Relationship	Age

4.a. Owner Name	Relationship	Social Security Number

Owner Street Address	City	State	Zip Code

4.b. Contingent Owner Name	Relationship	Social Security Number

5. Billing Street Address	City	State	Zip Code

Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code

6.a. Plan of Insurance ❑ Express Issue Term Deluxe 20
❑ Express Issue Term + ❑Premier 20 ❑ Express Issue Term 30 ❑ Premier 30 ❑ Express Issue Term 65 ❑ Premier 65

6.b. Face Amount: $_____	6.c. ❑ Accidental Death Benefit (not available with Premier 20, Premier 30 or Premier 65	6.d. ❑ Waiver of Premium (not available with EIT Deluxe 20, Premier 20, Premier 30, or Premier 65)

6.e. Modal Premium: ❑ PAC ❑ Quarterly ❑ Semi-Annual ❑ Annual
Modal Premium Amount $_____

7. Will this insurance replace or change any other insurance policies or annuities? ❑ Yes ❑ No If "Yes," please complete any necessary replacement forms.

8. Has the proposed insured used nicotine in any form in the past 12 months? ❑ Yes ❑ No

9. Name and Address of Family Physician (Required)	Family Physician Telephone Number (Required) ( ) -

SECTION I – EXPRESS ISSUE TERM DELUXE 20 – COMPLETE SECTION I ONLY

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been told that you need an organ transplant or have you been diagnosed as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)	❑ Yes ❑ No
B. Do you require assistance to feed, bathe, dress or take your own medication or are you currently confined to a hospital, nursing home, mental facility, hospice, or require home health care?	❑ Yes ❑ No
C. Have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immune disorder?	❑ Yes ❑ No
D. In the past twelve (12) months:	
1. Other than for temporary or minor conditions, have you been hospitalized two or more times?	❑ Yes ❑ No
2. Other than preventive, maintenance or risk lowering medications prescribed, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), heart attack, stroke, or had heart surgery (including angioplasty)?	❑ Yes ❑ No
3. Have you used any illegal drugs, been treated for or advised to have treatment for drug abuse?	❑ Yes ❑ No
E. In the past 5 years:	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer's Disease or Dementia?	❑ Yes ❑ No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	❑ Yes ❑ No
c. Other than preventive, maintenance or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension) or Stroke?	❑ Yes ❑ No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	❑ Yes ❑ No
e. Sickle Cell Anemia or Kidney Disease (including dialysis) or Liver Disease (including hepatitis B & C)?	❑ Yes ❑ No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	❑ Yes ❑ No

g. ALS (Lou Gehrig's Disease) or Neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years)?	❑ Yes ❑ No
2. Have you been advised by a medical professional to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	❑ Yes ❑ No
3. Have you excessively used, been treated for or been advised to have treatment for alcohol or drug abuse?	❑ Yes ❑ No
F. In the past 2 years have you been declined or postponed for Life Insurance?	❑ Yes ❑ No
G. In the past 10 years have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	❑ Yes ❑ No
H. If under age 65, are you currently disabled, or been disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	❑ Yes ❑ No

If any question in Section I is answered "Yes", you are not eligible for any plan of insurance.

SECTION II – ALL OTHER TERM PLANS – COMPLETE SECTIONS I & II

A. In the past 5 years:	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	❑ Yes ❑ No
b. Diabetes requiring insulin treatment?	❑ Yes ❑ No
c. SLE (Systemic Lupus Erythematosus)?	❑ Yes ❑ No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	❑ Yes ❑ No
B. Do you now participate in, or do you have plans to participate in any hazardous sport or aviation?	❑ Yes ❑ No

If any question in Section II is answered "Yes", you are not eligible for any of the term plans in Section II. Submit the case as Express Issue Term Deluxe 20.

I hereby apply for the insurance indicated above and I am submitting the first premium. I certify that the answers are true and accurate whether written by my own hand or not. I understand that my policy will not be effective until the date it is issued by the company.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

WARNING

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.

$_____ paid with application.

☐ I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount. (This benefit is not available with the Express Issue Term Deluxe 20 plan.)

Dated _____ , this _____ day of _____ , _____
City State Month Year

X _____ X _____
Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

To the best of my knowledge and belief the insurance applied for herein is ☐ is not ☐ intended to replace or change any existing life insurance or annuity coverage.

☐ I certify that I have provided the proposed insured a copy of the Terminal Illness Accelerated Benefit Disclosure Statement and a numerical illustration.

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail _____

Agent: Phone # _____ Fax# _____ License Identification Number (_____)_____
State

Check or money order must accompany. All premium checks must be made payable to United Home Life Insurance Company. Do not make check or money order payable to the agent or leave the Payee blank. Include copy of voided check for bank draft.

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

Please select ONLY one option, complete bank information and sign authorization below.

☐ Draft my account for the first premium (initial premium may be drafted upon receipt of this application). Please draft subsequent premiums on the _____ day of each month.

☐ Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day each month.
Month, Day

☐ Do NOT draft my account for the first premium. The initial premium is attached, is being mailed or will be collected on delivery. Please draft subsequent premiums on the _____ day of each month.

I understand that my policy will not be effective until the date it is issued by the Company.

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

TO: _____ Bank _____Bank Address

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority 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 debit entry.

I further agree that if any such debit entry 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.

Account No._____ Date_____ Bank signature of Premium Payor _____

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application, please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

I understand that my policy will not be effective until the date it is issued by the company.

RECEIPT

Received from _____ The sum of $ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance $ _____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____ , _____

Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) 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 it may have in your file. 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, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Terminal Illness Accelerated Benefit Disclosure Statement

(This benefit is not available with the Express Issue Term Deluxe 20 plan.)

Benefits paid under this benefit may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit.

Description of Benefits - This Benefit provides you with the right to access the Death Benefit (discounted at interest for one year)* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

Effect on the Policy - When the accelerated benefit is paid, the policy terminates.

Example - This example is for illustration only, uses a $100,000 policy and an interest rate of 7%.* **The amounts shown are not based on your specific policy.**

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Death Benefit	$100,000.00
Less 7%	6,542.06
Accelerated Benefit	**$ 93,457.94**

*The interest rate used to discount this benefit is defined in Section A of your Terminal Illness Accelerated Benefit Rider.

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Readability - Signed.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: N/A - Application included in Form Schedule tab.

Comments:

225 South East Street • P.O. Box 7192 • Indianapolis, IN 46207-7192

CERTIFICATION

I hereby certify the following score on the Flesch Reading Ease Test.

Form 200-642A 8-09 Score 53.6

Date: 6/26/2009

Carl L. Shepherd
Senior Vice President
United Home Life Insurance Company

1-800-428-3001 • 1-317-692-7979 • FAX 1-317-692-7711 • www.unitedhomelife.com