

SERFF Tracking Number: AFDL-126267631 State: Arkansas
Filing Company: American Fidelity Assurance Company State Tracking Number: 43274
Company Tracking Number: A1159.R609
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: A1159.R609
Project Name/Number: A1159.R609/A1159.R609

Filing at a Glance

Company: American Fidelity Assurance Company

Product Name: A1159.R609

SERFF Tr Num: AFDL-126267631 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 43274

Sub-TOI: L08.000 Life - Other

Co Tr Num: A1159.R609

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Shari Vick, Melissa
Mahanes, Ashlie Snyder, Tonya
Bittle

Disposition Date: 08/21/2009

Date Submitted: 08/20/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: A1159.R609

Status of Filing in Domicile: Authorized

Project Number: A1159.R609

Date Approved in Domicile: 08/14/2009

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: 08/21/2009

Explanation for Other Group Market Type:

State Status Changed: 08/21/2009

Deemer Date:

Created By: Tonya Bittle

Submitted By: Tonya Bittle

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for submission is the above referenced form. This is a new form and does not replace any previously approved form. This application will be used to apply for reinstatement of all individual life and health policies previously approved for use in your state. The form is completed in John Doe fashion. Variable information is marked in brackets []. The flesch score application is 48, excluding state mandated language and medical terminology.

We are filing this application under L08, Life - Other Type of Insurance; however, this application filing will apply to all of our previously approved individual products, even if those products are other than Individual Life - Other Type of

<i>SERFF Tracking Number:</i>	<i>AFDL-126267631</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>American Fidelity Assurance Company</i>	<i>State Tracking Number:</i>	<i>43274</i>
<i>Company Tracking Number:</i>	<i>A1159.R609</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
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Insurance.

This form may eventually be issued from an automated system. As denoted in our Statement of Variability, the final printed version of the form may vary. When printing the application in its entirety, we will make every attempt to produce the automated version to duplicate this final printed format; however, fonts and word wrap can vary when going from one system or printer to another. We will not alter the wording and will try to duplicate all pages, including keeping the verbiage on each page as submitted for approval. The pages may print on different colors of paper depending upon the market.

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state and such forms contain no provisions previously disapproved by the Department.

Thank you for your assistance with this matter. If you have any questions, please feel free to contact me at the telephone or fax numbers, or e-mail address listed under the Contact Information tab.

Company and Contact

Filing Contact Information

Melissa Mahanes, Compliance Analyst II	melissa.mahanes@af-group.com
2000 Classen Blvd	800-654-8489 [Phone] 2035 [Ext]
Oklahoma City, OK 73106	405-523-5793 [FAX]

Filing Company Information

American Fidelity Assurance Company	CoCode: 60410	State of Domicile: Oklahoma
2000 North Classen Blvd	Group Code:	Company Type: LAH
Oklahoma City, OK 73106	Group Name:	State ID Number:
(405) 523-2000 ext. [Phone]	FEIN Number: 73-0714500	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$25.00
Retaliatory?	Yes
Fee Explanation:	\$25.00/Application
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Fidelity Assurance Company	\$25.00	08/20/2009	29994893

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/21/2009	08/21/2009

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Disposition

Disposition Date: 08/21/2009

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	Filing Fee Form		Yes
Form	A1159.R609		Yes

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Form Schedule

Lead Form Number: A1159.R609

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	A1159.R609 9	Application/ Enrollment Form	Initial		48.000	A1159.R609 AFA Reinstatement.pdf

REINSTATEMENT APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N Classen Blvd Oklahoma City, Oklahoma 73106

POLICY NUMBER

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Last Name		First Name		Full Middle Name		Suffix	
Number and Street		Work Phone # ()		Best time to call am pm		Home Phone # () am pm	
City		State		Zip		Date of Birth / /	
State/Place of Birth		Social Security Number		Employer		Employer Address	
Height ft. in.		Weight lbs.		Occupation		Date Employed	

Additional Insured Name		Height ft. in.		Weight lbs.	
Additional Insured Name		Height ft. in.		Weight lbs.	
Additional Insured Name		Height ft. in.		Weight lbs.	

1. a. Name, address and phone number of your personal physician? (If none, so state) _____
- b. Patient ID Number. (If applicable) _____
- c. Date and reason last consulted. _____
- d. Treatment given or recommended. _____
- e. List all current medications. _____

2. In the last 5 years has ANY person to be covered:

	YES	NO
a. applied for life or health insurance or reinstatement which was declined, postponed, rated, or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>
b. been convicted of a felony, or awaiting trial for a felony?	<input type="checkbox"/>	<input type="checkbox"/>
c. used any illegal, restricted, or controlled substance except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
d. been counseled, or advised to undergo counseling or treatment for alcohol or drug use, addiction or abuse?	<input type="checkbox"/>	<input type="checkbox"/>
e. engaged in aviation activities or any hazardous sports, avocations or hobbies, or do you expect to do so?	<input type="checkbox"/>	<input type="checkbox"/>
3. In the last 12 months has ANY person to be covered used nicotine or nicotine products in any form? YES NO

4. In the last 5 years has ANY person to be covered received treatment, consulted a physician or been hospitalized for any medical condition shown below? If the YES box is checked, write the name of the person and the number of the condition in the provided section on the back of this application. Provide a description of the condition, date of diagnosis, indicate any treatment or medications, the name, address, and phone number of physician and current status or outcome of condition. If additional space is needed, please use a separate sheet of paper dated and signed by the applicant.

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Adrenal/Pituitary Disorders	<input type="checkbox"/>	<input type="checkbox"/>	18. Kidney/Bladder/Prostate Disorder
<input type="checkbox"/>	<input type="checkbox"/>	2. Aneurysm/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	19. Liver Disorder/Hepatitis/Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	3. Arthritis/Gout/Joint Disorder	<input type="checkbox"/>	<input type="checkbox"/>	20. Lung Disorder/Respiratory/Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	4. Asthma/Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	21. Lupus
<input type="checkbox"/>	<input type="checkbox"/>	5. Back Disorder	<input type="checkbox"/>	<input type="checkbox"/>	22. Lymphatic Disorder
<input type="checkbox"/>	<input type="checkbox"/>	6. Birth Defects/Congenital Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	23. Mental Illness/Emotional Disorder
<input type="checkbox"/>	<input type="checkbox"/>	7. Blood Disorder/Transfusion/Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	24. Neurological Disorder/Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	8. Cancer/Leukemia/Hodgkins	<input type="checkbox"/>	<input type="checkbox"/>	25. Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	9. Circulatory/Vascular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	26. Paralysis/Polio Residuals
<input type="checkbox"/>	<input type="checkbox"/>	10. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	27. Proctitis/Rectal Disorder
<input type="checkbox"/>	<input type="checkbox"/>	11. Dizziness/Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	28. Reproductive/Breast Disorder
<input type="checkbox"/>	<input type="checkbox"/>	12. Epilepsy/Convulsions/Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	29. Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	13. Gastrointestinal Disorder/Ulcer/Crohn's/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	30. Surgery
<input type="checkbox"/>	<input type="checkbox"/>	14. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	31. Thyroid/Goiter
<input type="checkbox"/>	<input type="checkbox"/>	15. Heart Disease/Heart Disorder/Angina	<input type="checkbox"/>	<input type="checkbox"/>	32. Tumor/Abscess/Cyst
<input type="checkbox"/>	<input type="checkbox"/>	16. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	33. Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	17. Immunodeficiency Disorder	<input type="checkbox"/>	<input type="checkbox"/>	34. Any Health Condition Not Listed

- | | | |
|---|---------------------------------|--------------------------------|
| 5. Has ANY person to be covered had any positive test results indicating Human Immunodeficiency Virus (HIV), or been medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC)? | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 6. Has ANY person to be insured received medical advice to have any diagnostic tests, examinations, or consultations for any condition that have not been completed; or had tests and results that have not been received; or test results were abnormal and no follow-up or resolution has occurred? | <input type="checkbox"/> | <input type="checkbox"/> |

Give details in the space below to any "YES" answers for questions 2, 3, 4, 5 and 6.

SIGNATURE AND AUTHORIZATION

I hereby apply to American Fidelity Assurance Company for reinstatement of the above numbered policy (policies) and any attached riders. I understand and agree that if the policy (policies) is (are) reinstated, then it (they) will be contestable for two years from the date shown below with respect to answers and statements in this application. This application and/or riders will be attached to and become a part of any policy (policies) reinstated and will constitute the entire contract between the parties. No statement shall void this reinstated policy or be used in defense of a claim unless contained in the written reinstatement application. The policy to which this application is attached shall be incontestable after two years from the date of issue except for non-payment of premiums or provisions and conditions relating to disability benefits and those granting additional insurance in the event of death or as specific loss by accident or accidental means when contained in or issued in connection with this reinstated policy.

Signed at _____
(City and State)

this _____ day of _____, 20 _____

Notary Public Seal Commission Expires

Signature of Proposed Insured

Notary Public Seal Commission Expires

Signature of Additional Insured (if any)

Notary Public Seal Commission Expires

Signature of Owner (if other than Proposed Insured)
(If owner is a Corporation, please affix Corporate Seal with Signature and Title of Authorized Officer)

FRAUD 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 or knowingly presents false information in an application may be guilty of insurance fraud.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purposes of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny benefits if false information materially related to a claim was provided by the applicant.

NEW MEXICO: 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.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR Compliance Certification.pdf

FleschCert.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: N/A

Comments:

Item Status: **Status Date:**

Satisfied - Item: Filing Fee Form

Comments:

Attachment:

AR Filing Fee Form.pdf



American Fidelity Assurance Company

A member of the American Fidelity Group®

STATE OF ARKANSAS

COMPLIANCE CERTIFICATION

Form Number and Name: **A1159.R609 Individual Life and Health Reinstatement Application**

I hereby certify that this filing does not discriminate unfairly between Policyholders and that it meets requirements set forth in Arkansas Rule and Regulation 19. I further certify, that to the best of my knowledge and judgment this filing is complete and accurate, and in compliance with the applicable laws and regulations of the State of Arkansas.

A handwritten signature in black ink, appearing to read 'Alex M. Bagby'.

Alex M. Bagby, ASA, MAAA
Vice President & Chief Risk Officer
American Public Life Insurance Company

August 19, 2009

Date



A member of the American Fidelity Group®

READABILITY CERTIFICATION

I, Melissa Mahanes, hereby certify that form A1159.R609 Individual Life and Health Reinstatement Application meets the minimum reading ease score required by the Insurance Code in your state. The Flesch Score for this form is a 48 excluding medical terminology and state mandated language.

For AR and VA: the word count for the A1159.R609 is 404.

A handwritten signature in black ink, appearing to read 'Alex M Bagby', with a long horizontal flourish extending to the right.

Alex M Bagby, A.S.A., M.A.A.A.
Senior Vice President & Director of Products
American Fidelity Assurance Company

August 12, 2009
Date

ARKANSAS INSURANCE DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

501-686-2900

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: American Fidelity Assurance Company

Company NAIC Code: 60410

Company Contact Person & Telephone # Melissa Mahanes 800-654-8489 x 2035

* INSURANCE DEPARTMENT USE ONLY *
* *
* ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____ *

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS,
UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.	* _____ x\$ 50= _____
Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.	**Retaliatory _____ * _____ x\$ 50= _____

Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.	_____ 1 x\$ 20= <u>20.00</u>
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Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.	_____ x\$ 25= _____ **Retaliatory <u>\$25.00</u>
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AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority.	* _____ x\$400= _____
Filing to amend Certificate of Authority.	* _____ x\$100= _____