

<i>SERFF Tracking Number:</i>	<i>SEFL-126217550</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Assurity Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>43098</i>
<i>Company Tracking Number:</i>	<i>HLTH CHG</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>HLTH CHG</i>		
<i>Project Name/Number:</i>	<i>HLTH CHG /HLTH CHG</i>		

## Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: HLTH CHG

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: SEFL-126217550

SERFF Status: Closed

Co Tr Num: HLTH CHG

Co Status: Sent to State

Author: Kristi Hendrickson

Date Submitted: 07/31/2009

State: ArkansasLH

State Tr Num: 43098

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 08/10/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: HLTH CHG

Project Number: HLTH CHG

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/10/2009

Deemer Date:

Filing Description:

Form No. Title

75-611-02255 Application for Changes to Health Policy

75-859-05051 Evidence of Insurability

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 07/24/2009

Domicile Status Comments: Approved

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/10/2009

Corresponding Filing Tracking Number:

We respectfully ask your review and approval of the above forms. The forms are new and have not been previously been submitted for review. Once approved, they will replace DI/A-43 (8/03) which was previously approved on October 9, 2003.

SERFF Tracking Number: SEFL-126217550 State: Arkansas  
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 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: HLTH CHG  
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Form 75-611-02255 is an administrative form for individual health policyholders requesting changes to their current coverage. When evidence of insurability is required for the change, the policyholder will be required to complete Form 75-859-05051.

## Company and Contact

### Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist policyfiling@assurity.com  
 1526 K Street (402) 437-3452 [Phone]  
 Lincoln, NE 68508 (402) 437-3802[FAX]

### Filing Company Information

Assurity Life Insurance Company CoCode: 71439 State of Domicile: Nebraska  
 1526 K Street Group Code: -99 Company Type: Life/Health  
 P.O. Box 82533  
 Lincoln, NE 68501-2533 Group Name: State ID Number:  
 (800) 276-7619 ext. [Phone] FEIN Number: 38-1843471  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$40.00  
 Retaliatory? No  
 Fee Explanation: 20 per form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	\$40.00	07/31/2009	29566301

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/10/2009	08/10/2009

*SERFF Tracking Number:* SEFL-126217550      *State:* Arkansas  
*Filing Company:* Assurity Life Insurance Company      *State Tracking Number:* 43098  
*Company Tracking Number:* HLTH CHG  
*TOI:* H21 Health - Other      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* HLTH CHG  
*Project Name/Number:* HLTH CHG /HLTH CHG

## **Disposition**

Disposition Date: 08/10/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* SEFL-126217550      *State:* Arkansas  
*Filing Company:* Assurity Life Insurance Company      *State Tracking Number:* 43098  
*Company Tracking Number:* HLTH CHG  
*TOI:* H21 Health - Other      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* HLTH CHG  
*Project Name/Number:* HLTH CHG /HLTH CHG

<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>Form</b>	Application for Changes to Health Policy	Approved-Closed	Yes
<b>Form</b>	Evidence of Insurability	Approved-Closed	Yes

SERFF Tracking Number: SEFL-126217550 State: Arkansas  
 Filing Company: Assurity Life Insurance Company State Tracking Number: 43098  
 Company Tracking Number: HLTH CHG  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: HLTH CHG  
 Project Name/Number: HLTH CHG /HLTH CHG

## Form Schedule

**Lead Form Number:** 75-611-02255

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	75-611-02255	Application/Enrollment Form	Application for Changes to Health Policy	Initial		50	75-611-02255_06-29_.pdf
Approved-Closed	75-859-05051	Other	Evidence of Insurability	Initial		50	75-859-05051 Evidence of Insurability.pdf





**PLEASE PRINT WITH BLACK INK**

PRIMARY INSURED				
Legal Name	<i>First</i>	<i>Middle</i>	<i>Last</i>	Policy No.
Home Address	<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>ZIP+4</i>

**GENERAL SECTION**

Please answer the following questions for any person to be insured: If more space is needed, please provide details on page 4.

1. Does any Insured belong to or intend to join the National Guard or military? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  
2. During the past **5 years** or within the next **12 months** (If YES to any of the following, please complete and return the Avocation Questionnaire):
  - a. Has any Insured flown other than as a fare-paying passenger, or is any Insured contemplating flying as a pilot, crew member or student? .....  Yes  No
  - b. Has any Insured participated in, or contemplated participation in, any hazardous sport or activities?  Yes  No  
 If YES, check all that apply:     Skin/Scuba Diving                       Bungee Jumping                       Skydiving/Parachuting/Hang Gliding  
 Motor-powered Racing             Boxing                                       Rodeo                                       Professional, Semi-professional or Club Sports  
 Cave Exploration                       Mountain/Rock/Ice Climbing     Hot Air Ballooning
  
3. During the next **12 months**, does any Insured contemplate residence or travel outside of the United States? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  
4. During the past **12 months**, has any Insured had a change in weight of more than 10 pounds? .....  Yes  No  
 If YES, please list the Insured's name, amount of weight change and reason for change:  
 \_\_\_\_\_
  
5. During the past **5 years**, has any Insured:
  - a. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined, or had insurance renewal or reinstatement refused? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  - b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  
6. Is any Insured currently negotiating for other insurance coverage? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  
7. During the past **5 years**, has any Insured:
  - a. Had their driver's license suspended or revoked, been convicted of or pleaded "guilty" or "no contest" to driving under the influence (DUI/DWI), or had more than 3 moving violations? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  - b. Been convicted of a felony? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  
8. Is any Insured currently on probation? .....  Yes  No  
 If YES, please list the Insured's name, reason for probation and length of probationary period:  
 \_\_\_\_\_
  
9. Does any Insured have other insurance coverage in force? .....  Yes  No  
 If YES, please provide details below. If applying for life coverage, complete and return the appropriate State Replacement Form.

Company Name	Policy No.	Individual (I) Group (G)	Benefits (mo. benefit and benefit period for DI or face amt. for Life)	Issue Date (MM/DD/YYYY)	DI COVERAGE ONLY	
					Coordinates w/ Soc. Sec.?	Employer Paid?
		<input type="checkbox"/> I <input type="checkbox"/> G		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> I <input type="checkbox"/> G		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



**HEALTH SECTION**

Please answer the following questions. If YES to any of the following, please provide details on page 3.

- 1. Has any Insured **ever** consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
  - a. Heart disorder, including a heart attack (*myocardial infarction*), angina, irregular heartbeat or abnormal heart rhythm (*arrhythmia*), chest pain, hypertension (*high blood pressure*), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (*TIA or mini-stroke*), or rheumatic fever? .....  Yes  No
  - b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease (*other than kidney stones*), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? .....  Yes  No
  - c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? .....  Yes  No
  - d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (*including Down's syndrome*), multiple sclerosis (*MS*), muscular dystrophy (*MD*), Parkinson's disease, amyotrophic lateral sclerosis (*ALS*), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy?.....  Yes  No
  - e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (*COPD*), shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (*lupus or scleroderma*)? .....  Yes  No
  - f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder?.....  Yes  No
  - g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? .....  Yes  No
  - h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? .....  Yes  No
  - i. Any disease or disorder of the eyes, ears, nose or throat? .....  Yes  No
  - j. Any other illness or injury requiring medical attention or blood transfusions? .....  Yes  No
- 2. During the past **5 years**, has any Insured:
  - a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?.....  Yes  No
  - b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? .....  Yes  No
  - c. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? .....  Yes  No
  - d. Been advised to have any test (*except HIV tests*), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received?.....  Yes  No
  - e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related blood tests*) or urine tests? .....  Yes  No
- 3. Has any Insured **ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*); or had a positive test for human immunodeficiency virus (*HIV*) antibodies? .....  Yes  No
- 4. a. Has any Insured **ever** had any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? .....  Yes  No  
b. Is any Insured currently pregnant? .....  Yes  No  
If YES, date child is expected (*MM/DD/YYYY*) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 5. Has any Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, please identify family member, relationship to Insured, disorder and age at death. ....  Yes  No  
\_\_\_\_\_

**DETAILS:** Enter complete details from questions #1-4 on page 3. If more space is needed, attach additional Supplemental Information form.



Information	Payor	Spouse	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name (First, Middle, Last)					
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /	/ /
Age					
Social Security No.					
Birth State/Country					
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female				
Height/Weight	ft. in. / lbs.				
Residing with Primary Insured			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Primary Insured					
Employer					
Occupation					
Duties					
Gross monthly income	\$	\$			
If self-employed, net mo. income	\$	\$			

Has the Payor/Spouse ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? .....  Yes  No  
 (Not applicable to Child Riders.)

If YES, please list person(s), type and last date of use (MM/DD/YYYY) \_\_\_\_\_ / /  
 \_\_\_\_\_ / /

SUPPLEMENTAL INFORMATION					
Question #/Letter	Name (First, Middle, Last)	Onset Date (MM/DD/YYYY)	Duration (Days, Mos, Yrs)	Health Condition and Details	Medical Care Provider's Name/Address/Phone
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			



**REPRESENTATION**

I represent that these statements are true and complete to the best of my knowledge and belief. I understand and agree that the Company shall not incur any liability under this application until the application this is attached to is approved by the Company. I hereby acknowledge that I have read and understand the applicable state fraud information given below.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Signature of Owner (if other than Insured)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Signature of Joint Insured

**FRAUD NOTICES**

Unless specific state language is provided below, the following general fraud notice applies.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

**CO RESIDENTS:** Knowingly providing false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud is unlawful. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or its agent that knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant regarding amounts payable from insurance proceeds for the purpose of defrauding or attempting to defraud shall be reported to the Colorado Department of Regulatory Agencies, Division of Insurance.

**FL RESIDENTS:** Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony in the third degree.

**GA RESIDENTS:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law as determined by a court of competent jurisdiction.

**KS RESIDENTS:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime as determined by a court of law and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

**KY RESIDENTS:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

**MA, MD RESIDENTS:** Any person who knowingly and willfully presents a fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**MN RESIDENTS:** Any solicitor, agent, examining physician or other person who knowingly and willfully makes a fake or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

**NC RESIDENTS:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to a substantial civil penalty where and to the extent allowed by state law.

**NJ RESIDENTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

**OR RESIDENTS:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, and may be subject to a substantial civil penalty where and to the extent allowed by state law.

**PA RESIDENTS:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**TN, VA, WA RESIDENTS:** 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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<i>Product Name:</i>	<i>HLTH CHG</i>		
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## **Rate Information**

Rate data does NOT apply to filing.

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## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 08/10/2009  
**Comments:**  
**Attachment:**  
READ CERT.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 08/10/2009  
**Bypass Reason:** N/A Policy Change Form and Evidence of Insurability if needed these forms are used on products that have already been issued.  
**Comments:**

**Bypassed -Name:** Health - Actuarial Justification **Review Status:** Approved-Closed 08/10/2009  
**Bypass Reason:** N/A Policy Change Form and Evidence of Insurability if needed these forms are used on products that have already been issued.  
**Comments:**

**Bypassed -Name:** Outline of Coverage **Review Status:** Approved-Closed 08/10/2009  
**Bypass Reason:** N/A Policy Change Form and Evidence of Insurability if needed these forms are used on products that have already been issued.  
**Comments:**

## READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word 2007 program and achieved the following test results:

**Company Name:** Assurity Life Insurance Company

**Type of Form:** Policy Change and Evidence of Insurability

<b>Form No.</b>	<b>Description</b>	<b>Flesch Score</b>
75-611-02255	Application for Changes to Health Policy	50.4
75-859-05051	Evidence of Insurability	50.2



Signature

July 7, 2009

Date

Carol Watson  
Vice President, General Counsel  
Secretary