

SERFF Tracking Number: AAAL-126295950 State: Arkansas
Filing Company: AAA Life Insurance Company State Tracking Number: 43433
Company Tracking Number: GT20902APPRC
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Group Term Life Insurance Reinstatement Change Application
Project Name/Number: GP Term Life Reinstatement/Change App/GT20902APPRC

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	09/14/2009	09/14/2009

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Disposition

Disposition Date: 09/14/2009

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	No	No
Supporting Document	Application	No	No
Supporting Document	Cover Letter	No	No
Supporting Document	App Attachment - Additional Information form	No	No
Form	Application for Reinstatement or Change - Group Term Life	No	No



**APPLICATION FOR REINSTATEMENT OR CHANGE IN COVERAGE
GROUP TERM LIFE INSURANCE**

17900 N. Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

Section A. Insured's Information *Please complete entire section*

Certificate Number:			AAA Member Number:		
Insured Name:			Insured SSN: - -		
Street Address:			Insured Date of Birth:		
City:	State:	Zip:	Daytime Phone:		
Owner Name (if different than Insured):			Email Address:		

Section B. Type of Request *Choose only one*

Reinstatement <input type="checkbox"/>	I hereby apply for reinstatement in accordance with all its terms and conditions.
Nicotine Change <input type="checkbox"/>	I am requesting a rate class change from Nicotine to Non-Nicotine as I have not used any form of nicotine in the past 12 months. Date of Last Nicotine Use: _____

Section C. Underwriting Information *Please complete entire section*

The Insured must answer ALL of the following questions. Provide details to any "Yes" answers in the space provided. Use the enclosed Additional Information page, if necessary.

Height: _____ft. _____in.	Weight: _____lbs.	Weight Change in past 12 Months: _____lbs.	<input type="checkbox"/> Gain <input type="checkbox"/> Loss
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Since the date of the original application:

- Has there been any change in your health that required you to consult a member of the medical profession? Yes No
- Have you consulted with, been diagnosed, or treated by a medical professional for cancer, tumor, diabetes, stroke, heart, circulatory or blood disorder, brain or neurological disorder, kidney or liver disorder, lung or breathing disorder? Yes No
- Have you been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for HIV (Human Immunodeficiency Virus) infection? Yes No
- Have you been diagnosed, received or been advised to receive treatment by a member of the medical profession for alcohol, substance abuse, emotional, mental or nervous disorder? Yes No
- Have you been advised by a medical professional to have any surgery, treatment, hospital care or medical testing or are you currently taking any medication? Yes No

Details to "Yes" answers. Use the enclosed Additional Information page, if necessary.

Question #	Conditions/Reasons	Date	Test Results	Name and Address Where Treatment Received

Section D. Premium Payments *Please complete entire section*

I wish to keep paying my premium based on the existing payment method on file.

I wish to update my premium payment information. I authorize, until I revoke in writing, deduction of the premium as outlined below.

Signature: _____

Pay my premium Annually Semi-Annually Quarterly Monthly (*Bill Directly Not Available*)

Deduct from my checking account (*Attach a voided check for this option*)

Charge to my credit card (*Visa, MasterCard, Discover, & AmEx*) Number _____ Exp. Date ____/____/____

Send me a bill directly (*Not available monthly*)

Section E. Signatures *Please read, sign, and date*

Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines or penalties.

Applicable to residents of:

Arkansas: 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.

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 insurance benefits if false information materially related to a claim was provided by the applicant.

Nebraska: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud and may be subject to fines and penalties.

New Jersey: Any person who includes false or misleading information on an application for an insurance Certificate is subject to criminal and civil penalties.

Oregon: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud and may be subject to fines and penalties.

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

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

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 may include imprisonment, fines or a denial of insurance benefits.

I declare that all statements and answers in this application for reinstatement or change in coverage are, to the best of my knowledge and belief, true, complete, and correctly recorded. A copy of the application will be attached to the Certificate which is being changed or reinstated. I understand this application will be used to determine my insurability with regard to the requested change or reinstatement.

I acknowledge that if there is a change in my health after the date this application is signed but prior to its approval, I must inform the Company in writing.

I understand that no change in coverage or reinstatement will become effective unless and until this application is approved by the Company at its Home Office, and the full amount of premium due is paid during the lifetime of the insured. I further understand that this Certificate's Incontestability Provision will apply from the date the Certificate is changed or reinstated with regard to statements made on this application.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), pharmacy, pharmacy benefit manager, or other organization, institution or person that has any records or knowledge of the Proposed Insured's medical or prescription history to give any such information to the Company, its representatives or reinsurers. I understand that my medical records may be protected by certain federal regulations, especially as they apply to any drug or alcohol abuse data. I understand that I may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original.

I understand that I or my authorized representative have the right to a copy of this authorization.

Printed Name of Insured	Printed Name of Owner (<i>If Other Than Insured</i>)
Signature of Insured	Signature of Owner (<i>If Other Than Insured</i>)
Date	Date

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: READABILITY CERTIFICATION.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: Please refer to the Forms Schedule tab.		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment: AR Cover Letter draft.pdf		

	Item Status:	Status Date:
Satisfied - Item: App Attachment - Additional Information form		
Comments:		
Attachment: App Attachment - Additional Information form.pdf		

READABILITY CERTIFICATION

COMPANY NAME: AAA Life Insurance Company

I hereby certify that the form listed below has (have) the following score as calculated by the Flesch Reading Ease Test.

<u>Form Number</u>	<u>Score</u>
GT20902APPRC	45.5



Company Officer: Robert J Dotson

Title: Secretary and General Counsel

September 2, 2009

Date



Barbara G. Hassell, AIRC
Compliance Specialist II

17900 N. Laurel Park Drive
Livonia, Michigan 48152-3985
Phone: 734-779-2942
Fax: 734-805-2915
bhassell@aaalife.com

September 9, 2009
Arkansas Department of Insurance

RE: **AAA Life Insurance Company**
NAIC No.: 71854 **FEIN:** 52-0891929

Form Number
GT20902APPRC

Description
Application for Reinstatement or Change in Coverage
Group Term Life Insurance

Dear Reviewer:

Attached is the above referenced application form for your review and approval. This is a new application and will not replace any previously approved forms. Once approved, this application will be used by Certificate holders in your state, to request reinstatement or a change in coverage under our Group Term Life Insurance products currently in force in your state, approved as follows:

Certificate Form Number	Approval Date
GT8107CERT	11/28/07
LTL-97(9/03)CERT(AR)	2/23/2004

This form is exempt from prior review and approval in our domiciliary state of Michigan. No part of the form contains any unusual or potentially controversial items apart from normal Company or industry standards.

We reserve the right to change fonts or layout of this form. However, we certify the font size will never be less than a minimum of 10-point

We are also attaching, for informational purposes, our "Additional Information" form, which we provide for the convenience of the applicant, and which can be used when there isn't room for a complete answer on the application itself.

To the best of our knowledge and belief, this submission complies with all the relevant statutes and regulations of Arkansas, and includes nothing that has been previously objected to or disapproved by your Department.

Please feel free to contact me personally if you should have any questions, or require any further information to complete your review. My contact information is at the top of this letter. Thank you for your time and consideration.

Sincerely,

Barbara G. Hassell, AIRC
Compliance Specialist II



INSURANCE MARKETPLACE
STANDARDS ASSOCIATION



**Life Insurance
Company**

Additional Information

17900 N. Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

Question #	Remarks