

<i>SERFF Tracking Number:</i>	<i>CUNA-126285095</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>CUNA Mutual Insurance Society</i>	<i>State Tracking Number:</i>	<i>43379</i>
<i>Company Tracking Number:</i>	<i>B10F-029-2003 ET AL</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>NAIC Replacement Model</i>		
<i>Project Name/Number:</i>	<i>Replacement Regulation/</i>		

Filing at a Glance

Company: CUNA Mutual Insurance Society

Product Name: NAIC Replacement Model

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: CUNA-126285095 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 43379

Co Tr Num: B10F-029-2003 ET AL State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Kari Hamrick, Kathy

Strauser, Carma Bouska, Kimberly

Steggall

Date Submitted: 08/28/2009

Disposition Date: 09/02/2009
Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Replacement Regulation

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/02/2009

Deemer Date:

Submitted By: Carma Bouska

Filing Description:

The attached application forms are filed to comply with the state of Arkansas's adoption of the NAIC Replacement Model effective January 1, 2010. The applications provided will replace currently used applications as follows:

B10f-029-2003 replaces B10f-029-2003(B), approved 12/29/2003.

B10f-029-2003(J) replaces B10f-029-(J)(B), approved 12/29/2003.

B10f-029-2003v1 replaces B10f-029-2003(B)v1, approved 9/10/2008.

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 09/30/2003

Domicile Status Comments: 9/30/03, 4/19/06,
11/13/07, and 12/18/07.

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Trust

Explanation for Other Group Market Type:

State Status Changed: 09/02/2009

Created By: Carma Bouska

Corresponding Filing Tracking Number:

SERFF Tracking Number: CUNA-126285095 State: Arkansas
 Filing Company: CUNA Mutual Insurance Society State Tracking Number: 43379
 Company Tracking Number: B10F-029-2003 ET AL
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: NAIC Replacement Model
 Project Name/Number: Replacement Regulation/

B10f-029-2005 replaces B10f-029-2005(B), approved 9/10/2008.
 B10f-036-2007(J) replaces B10f-036-2007(J)(B), approved 2/7/2008 CUNA-125419728, 37944.
 B10f-037-2007(J)(B) replaces B10f-037-2007(J)(B), approved 2/28/2008 CUNA-125469063, 38197.

Thank you for your review of these applications.

Company and Contact

Filing Contact Information

Carma Bouska, carma.bouska@cunamutual.com
 2000 Heritage Way 319-483-3511 [Phone]
 Waverly, IA 50677

Filing Company Information

CUNA Mutual Insurance Society CoCode: 62626 State of Domicile: Iowa
 2000 Heritage Way Group Code: 306 Company Type:
 Waverly, IA 50677 Group Name: State ID Number:
 (319) 352-4090 ext. [Phone] FEIN Number: 39-0230590

Filing Fees

Fee Required? Yes
 Fee Amount: \$120.00
 Retaliatory? No
 Fee Explanation: \$20 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
CUNA Mutual Insurance Society	\$120.00	08/28/2009	30186333

SERFF Tracking Number: CUNA-126285095 State: Arkansas
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Company Tracking Number: B10F-029-2003 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NAIC Replacement Model
Project Name/Number: Replacement Regulation/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/02/2009	09/02/2009

<i>SERFF Tracking Number:</i>	<i>CUNA-126285095</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>CUNA Mutual Insurance Society</i>	<i>State Tracking Number:</i>	<i>43379</i>
<i>Company Tracking Number:</i>	<i>B10F-029-2003 ET AL</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>NAIC Replacement Model</i>		
<i>Project Name/Number:</i>	<i>Replacement Regulation/</i>		

Disposition

Disposition Date: 09/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CUNA-126285095 State: Arkansas
 Filing Company: CUNA Mutual Insurance Society State Tracking Number: 43379
 Company Tracking Number: B10F-029-2003 ET AL
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: NAIC Replacement Model
 Project Name/Number: Replacement Regulation/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	2003 2QWL Application		Yes
Form	2003 2QWL Spouse Application		Yes
Form	2QWL Application		Yes
Form	2005 2QWL Application		Yes
Form	Group Term to Age 80 Application		Yes
Form	Group Term to Age 80 Application		Yes

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 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: NAIC Replacement Model
 Project Name/Number: Replacement Regulation/

Form Schedule

Lead Form Number: B10f-029-2003

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	B10f-029-2003	Application/2003 2QWL Enrollment Application Form	Initial		50.000	B10f-029-2003.pdf
	B10f-029-2003(J)	Application/2003 2QWL Spouse Enrollment Application Form	Initial		47.500	B10f-029-2003(J).pdf
	B10f-029-2003v1	Application/2QWL Application Enrollment Form	Initial		50.000	B10f-029-2003v1.pdf
	B10f-029-2005	Application/2005 2QWL Enrollment Application Form	Initial		52.100	B10f-029-2005.pdf
	B10f-036-2007(J)	Application/Group Term to Age Enrollment 80 Application Form	Initial		51.900	B10f-036-2007(J).pdf
	B10f-037-2007(J)	Application/Group Term to Age Enrollment 80 Application Form	Initial		50.900	B10f-037-2007(J).pdf

CUNA MUTUAL INSURANCE SOCIETY

[P.O. Box 61, Waverly, IA 50677-0061]

[(Please print in black ink.)]

Name _____

First

Middle

Last

Address _____

Street or RD #

City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____

Best Time to Call _____ a.m. _____ p.m. Gender M F Age _____ Date of Birth _____

Month Day Year

I wish to apply for the amount of insurance checked below:

1 UNIT 2 UNITS 3 UNITS 4 UNITS 5 UNITS 6 UNITS

Are you a U.S. Citizen? Yes No Social Security # --

Beneficiary Names _____ Relationships _____

First

Middle

Last

[(For additional beneficiaries, please include a separate sheet with names and relationships, then date and sign.)]

PLEASE ANSWER THESE QUESTIONS:

Yes No Has illness or injury caused you to retire, or are you currently unable to work because of injury or illness?

Yes No Have you, within the past 5 years, been treated for or diagnosed by a physician as having insulin dependent diabetes; stroke; paralysis; heart disease or condition (except high blood pressure); cancer; kidney failure; lupus; chronic obstructive pulmonary disease (COPD) or emphysema; liver disorder; AIDS or AIDS Related Complex; mental disorder or disorder of the brain or spinal nerves; alcoholism or excessive use of alcohol?

Yes No Have you used tobacco, in any form, within the past 3 years?

Yes No Do you want the automatic premium loan provision?

Yes No Will the coverage you are applying for replace, discontinue, or change any life coverage or annuities?

AUTOMATIC PAYMENT AUTHORIZATION: By signing below, I (the member shown above) **authorize** CUNA Mutual Insurance Society to deduct premiums each month from my credit union **share draft (checking) account** for the life coverage(s) applied for on this application. This authorization will remain in effect until revoked by me in writing.

Deductions will be determined by the certificate effective date unless another date is selected. Circle the day of the month you prefer to be billed: **1 5 10 15 20 25 Other Day** ____ (Note: Allow 2 business days from the above selected date for deductions to occur from your account.)

AGREEMENT: All statements and answers made in this application are full, complete and true to the best of my knowledge and belief. This application will be the basis of any insurance issued. I understand that: (1) benefits may be denied during the first 2 years from the effective date if I fail to give true and complete answers in this application as described in the incontestability provision of the certificate; and (2) no insurance will take effect unless: (a) my application is approved, and a certificate is issued by the company; and (b) the full first premium is received by the company [within 21 days of the effective date of the certificate] and while the applicant is alive; and (3) the answers on this application continue to be true and complete, and there has been no change in health or other factors affecting insurability, between the time I sign the application to the effective date of coverage.

Date Signed

Member's Signature

B10f-029-2003

[APPLICATION FORM]

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 may be guilty of a crime and may be subject to fines, confinement in prison, and denial of insurance benefits, depending on state law.

APPLICATION FORM FOR MEMBERS WHOLE LIFE INSURANCE

**CUNA MUTUAL INSURANCE SOCIETY
5910 Mineral Point Road, Madison, WI 53705**

MEMBER INFORMATION (Please print in black ink.)

John A. Member
123 Main Street
Address Line 2
Anytown, US 12345

Home Telephone() Work Telephone ()

Best time to Call: a.m. p.m. Gender M F

Age Date of Birth

I wish to apply for the amount of insurance checked below:
 \$10,000.00 \$8,000.00 \$6,000.00
 \$4,000.00 \$2,000.00

Are You a US Citizen? Yes No
Social Security Number

Beneficiary Name Relationship to You

SPOUSE INFORMATION (Please print in black ink.)

Name

Address

City State ZIP

Home Telephone() Work Telephone ()

Best time to Call: a.m. p.m. Gender M F

Age Date of Birth

I wish to apply for the amount of insurance checked below:
 \$10,000.00 \$8,000.00 \$6,000.00
 \$4,000.00 \$2,000.00

Are You a US Citizen? Yes No
Social Security Number

Beneficiary Name Relationship to You

	MEMBER	SPOUSE
Has illness or injury caused you to retire, or are you currently unable to work because of injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you, within the past 5 years, been treated for or diagnosed by a physician as having insulin dependent diabetes; stroke; paralysis; heart disease or condition (except high blood pressure); cancer; kidney failure; lupus; chronic obstructive pulmonary disease (COPD) or emphysema; liver disorder; AIDS or AIDS Related Complex; mental disorder or disorder of the brain or spinal nerves; alcoholism or excessive use of alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you used tobacco, in any form, within the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you want the automatic premium loan provision?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will the coverage you are applying for replace, discontinue, or change any life coverage or annuities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTOMATIC PAYMENT AUTHORIZATION: By signing below, I (the member shown above) authorize CUNA Mutual Insurance Society to deduct premiums each month from my credit union **share draft (checking) account** for the life coverage(s) applied for on this application. This authorization will remain in effect until revoked by me in writing.

Deductions will be determined by the certificate effective date unless another date is selected. Circle the day of the month you prefer to be billed: **1 5 10 15 20 25 Other Day** (Note: Allow 2 business days from the above selected date for deductions to occur from your account.)

AGREEMENT: All statements and answers made in this application are full, complete and true to the best of my knowledge and belief. This application will be the basis of any insurance issued. I understand that: (1) benefits may be denied during the first 2 years from the effective date if I fail to give true and complete answers in this application as described in the incontestability provision of the certificate; and (2) no insurance will take effect unless: (a) my application is approved, and a certificate is issued by the company; and (b) the full first premium is received by the company [within 21 days of the effective date of the certificate] and while the applicant(s) is (are) alive; and (3) the answers on this application continue to be true and complete, and there has been no change in health or other factors affecting insurability, between the time I sign the application to the effective date of coverage.

Member's Signature Date Spouse's Signature (if to be insured) Date
B10f-029-2003(J) [APPLICATION FORM]

CUNA MUTUAL INSURANCE SOCIETY

[P.O. Box 61, Waverly, IA 50677]

[(Please print in black ink.)]

Name _____
First Middle Last

Address _____

City _____ Street or RD # _____ State _____ Zip _____

Home Telephone (____) _____ [Work Telephone (____) _____]

Best Time to Call _____ a.m. _____ p.m. Male Female Date of Birth _____
Month Day Year

I wish to apply for the amount of insurance checked below. [If no amount is checked, smallest coverage amount is assumed.]

[\$10,000 \$8,000 \$6,000 \$4,000 \$2,000]

[Are you a U.S. Citizen? Yes No Social Security # _____ - _____ - _____]

Beneficiary Name _____ Relationship to Applicant _____
First Middle Last

PLEASE ANSWER THESE QUESTIONS:

Yes No Has illness or injury caused you to retire, or are you currently unable to work because of injury or illness?

Yes No Have you, within the past 5 years, been treated for or diagnosed by a physician as having insulin dependent diabetes; stroke; paralysis; heart disease or condition (except high blood pressure); cancer; kidney failure; lupus; chronic obstructive pulmonary disease (COPD) or emphysema; liver disorder; AIDS or AIDS Related Complex; mental disorder or disorder of the brain or spinal nerves; alcoholism or excessive use of alcohol?

Yes No Will the coverage you are applying for replace, discontinue, or change any life coverage or annuities?

AUTOMATIC PAYMENT AUTHORIZATION: By signing below, I (the member shown above) **authorize** CUNA Mutual Insurance Society to retain my account information and deduct premiums each month from my credit union [**share draft (checking)**] **account** for the life coverage applied for on this application. This authorization will remain in effect until revoked by me in writing or by telephone.

Deductions will be determined by the certificate effective date unless another date is selected. Circle the day of the month you prefer to be billed: [**1 5 10 15 20 25 Other Day** _____] (Note: Allow 2 business days from the above selected date for deductions to occur from your account. The *first* deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the deduction occurs.)

AGREEMENT: All my statements and answers are true to the best of my knowledge and belief. I understand this insurance becomes effective only if: 1) my application is approved and a certificate issued; 2) my first full payment is received while I am alive and within 21 days of my certificate's effective date; and 3) my health and other factors that affect approval of my application do not change between the date I sign this application and the effective date of coverage.

Date Signed

Member's Signature

Date Signed

Account Owner's Signature (If other than insured)

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 may be guilty of a crime and may be subject to fines, confinement in prison and denial of insurance benefits, depending on state law.

CUNA MUTUAL INSURANCE SOCIETY

[P.O. Box 61, Waverly, IA 50677]

[(Please print in black ink.)]

Name _____
First Middle Last

Address _____
Street or RD #

City _____ State _____ Zip _____

Home Telephone () _____ Best Time to Call _____ a.m. _____ p.m. [Work Telephone () _____]

Male Female Date of Birth _____ [Height _____ ft. _____ in. Weight _____ lbs]
Month Day Year

Amount Desired (check one). [If no amount is checked, smallest coverage amount is assumed.]

[\$10,000 \$8,000 \$6,000 \$4,000 \$2,000]

Beneficiary Name _____ Relationship to Applicant _____
First Middle Last

[Yes No Are you a U.S. Citizen? Social Security # _____ - _____ - _____]

PLEASE ANSWER THESE QUESTIONS:

- 1. Has illness or injury caused you to retire, or are you currently unable to work because of injury or illness?
2. Have you, within the past 5 years, been treated for or diagnosed by a physician as having:
a. cancer; chronic kidney disease or failure; chronic lung condition; liver disorder; AIDS or AIDS Related Complex; mental disorder or disorder of the brain or spinal nerves; paralysis; alcoholism; excessive use of alcohol or drugs?
b. stroke; heart disease or condition (except high blood pressure); peripheral vascular disease?
c. diabetes? (If yes, circle treatment(s): diet pills insulin)
3. Will the coverage you are applying for replace, discontinue, or change any life coverage or annuities?

AUTOMATIC PAYMENT AUTHORIZATION: By signing below, I (the member shown above) authorize CUNA Mutual Insurance Society to retain my account information and deduct premiums each month from my credit union [share draft (checking)] account for the life coverage applied for on this application. This authorization will remain in effect until revoked by me in writing or by telephone.

Deductions will be determined by the certificate effective date unless another date is selected. Circle the day of the month you prefer to be billed: [1 5 10 15 20 25 Other Day _____] (Note: Allow 2 business days from the above selected date for deductions to occur from your account. The first deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the deduction occurs.)

AGREEMENT: All my statements and answers are true to the best of my knowledge and belief. I understand this insurance becomes effective only if: 1) my application is approved and a certificate issued; 2) my first full payment is received while I am alive and within 21 days of my certificate's effective date; and 3) my health and other factors that affect approval of my application do not change between the date I sign this application and the effective date of coverage.

Date Signed

Member's Signature

Date Signed

Account Owner's Signature (If other than insured)

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 may be guilty of a crime and may be subject to fines, confinement in prison and denial of insurance benefits, depending on state law.

AUTOMATIC PAYMENT AUTHORIZATION: By signing below, I (the member shown above) **authorize** CUNA Mutual Insurance Society to deduct premiums each month from my **[share draft (checking)] account** for the life coverage(s) applied for on this application. This authorization will remain in effect until revoked by me in writing or by telephone.

Deductions will be determined by the certificate effective date unless another date is selected. Circle the day of the month you prefer for account deductions: [1 5 10 15 20 25 Other Day ____]

(Note: Allow 2 business days from the above selected date for deductions to occur from your account. The *first* deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the deduction occurs.)

X _____	X _____
Member's Signature	Spouse's Signature (if applying)
Date Signed	Date Signed
X _____	
Account Owner's Signature (If other than [Member])	
Date Signed	

B10f-036-2007(J)

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 may be guilty of a crime and may be subject to fines, confinement in prison and denial of insurance benefits, depending on state law.

RESIDENTS OF DC: 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.

Member Coverage Select the amount of [term] coverage (Check one): **Spouse Coverage** (if applying) Select the amount of [term] coverage for Spouse (Check one):

\$100,000.00 \$75,000.00 \$50,000.00]
 [If no amount is selected, lowest amount is assumed]

\$100,000.00 \$75,000.00 \$50,000.00]
 [If no amount is selected, lowest amount is assumed]

Please add \$25,000 Accidental Death Protection
 \$XX/mo. automatic (ages 18-49) \$XX/mo. automatic (ages 50-59)
 \$XX/mo. automatic (ages 60-69)

Please add \$25,000 Accidental Death Protection
 \$XX/mo. automatic (ages 18-49) \$XX/mo. automatic (ages 50-59)
 \$XX/mo. automatic (ages 60-69)

[Family Coverage Rider] Please Add:

Two Parent & Children Coverage [\$XX/mo. automatic]
 Single Parent & Children Coverage [\$XX/mo automatic]
 [The beneficiary for children and spouse coverage provided by the rider will be the primary insured to which it is attached.]

[Family Coverage Rider will be attached to the Member's certificate, if issued, otherwise to the Spouse's certificate, if issued.]

[Children's Coverage Rider (age 14 days to age 18)] [Please Add:]

[Please add][Please check if] [\$5,000] of children's insurance rider coverage [is desired]. [for the following children:]
 [List birth date of youngest child _____]

[Children's Coverage Rider will be attached to the Member's certificate, if issued, otherwise to the Spouse's certificate, if issued.] [The beneficiary for children's coverage provided by the rider will be the primary insured to which it is attached.]

[List name, birth date, and gender of eligible children age 14 days to age 18.]
 [If additional room is needed, use a separate sheet of paper and sign and date it.]

Child's Name	Child's Birth Date (mm/dd/yyyy)	Child's Gender
1.		<input type="checkbox"/> Male <input type="checkbox"/> Female
2.		<input type="checkbox"/> Male <input type="checkbox"/> Female
3.		<input type="checkbox"/> Male <input type="checkbox"/> Female
4.		<input type="checkbox"/> Male <input type="checkbox"/> Female

MEMBER INFORMATION **SPOUSE INFORMATION**

John A. Member
 123 Main Street
 Address Line 2
 Anytown, US 123456

Name _____
 Address _____
 City _____ State _____ ZIP _____

Social Security Number _____ Date of Birth _____ Age _____
 (_____) _____
 Home Phone Number _____ Best Time to Call a.m. p.m.
 (_____) _____
 Work Phone Number _____ Best Time to Call a.m. p.m.

Social Security Number _____ Date of Birth _____ Age _____
 (_____) _____
 Home Phone Number _____ Best Time to Call a.m. p.m.
 (_____) _____
 Work Phone Number _____ Best Time to Call a.m. p.m.

[Email Address] _____
 Are You a US Citizen? Yes No
 Gender M F _____
 Occupation _____
 _____ ft. _____ in. _____ lbs. _____
 Height _____ Weight _____ State Where Born _____

[Email Address] _____
 Are You a US Citizen? Yes No
 Gender M F _____
 Occupation _____
 _____ ft. _____ in. _____ lbs. _____
 Height _____ Weight _____ State Where Born _____

Beneficiary Name [Term Coverage Only] _____ Relationship to You _____

Beneficiary Name [Term Coverage Only] _____ Relationship to You _____

Your Physician or Clinic (If none, write "none") _____ City _____ State _____

Your Physician or Clinic (If none, write "none") _____ City _____ State _____

Date last seen by a Physician or Clinic: _____ / _____
 Month Year

Date last seen by a Physician or Clinic: _____ / _____
 Month Year

Reason for last visit: _____

Reason for last visit: _____

[CONTINUE ON BACK AND SIGN AND DATE]

PLEASE ANSWER THESE QUESTIONS:	MEMBER	SPOUSE
---------------------------------------	---------------	---------------

- Will the coverage applied for replace, discontinue, or change any existing life coverage or annuities in this or any other company?** Yes No Yes No
1. Have you, in the past 5 years, had your driver's license suspended or revoked, or received 3 or more moving violations? Yes No Yes No
 2. Are you involved in the operation of any non-commercial aircraft or involved in any hazardous sports? Yes No Yes No
 3. Are you now using, or during the past 5 years have you used, narcotic or hallucinogenic drugs other than those administered by a doctor? Yes No Yes No
 4. Have you ever had any insurance declined, postponed, altered or offered at a higher premium (Missouri Residents: postponed, altered or offered at a higher premium)? Yes No Yes No
 5. Have you used any form of tobacco in the last 12 months?..... Yes No Yes No
 6. Have you ever been treated or diagnosed by a member of the medical profession as having:
 - a.) diabetes; high blood pressure; cancer; heart condition; lupus; paralysis or stroke; alcoholism; or disorders related to: intestines; breathing; blood; seizures; mental or nervous system; muscles; liver; or kidney? Yes No Yes No
 - b.) Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for antibodies to the AIDS virus? Yes No Yes No
 7. During the last 5 years, have you consulted a physician or received treatment for any disease, injury, or illness not listed in Question number 6? Yes No Yes No
 8. Are you now unable to work because of any illness or injury?..... Yes No Yes No

[Give dates and details below for any "Yes answers to questions 1-8 above. If more space is needed, attach a signed and dated separate sheet.]

Question Number	Name of Person	Details or Reasons	Dates		Details of Treatment or Follow-Up	Name & Address of Physician, Clinic or Hospital
			Began	Ended		

TEMPORARY INSURANCE AGREEMENT: This Agreement provides temporary life insurance on the proposed insured(s) for a limited time while the Company considers your application for coverage. The temporary coverage amount is limited to the amount of term life coverage applied for up to a maximum benefit of \$75,000 per proposed insured. [It does not apply to any rider.]

TEMPORARY COVERAGE BEGINS under this Agreement when we receive your application in our Administrative Office along with the full first premium required by the Company.

TEMPORARY COVERAGE ENDS automatically under this Agreement on the EARLIEST of the following: (1) When coverage starts under the certificate applied for or we offer coverage other than as applied for; (2) When we mail notice to the owner of our decision to decline the application or terminate coverage under this Agreement; (3) When you request cancellation; or (4) [60] days after the date of the application.

TEMPORARY COVERAGE EXCLUSIONS. No coverage will take effect under this Agreement if: (1) Any proposed insured commits suicide (and for Missouri residents, we can show that s/he intended suicide at the time of this Agreement); (2) Any proposed insured has received, sought or had recommended any treatment for cancer, stroke, or any disease or disorder of the heart, liver or immune system within the past 12 months; (3) Any proposed insured has been advised to be hospitalized or is a patient in a hospital or medical facility at the time of this Agreement; (4) The application contains material misrepresentation or is fraudulently completed; or (5) Payment of premium is not honored for payment when first presented or the Company is unable to collect the first premium payment due to incomplete or incorrect payment information.

IF ANY OF THE CONDITIONS OF THIS AGREEMENT ARE NOT MET, IT IS NOT IN EFFECT AND THE COMPANY'S SOLE LIABILITY WILL BE TO RETURN ANY PREMIUM RECEIVED TO YOU.

[CONTINUE ON BACK AND SIGN AND DATE]

PAYMENT INFORMATION

AUTOMATIC PAYMENT AUTHORIZATION: By signing below, I (the member shown above) **authorize** CUNA Mutual Insurance Society to retain my account information and deduct premiums each month from my credit union **[share draft (checking)] account** for the life coverage applied for on this application. This authorization will remain in effect until revoked by me in writing or by telephone.

Deductions will be determined by the certificate effective date unless another date is selected. Circle the day of the month you prefer to be billed: [**1 5 10 15 20 25 Other Day ____**]

(Note: Allow 2 business days from the above selected date for deductions to occur from your account. The *first* deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the deduction occurs.)

[AGREEMENT – AUTHORIZATION – SIGNATURE]

I declare that I am a credit union member, or the spouse of a member. All my statements and answers are true to the best of my knowledge and belief. I understand insurance becomes effective [except as stated in the Temporary Insurance Agreement] only if: (1) my application is approved and a certificate issued; (2) my first full payment is received while I am alive and within 21 days of my certificate's effective date; and (3) my health and other factors that affect approval of my application do not change between the date I sign this application and the effective date of coverage.

I authorize any health care providers, pharmacy benefit manager or other pharmaceutical firm, insurance companies, MIB, Inc., consumer reporting agency, the Department of Motor Vehicles, financial institution, or employer having information about my physical or mental condition, prescription drug records, financial status, employment status, or other relevant information about me, to give all information (except psychiatric treatment notes) to CUNA Mutual Insurance Society ("Company") or its reinsurers to determine eligibility for insurance or benefits. Information obtained will be released only to reinsurers, MIB, Inc., persons performing business duties as delegated or contracted for by the Company related to my application and subsequent insurance-related functions, as permitted or required by law, or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I agree this authorization is valid for 24 months, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims or process applications and may be a basis for denying this application or a claim for benefits. The Notice to Applicant has been received by me.

X _____
Member's Signature Date Signed

X _____
Spouse's Signature (if applying) Date Signed

X _____
Account Owner's Signature (if other than Member/Spouse) Date Signed

B10f-037-2007(J)

In order to qualify for this coverage, applicants may be required to undergo a paramedical examination and blood/urine testing which will include testing for the presence of antibodies to the AIDS virus. Applicants will receive additional information and be required to authorize the tests(s) to be performed. Based on your health and other factors affecting your insurability, you may be offered a higher premium rate or you may be denied coverage.

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 may be guilty of a crime and may be subject to fines, confinement in prison and denial of insurance benefits, depending on state law.

RESIDENTS OF DC: 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.

SERFF Tracking Number: CUNA-126285095 State: Arkansas
Filing Company: CUNA Mutual Insurance Society State Tracking Number: 43379
Company Tracking Number: B10F-029-2003 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NAIC Replacement Model
Project Name/Number: Replacement Regulation/

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR Cert of Comp w Rule 19.pdf

AR Flesch Cert.pdf

Item Status:

Status

Date:

Bypassed - Item: Application

Bypass Reason: This is an application filing.

Comments:

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: CUNA Mutual Insurance Society

Form Number(s): B10f-029-2003; B10f-029-2003(J); B10f-029-2003v1; B10f-029-2005; B10f-036-2007(J); B10f-037-2007(J).

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Alastair Shore

Name

Senior Vice President, Chief Underwriter

Title

August 28, 2009

Date

CERTIFICATION

This is to certify that the attached Policy Forms comply with the requirements of the Life and Disability Insurance Policy Language Simplification Act. The Flesch reading ease scores for these form(s) are shown below.

Form Number(s) and Title(s):	Flesch Score:
B10f-029-2003 2003 2QWL Application	50
B10f-029-2003(J) 2003 2QWL Spouse Application	47.5
B10f-029-2003v1 2QWL Application	50
B10f-029-2005 2005 2QWL Application	52.1
B10f-036-2007(J) Group Term to Age 80 Application	51.9
B10f-037-2007(J) Group Term to Age 80 Application	50.9



Signature of Officer of the Company

August 28, 2009
Date