Filing at a Glance

Company: EMC National Life Company
Product Name: Simplified Issue Term Life Application
SERFF Tr Num: EMCN-126281360
State: Arkansas
TOI: L04I Individual Life - Term
SERFF Status: Closed-Approved-Closed
State Tr Num: 43380
Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Co Tr Num:
State Status: Approved-Closed
Filing Type: Form
Reviewer(s): Linda Bird
Author: Daryl Schoenfeld
Disposition Date: 09/02/2009
Date Submitted: 08/28/2009
Disposition Status: Approved-Closed
Implementation Date Requested: On Approval
Implementation Date:
State Filing Description:

General Information

Project Name:
Status of Filing in Domicile: Authorized
Project Number:
Date Approved in Domicile: 08/24/2009
Requested Filing Mode: Review & Approval
Domicile Status Comments: Filed and approved.
Explanation for Combination/Other:
Market Type: Individual
Submission Type: New Submission
Group Market Size:
Overall Rate Impact:
Group Market Type:
Filing Status Changed: 09/02/2009
Explanation for Other Group Market Type:
State Status Changed: 09/02/2009
Deemer Date:
Created By: Daryl Schoenfeld
Submitted By: Daryl Schoenfeld
Corresponding Filing Tracking Number:
Filing Description:

Attached for your review and approval is a new application form EAP008 (8-09) for simplified issue term life insurance. It is a new form and it will not replace any previously approved forms. The application will be used to solicit our Renewable Term Life Insurance to Age 95 product ELP240 (4-07) which was previously approved April 16, 2007.

Our licensed representatives will use this application when meeting with clients face-to-face and applying online for

individual term life insurance. The information needed to complete the application is input into the agent's computer. A number of different screens open in series on the computer and information is entered to fill out the application. Once completed, the information is transmitted to the home office via a secured web protocol. At the end of the process the completed application will be printed and be formatted the same as the application submitted in this filing. This electronic process is convenient for our agents and policyholders and helps ensure that information is complete and accurate and can be processed quickly.

The online screens will be used to
(1) Record the applicant's pertinent and personal information
(2) Indicate the applicant's desired term period and amounts of coverage
(3) Record the applicant's answers to underwriting questions

The online screens will also be used to ensure completion of proper representations and authorizations, including the fraud warning language. The policy obtained through this application process will not replace any existing coverage currently held by the applicant, so no replacement notices or forms are involved.

The application process complies with the Uniform Electronic Transaction Act. The applicant can review and/or correct any information entered into the application screens before signing the application. Appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it. Both internal and external safeguards for electronic information have been implemented by our Technical Services Department.

This submission contains no unusual or possibly controversial items which may deviate from normal company or industry standards. Please inform us of your approval. Thank you.

Company and Contact

Filing Contact Information

Daryl Schoenfeld, Assistant Secretary
4095 NW Urbandale Drive
Urbandale, IA 50322-7914
Dschoenfeld@emcnl.com
515-237-2032 [Phone]

Filing Company Information

EMC National Life Company
4095 NW Urbandale Drive
Urbandale, IA 50322-7914
(515) 645-4000 ext. 4094[Phone]

CoCode: 62928
Group Code:
Group Name:
FEIN Number: 42-0868851

State of Domicile: Iowa
Company Type: L and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
EMC National Life Company	$50.00	08/28/2009	30185625

Correspondence Summary

Dispositions

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

SERFF Tracking Number:	*EMCN-126281360*	*State:*	*Arkansas*
Filing Company:	*EMC National Life Company*	*State Tracking Number:*	*43380*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Simplified Issue Term Life Application*		
Project Name/Number:	*/*		

Disposition

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

Rate data does NOT apply to filing.

SERFF Tracking Number:	*EMCN-126281360*	*State:*	*Arkansas*
Filing Company:	*EMC National Life Company*	*State Tracking Number:*	*43380*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Simplified Issue Term Life Application*		
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	Simplified Issue Term Application		Yes

Form Schedule

Lead Form Number: EAP008 (8-09)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	EAP008 (8-09)	Application/ Enrollment Form	Simplified Issue Term Application	Initial		52.000	EAP008(8-09).pdf

EMC NATIONAL LIFE COMPANY

LIFE APPLICATION

P.O. BOX 9144 • DES MOINES, IA 50306-9144

1.

Proposed Insured Name (First, M.I., Last)	Age	Birthdate Mo-Day-Yr	Birth State	Social Security Number	Sex	Height	Weight

Address: _____
No. & Street City State Zip

Proposed Insured's phone numbers (include area codes): Home (_____)_____ Business (___)_____

Are you a U.S. Citizen? ☐ Yes ☐ No

Employment	Employer Name	Employer Address	# of Years	Ann. Earned Income
Insured				
	Occupation (Duties)			

2. Beneficiaries

	Name (First, M.I., Last)	Address	Birthdate	Soc. Sec./TIN	Relationship
Primary					
Contingent					

3. Life Insurance/Annuities in Force

Does the proposed insured have any life insurance policies or annuity contracts in force? ☐ Yes ☐ No

Is this policy being purchased to replace any existing life insurance policy or annuity contract? ☐ Yes ☐ No

Does the proposed insured have any life insurance with EMC National Life Company? ☐ Yes ☐ No

4.

Additional Person to Receive Lapse Notification (if desired): _____
Full Name Address/City/State/Zip

5. Additional Information _____

_____

_____

6.

Renewable Term Life Insurance to age 95

Level Term for: _____ Years Amount of Coverage: $_____

7.

Payment Option

☐ Check Plan ☐ Credit Card ☐ Other _____

Premium Mode

Mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly

8. Has the person proposed for coverage:

	Yes	No
A. Have any other application for personal insurance pending?	☐	☐
B. Within the last ten years applied for life, health, or disability insurance or reinstatement which was declined, postponed, rated, restricted or modified?	☐	☐
C. Within the last two years have you engaged in aviation activity other than as a passenger?	☐	☐
D. Within the last two years, have you engaged in ballooning, sky diving, racing, mountain climbing, rodeo competition, SCUBA diving or any hazardous sport or activity, or intentions to engage in such activities over the next 12 months?	☐	☐
E. Within the last three years, had a driver's license suspended or revoked for any reason, or been charged with or convicted of driving while intoxicated or under the influence of a controlled substance, or had more than two moving (traffic) violations?	☐	☐
F. Within the last ten years have you been convicted of a felony or are you currently on parole or probation?	☐	☐
G. (1) Have you ever used tobacco in any form?	☐	☐
(2) If yes, have you used any tobacco products within the last 12 months?	☐	☐

9. A. Within the last ten years, has the person proposed for coverage:	Yes	No
(1) Had any diagnosis or treatment for: high blood pressure not controlled by medication, chest pain or angina, heart attack, stroke, or disease or disorder of the heart, heart valves, blood, or blood vessels?	☐	☐
(2) Had any diagnosis or treatment for: cancer (except for basal cell or squamous cell skin cancer), tumor, leukemia, epilepsy, diabetes, hepatitis, disease or disorder of the pancreas, stomach or intestines, brain or nervous system, kidney or liver?	☐	☐
(3) Had any diagnosis or treatment for: lung disorders including emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, tuberculosis or asthma (except for mild or exercise induced)?	☐	☐
(4) Been diagnosed as having or been treated for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a member of the medical profession?	☐	☐
(5) Been diagnosed as having or been treated for any immune deficiency disorder or autoimmune or connective tissue disease or disorder (not HIV related)?	☐	☐
(6) Had mental illness, including depression or anxiety requiring inpatient treatment or hospitalization, bipolar disorder or history of suicide attempt?	☐	☐
(7) Except as prescribed by a physician, ever used marijuana, heroin, cocaine, barbiturates or other illegal drugs, joined any organization, received or had treatment or counseling for drug or alcohol abuse?	☐	☐
B. Within the last five years has the person proposed for coverage been hospitalized for treatment of any disease or condition not stated above?	☐	☐
C. Is the person proposed for coverage currently awaiting surgery, diagnostic testing, results of diagnostic testing or been advised to have diagnostic testing or consultation with a medical practitioner?	☐	☐

10. Taxpayer Identification Certification. Per Internal Revenue Service guidelines, use this area to report and certify the taxpayer identification number (typically this is your social security number or an employer identification number) of the owner of the policy.

Under penalties of perjury, by my signature on this form on page 3, I certify that:

1. The number shown on this form on page 1 is my correct taxpayer identification number, **and**
2. I am not subject to backup withholding either because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

11. Representations and Acknowledgments. I, the undersigned, represent, agree to and understand the following:

A. All of the answers and statements in this application are true, complete and correctly recorded and I agree that this application and any policy, amendments and riders shall constitute the entire contract.

B. The agent is not authorized to waive answers to any questions, modify the contract or grant acceptability of insurance and that notice to or knowledge of the agent, or any other person concerning the health or insurability of any proposed insured shall not be notice to or knowledge of the Company unless it is fully disclosed in writing in this application or as a signed and dated attachment.

C. I have received a copy of the Fair Credit Reporting Act and MIB, Inc. notices.

D. Fraud Information: The Company is relying on the information in this application to qualify all persons proposed for coverage under this insurance policy. Any false statement or misrepresentation may result in loss of coverage under this policy. 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. Caution: Read your state's specific fraud warning (as applicable).

STATE SPECIFIC FRAUD WARNINGS

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

FLORIDA – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KANSAS and WASHINGTON – 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 as determined by a court of law.

KENTUCKY – 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.

MAINE – 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.

MARYLAND – Any person who knowingly and willfully presents a false or 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.

NEBRASKA and TEXAS – Any person who knowingly presents a false or fraudulent claim for payment for 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 and confinement in prison.

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 the 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.

OKLAHOMA – 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 is guilty of a felony.

PENNSYLVANIA – 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.

TENNESSEE – 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.

VERMONT – Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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.

X_____	_____	_____
Proposed Insured's Signature	Signed At City/State	Date

Required Agent Report I, as agent, represent the following:

A. That I have accurately recorded information given to me by all persons proposed for coverage.

B. That I ☐ did ☐ did not see all persons proposed for coverage. If not, please explain _____

C. To the best of my knowledge, the insurance applied for ☐ will ☐ will not replace any existing life insurance policy or annuity contract.

_____	X_____	_____	_____	_____
Agent's Printed Name	Agent's Signature (witness)	Agent's Contract #	Commission %	Date

Commission Split if applicable:	_____	_____	_____
	Agent's Name	Agent's Contract #	Commission %

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the undersigned, understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, P.O. Box 9144, Des Moines, Iowa 50306-9144 or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.
- Protected Health Information: Any and all records and health information within such Medical Person's possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

This authorization will remain in effect from the date signed below for a period of two years, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to EMCNL at the address above. The right to revoke this authorization is limited to the extent that EMCNL has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize EMC National Life Company to obtain an investigative consumer report on me, if required.

X_____	_____	_____
Signature of Proposed Insured	Printed Name	Date

— ALWAYS DETACH AND GIVE TO APPLICANT —

FAIR CREDIT REPORTING ACT

In Compliance with 15 USC 1681 et. seq., this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, P.O. Box 9144, Des Moines, IA 50306-9144 within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. EMC National Life Company or its Reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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].

EMC National Life Company, or its Reinsurer(s) may also release information from its file to other 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.

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Certifications attached.

Attachments:

AR Certificate of Compliance.pdf
AR Readability Certification.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: NA This is an application submission.

Comments:

STATE OF ARKANSAS

CERTIFICATE OF COMPLIANCE

I hereby certify that this submission complies with the Arkansas Rule and Regulation 19 which relates to eliminating the act of denying benefits or coverage on the basis of sex or marital status in the terms and conditions of insurance contracts or underwriting criteria, as applicable.

I hereby certify that this submission complies with the Arkansas Rule and Regulation 49 which relates to providing Life and Health Guaranty Association notices, as applicable.

I hereby certify that this submission complies with the Arkansas Statutes – Insurance Laws 23-79-138 which relates to required policy information on every policy of life insurance, accident and health insurance issued, as applicable.

Daryl Schoenfeld
Assistant Secretary

August 28, 2009
Date

AR3

READABILITY

CERTIFICATION

I certify to the best of my knowledge that form EAP008 8-09) is readable based on the factors specified in Sections 66-3251 to 66-3258 of the Arkansas Statutes. The Flesch Scores are as follows:

Form Number	Flesch Score
EAP008 (8-09)	52

Daryl Schoenfeld
Assistant Secretary

August 28, 2009
Date

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