

SERFF Tracking Number: FEMC-126290510 State: Arkansas
Filing Company: Federated Life Insurance Company State Tracking Number: 43405
Company Tracking Number: L-17(02-09)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Reinstatement App
Project Name/Number: L-17/L-17

Filing at a Glance

Company: Federated Life Insurance Company

Product Name: Reinstatement App

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: FEMC-126290510 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 43405

Co Tr Num: L-17(02-09)

Author: Carolyn Kanne

Date Submitted: 09/02/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 09/03/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: L-17

Project Number: L-17

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/03/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/03/2009

Created By: Carolyn Kanne

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Carolyn Kanne

Filing Description:

Form L-17 (02-09) is a supplemental application for use in reinstatement and rate reconsideration situations. It has been printed in 10-point type with language to comply with standard readability regulations.

Company and Contact

Filing Contact Information

Carolyn Kanne, Life Product Compliance

crkane@fedins.com

Specialist

121 East Park Square

800-533-0472 [Phone]

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PO Box 328 507-444-4812 [FAX]
Owatonna, MN 55060

Filing Company Information

Federated Life Insurance Company CoCode: 63258 State of Domicile: Minnesota
121 East Park Square Group Code: 7 Company Type:
PO Box 328 Group Name: State ID Number:
Owatonna, MN 55060 FEIN Number: 41-6022443
(800) 533-0472 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: Fee listed for this type of form.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federated Life Insurance Company	\$20.00	09/02/2009	30286523

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/03/2009	09/03/2009

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Disposition

Disposition Date: 09/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Form	Supplemental Application for Life and Disability Income		Yes

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Form Schedule

Lead Form Number: L-17 (02-09)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-17 (02-09)	Application/ Supplemental Enrollment Form and Disability Income Application for Life and Disability Income	Initial		51.450	L-17 (02-09).pdf

Supplemental Application for Life and Disability Income

Instructions:

1. If your name has changed since the original policy was issued, provide both names and the reason for the change in section A.
2. Other than the primary insured (you), list any other persons insured under the policy. Give names and dates of birth of each other person. If any of the other insureds have died, please indicate which ones and their date of death.
3. Personal physician in section C includes physician's assistants and nurse practitioners. If you do not have a personal physician, write "none."
4. Attach an additional sheet if necessary to provide more details than space allows.
5. Other income includes rent, interest, dividends, etc.
6. Pages 1 - 2 and the authorization may be mailed to our Home Office at the address below.

Federated Life Insurance Company
121 East Park Square
Owatonna, MN 55060
(800) 533-0472

SUPPLEMENTAL APPLICATION - LIFE AND DISABILITY INCOME

For purposes of this application, "you" and "your" refers to the insured

A. Insured

1. Name of Insured:	2. Policy Number:	3. Phone Numbers: Home:
4. Address of Insured:		Work: Cell:

B. Application Information

This is an application for: Reinstatement Other (list):

List all insureds other than the insured listed above covered under the policy. (Give name and date of birth)

C. Medical Information - Provide details in C-9 below. Attach an additional sheet if necessary.

1.a. Full name and address of personal physician:	b. Phone Number:	
c. Date and Reason Last Consulted:		
2. Other medical providers seen in the past five years (include doctors, chiropractors, and therapists, date last seen and reason):		
3.a. Height:	3.b. Weight:	4. All Current Medications:
5. Have you ever had, been told you had, or received treatment for any of the following conditions (circle those that apply and give details in C-9 below):		Yes No
a. Arthritis; Disorder of Muscles, Bones, or Joints; Carpal Tunnel Syndrome; Back Pain or Back Disorder		
b. Asthma; Emphysema; Chronic Bronchitis; Sleep Apnea; or other Respiratory Disorder		
c. Anemia; Blood Disorder; Circulatory Disorder, Transient Ischemic Attack (TIA), or Stroke		
d. Chest Pain; Heart Murmur; or High Blood Pressure; Heart Disease or Heart Attack		
e. Brain or Nervous System Disorder; Multiple Sclerosis; Epilepsy or Seizures.....		
f. Diabetes or High Blood Sugar; Thyroid, Pancreas, or Endocrine Disorder		
g. Digestive or Intestinal Disorder; Hepatitis, Cirrhosis, or other Liver Disorder		
h. Kidney, Bladder, or Prostate Disorder, Urinary Tract or Reproductive System Disorder		
i. Cancer, Leukemia, Lymphoma, or Melanoma; Skin Disorder		
j. Depression, Stress, Anxiety, Other Psychological Disorder, Nerve or Nervous System Disorder		
6. Has your weight changed more than ten (10) pounds in the past year?		
7. Within the past 90 days, have you been admitted to a medical facility; been advised by a medical professional to be admitted; had surgery performed or recommended; or been advised by a medical professional to have a diagnostic test other than an HIV test?		
8. Any disease, disorder, syndrome or condition not listed above?		
9. Details to questions 1-8 (Include question #, dates, treatments/tests, and names/addresses of care providers.)		

D. Tobacco History

1.a. Have you ever used cigarettes or any other form of tobacco or nicotine based products? No Yes	b. Type - check all that apply Cigarettes Other _____	c. Usage per Day/Week d. Date of Last Use
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E. Personal Information <i>(If "yes," provide details in "Details" section below.)</i>	Yes	No
1. Do you have family history (parent or sibling) of heart or kidney disease, cancer, or stroke prior to age 60? (Provide age of diagnosis and death, if applicable).....		
2. Have you ever been refused life, health, or disability income insurance; charged additional premium; or had a request for reinstatement denied?		
3. In the past ten (10) years, have you used any illegal drug or controlled substance except as prescribed by a physician, or been advised to limit alcohol or received treatment for alcohol abuse or other addiction?		
4. In the past ten (10) years, have you been convicted of a misdemeanor, gross misdemeanor, or felony?		
5. In the last three (3) years, have you received a moving violation, been cited for a DUI/DWI, or had your driver's license restricted or revoked?		
6. In the last three (3) years, have you flown as a pilot, student pilot, or crewmember, or do you intend to do so?.....		
7. In the last three (3) years, have you engaged in any kind of racing; scuba or sky diving; hang-gliding; rock or mountain climbing; or any extreme or similar sports; or do you intend to do so?		
8. Do you intend to reside or travel outside the US or Canada within the next year?		

F. Personal Financial Information <i>(required for Life and Disability Income) - complete all questions</i>	
1. Job title/Occupation: _____	2. No. of hours worked per week: _____
3. Annual income - salary, wages, bonus, commission, etc.: \$ _____	
4. Annual income - other: \$ _____	5. Source of other income: _____
6. Have you ever filed for business or personal bankruptcy? No Yes (provide type, initiation date, discharge date in "Details")	
7. Employer's Name: _____	8. Employer's Address: _____

G. Details for Sections E and F - Attach an additional sheet if necessary.

AGREEMENT

The insured and the owner (if other than the insured), understand and agree that:

1. The insured authorizes and consents to this application for insurance.
2. This application shall be the basis for any policy issued or reinstated on this application.
3. The insured represents that the statements and answers given in this application are true, complete, and correctly recorded.
4. Conditional Receipt: No new insurance requested above (including a reinstatement) shall be in force until: (a) any required payment for the request is paid in full; (b) the request is approved by the Company while the facts and health condition of the insured remains the same as represented in this application; and (c) all of the statements and answers given in this Application are true and complete as of the date of Owner's personal receipt of the policy or notification that the policy has been reinstated. Even if the Company accepts payment made with this application, it may decline the request. The Company may require additional evidence of insurability before approving this request.
5. The insured will inform Federated Life Insurance Company of any changes in the proposed insured's health, mental or physical condition, or of any changes to any answers on this application, prior to or upon notification that this application has been approved.
6. No agent, marketing representative, telephone interviewer, or medical examiner is authorized to determine insurability, modify or waive any terms of this application or waive any of the Company's rights or requirements.
7. Knowledge of any fact not disclosed on this application on the part of any agent, marketing representative, telephone interviewer, medical examiner, or other person will not be considered knowledge by the company.
8. Incomplete statements or answers do not diminish the validity of other statements made in the application.
9. **INCONTESTABILITY:** if this policy is reinstated based on this application, the reinstatement date for the purpose of incontestability shall be the date Federated Life approved this application.

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

Signed this _____ day of _____, 20____ at _____ City _____ State _____ ZIP Code _____

Printed Name of Insured

Printed Name of Owner (if other than Insured)

Signature of Insured

Signature of Owner (if other than Insured)

NOTICE: TO BE GIVEN TO PROPOSED INSURED

We are glad you are applying to reinstate your Federated policy. There may be some significant benefits to reinstating an existing policy over applying for new coverage. We value your business.

Before a policy can be reinstated, we may need to obtain additional information. These underwriting requirements allow us to gather information needed in an efficient manner. Depending upon your health, your age and the amount of insurance, we may request you to complete one or more of these requirements:

- Telephone Interview.
- Exam to include blood specimen, urine specimen, blood pressure, height and weight.
- EKG or Treadmill EKG.
- Consumer Report.

We may contact you through a Federated employee who is a specially trained interviewer or use an outside agency. The telephone interview usually takes less than twenty (20) minutes. The information obtained in interview may become part of your application for insurance.

Conditional Receipt: No insurance requested (including a reinstatement) shall be in force until: (a) any required payment for the request is paid in full; (b) the request is approved by the Company while the facts and health condition of the insured remains the same as represented in this application; and (c) all of the statements and answers given in this Application are true and complete as of the date of Owner's personal receipt of the policy or notification that the policy has been reinstated. Even if the Company accepts payment made with this application, it may decline the request. The Company may require additional evidence of insurability before approving this request.

PRIVACY NOTICE

Your application is our main source of information. In addition, your health and lifestyle are two of the most important factors we consider when evaluating your application. As part of this evaluation we may: ask doctors or medical facilities for information about you; obtain information from the MIB, Inc., (50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone (866) 692-6901 Website www.mib.com), a consumer reporting agency and/or a credit reporting agency; and/or obtain information from other insurance companies you have applied to in the past. We and our affiliates use this information to evaluate this insurance application, existing insurance coverage, and eligibility for insurance coverages that we or our affiliates offer.

CONSUMER REPORTS

An investigative consumer report may be made to help us determine your eligibility for the insurance you have requested. This report may concern your lifestyle, character, general reputation and personal characteristics such as health, occupation, finances, and credit history. When applicable, it will also involve information on such matters as your driving record, health history, use of alcohol or drugs, and hazardous sports participation.

The consumer reporting agency may obtain information by interviewing you or members of your family, business associates, financial institutions and acquaintances. You may ask that the agency interview you in person or by telephone. This information is for insurance purposes only. We will not reveal it to anyone without your authorization. However, the consumer-reporting agency may retain and release information to others under certain circumstances. If you ask and give proper identification, the agency will provide you with a copy of the report and explain their retention and release practices.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file.

We are requesting information on this application in order to verify your identity as required by Federal Law. We reserve the right to request additional identifying information from you as needed to comply with Federal Law.

Please contact us if you wish to know more about the nature and scope of these reports and how we use them.

IMPORTANT NOTICES

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

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.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR cert for rule 19.pdf CO-60.pdf		
Bypassed - Item: Application Bypass Reason: Not applicable to this application submission Comments:		
Satisfied - Item: Cover Letter Comments: Attachment: AR Letter.pdf		

FEDERATED LIFE INSURANCE COMPANY

Owatonna, Minnesota

September 2, 2009

CERTIFICATE OF COMPLIANCE

Arkansas

L-17 (02-09) Supplemental Application for Life and Disability Income

This submission meets the provisions of Rule and Regulation 19, as well as all applicable requirements of the Arkansas Insurance Department.

A handwritten signature in black ink, reading "Allan E. Meyer". The signature is written in a cursive style with a horizontal line under the name.

Allan E. Meyer
Vice President

FEDERATED LIFE INSURANCE COMPANY

Owatonna, Minnesota

CERTIFICATE OF COMPLIANCE

Arkansas

Flesch Score

This is to certify that the attached Individual Life Forms No. (listed above) have achieved a Flesch Reading Ease Score of (shown above) and comply with the requirements of Arkansas Stat. Ann. § 66-3251, cited as the Life and Disability Insurance Policy Language Simplification Act.

The guidelines of Bulletin 11-83 have been reviewed and this submission is in compliance with these guidelines.



121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

September 2, 2009

Mr. Dan Honey
Compliance – Life & Health
Department of Insurance
1200 West Third St
Little Rock, AR 72201-1904

**INDIVIDUAL LIFE & DI FILING:
L-17 (02-09) SUPPLEMENTAL APPLICATION**

Dear Mr. Honey:

Attached is a copy of the above listed form, submitted for your review and approval for use in Arkansas. This is a new form, never before submitted to your department.

Form L-17 (02-09) is a supplemental application for use in reinstatement and rate reconsideration situations. It has been printed in 10-point type with language to comply with standard readability regulations. The Flesch Scale analysis score for this form is 51.45 when scored with the policy.

We respectfully request your review and approval of this filing for use in Arkansas.

Sincerely,

A handwritten signature in cursive script that reads "Carolyn Kanne".

Carolyn Kanne, FLMI, ACS, AIRC
Life Contract Compliance Analyst
(800) 533-0472, ext. 5214
Federated Life Insurance Company
Email: crkane@fedins.com
NAIC #007-63258