

SERFF Tracking Number: LBLI-126301095 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 43554
Company Tracking Number: DTA300SEN(10-09)ET AL
TOI: L04G Group Life - Term Sub-TOI: L04G.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium
Product Name: Sentinel Agent Assisted Application
Project Name/Number: /

Filing at a Glance

Company: Liberty Life Insurance Company

Product Name: Sentinel Agent Assisted Application SERFF Tr Num: LBLI-126301095 State: Arkansas

TOI: L04G Group Life - Term SERFF Status: Closed-Approved- Closed State Tr Num: 43554

Sub-TOI: L04G.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium Co Tr Num: DTA300SEN(10-09)ET State Status: Approved-Closed AL

Filing Type: Form Reviewer(s): Linda Bird

Authors: Julie Duncan, Holly Carver, Dianne Harris Disposition Date: 09/25/2009

Date Submitted: 09/21/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Pending

Project Number: Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments: Filed Simultaneously

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small and Large

Overall Rate Impact: Group Market Type: Trust

Filing Status Changed: 09/25/2009 Explanation for Other Group Market Type:

State Status Changed: 09/25/2009

Deemer Date: Created By: Dianne Harris

Submitted By: Dianne Harris Corresponding Filing Tracking Number:

Filing Description:

Form Number DTA300SEN(10-09)AR

Liberty Life Insurance Company, NAIC Co. No. 61492, Group 0000, FEIN 44-0188050

The referenced form is being submitted for your review and approval. This is a new form and will not replace any forms

SERFF Tracking Number: LBLI-126301095 State: Arkansas
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Fixed/Indeterminate Premium

Product Name: Sentinel Agent Assisted Application

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currently on file with your department. This application form is to be used with policy form number L-338 et al, which was approved by your department on 5-15-89 and recently updated for 2001 CSO on 4-30-08.

Form Number DTA300SEN(10-09)AR is an application to be used with the above referenced decreasing term life product. This application will be used to market this product through licensed brokers, including mortgage brokers. We may also use this application for internet sales, telesales, and other licensed agent sales. Please find attached a bracketed version completed in John Doe fashion. All bracketed sections are considered variable, and an Explanation of Brackets is enclosed to explain each variable section. The applicants' and/or agents' signatures may be captured traditionally with a wet signature, electronically or via voice signature.

The form submitted is in final print and is subject to only minor modification in paper size and stock, formatting, ink, border, Company logo, and adaptation to computer printing.

To the best of my knowledge and belief, these forms comply with the statutory and regulatory requirements of your state. These forms contain no unusual or possible controversial items from normal company or industry standards. Please contact me if you need additional information. If you have any questions or need additional information, please contact me at 864-609-8350 or by email at Dianne.K.Harris@rbc.com.

Company and Contact

Filing Contact Information

Dianne Harris, Compliance Analyst dianne.k.harris@rbc.com
2000 Wade Hampton Blvd 864-609-1198 [Phone]
Greenville, SC 29615 864-609-1039 [FAX]

Filing Company Information

Liberty Life Insurance Company CoCode: 61492 State of Domicile: South Carolina
2000 Wade Hampton Blvd Group Code: Company Type:
Greenville, SC 29602 Group Name: State ID Number:
(864) 609-4815 ext. [Phone] FEIN Number: 44-0188050

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:

SERFF Tracking Number: LBLI-126301095 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 43554
Company Tracking Number: DTA300SEN(10-09)ET AL
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Fixed/Indeterminate Premium
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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty Life Insurance Company	\$20.00	09/21/2009	30701766

SERFF Tracking Number: LBLI-126301095 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	09/25/2009	09/25/2009

SERFF Tracking Number: *LBLI-126301095* *State:* *Arkansas*
Filing Company: *Liberty Life Insurance Company* *State Tracking Number:* *43554*
Company Tracking Number: *DTA300SEN(10-09)ET AL*
TOI: *L04G Group Life - Term* *Sub-TOI:* *L04G.314 Decreasing - Joint (First to Die) -
Fixed/Indeterminate Premium*

Product Name: *Sentinel Agent Assisted Application*
Project Name/Number: /

Disposition

Disposition Date: 09/25/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *LBLI-126301095* State: *Arkansas*
 Filing Company: *Liberty Life Insurance Company* State Tracking Number: *43554*
 Company Tracking Number: *DTA300SEN(10-09)ET AL*
 TOI: *L04G Group Life - Term* Sub-TOI: *L04G.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium*

Product Name: *Sentinel Agent Assisted Application*

Project Name/Number: */*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Explanation of Variability		Yes
Form	Decreasing Term Life Insurance Application		Yes

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Form Schedule

Lead Form Number: DTA300SEN(10-09)et al

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	DTA300SE N(10- 09)AR	Application/ Enrollment Form	Decreasing Term Life Insurance Application	Initial		51.000	DTA300SEN(10-09)AR- Doe.pdf DTA300SEN(10-09)AR- bracket.pdf



Liberty Life Insurance Company
Decreasing Term Life Insurance Application

PO Box 19099, Greenville, SC 29602-9099

Questions? Contact us at: 1-800-845-9265

Name of Mortgage Company

MORTGAGE INFORMATION

Reference Number 12378	CIDN 9876	Insurance Term 30 yrs.	Mortgage Amount \$120,000	Initial Insurance Amount \$120,000	Loan Term 30 yrs.	Loan Interest Rate 6%	Loan Closing Date 9/05/11
Loan Officer/Agent RBC Liberty		Loan Officer/Agent ID		Product			
Mortgage Property Address Street 1 Cox Street			City Anywhere			State AS	Zip 25378

FIRST APPLICANT (Please Print)

SECOND APPLICANT (Please Print)

First Name John	Middle Initial	Last Name Doe		First Name	Middle Initial	Last Name	
Date of Birth 5/20/1968	Social Security Number xxx-xx-xxxx	<input type="checkbox"/> Female <input checked="" type="checkbox"/> Male		Date of Birth	Social Security Number	<input type="checkbox"/> Female <input type="checkbox"/> Male	
Residence Address Street 345 Any Street				Residence Address Street			
City Anywhere		State AS	Zip xxxxx	City	State	Zip	
Mailing Address (if different) Street				Mailing Address (if different) Street			
City		State	Zip	City	State	Zip	
Home Phone Number 123-456-7891		Business Phone Number 987-654-3210		Home Phone Number		Business Phone Number	
Email Address jdoe@aol.com		State of Birth AS		Email Address		State of Birth	
First Applicant's Beneficiary Jane Doe				Second Applicant's Beneficiary			
Relationship of First Applicant's Beneficiary Wife				Relationship of Second Applicant's Beneficiary			

	FIRST		SECOND	
	APPLICANT		APPLICANT	
	YES	NO	YES	NO
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 1) In the past 12 months, have you used any form of tobacco or nicotine products?
- 2) In the past 5 years, have you received any treatment, medical advice, or consultation for; been diagnosed with; or required follow-up for:
 - any disease or disorder of the heart, coronary arteries, aorta, or peripheral arteries; stroke or TIA (transient ischemic attack); diabetes, borderline diabetes, elevated blood sugar or any other disease or disorder of the pancreas; tumor or cancer (other than basal cell or squamous cell carcinoma of the skin); chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, or any other chronic lung disease; or
 - chronic renal (kidney) insufficiency or failure or any other chronic disease or disorder of the kidney; hepatitis or any other chronic disease or disorder of the liver; ulcerative colitis or Crohn's disease; any chronic blood disease or disorder; rheumatoid arthritis or any other chronic disease or disorder of the muscles, joints, connective tissues, or bones; or
 - alcohol or drug use or abuse; current use of 2 or more prescribed pain medications; major depression; bipolar disorder; schizophrenia or any other chronic mental disorder; or any chronic disease or disorder of the brain or nerves; seizures, multiple sclerosis, paralysis, or any form of dementia (including Alzheimer's disease)?
- 3) Have you been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or have you tested positive for HIV (Human Immunodeficiency Virus)?

	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

First Name	Middle Initial	Last Name	Reference Number
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<u>FIRST APPLICANT</u>		<u>SECOND APPLICANT</u>	
YES	NO	YES	NO
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4) Do you have any existing life insurance or annuity contracts?

If "yes", give company name and amount:

First Applicant: _____

Second Applicant: _____

The Applicant(s) represent(s) that the following are the complete details to "Yes" answers in Questions 2 and 3:

Premium Payment Method:

- Checking / Savings Account
- Collect premiums with my/our Mortgage Payment

Premium Amount: \$50.00 **Frequency:** monthly

Acknowledgement - By signing below, each person applying for coverage represents and agrees to the following. The statements and answers made in this application are true and complete and are made to obtain the insurance applied for. It is understood that insurance will take effect only if Liberty Life Insurance Company (the "Company") accepts this application and issues a policy/certificate and if, on the date of issue, (1) the first premium has been paid, (2) you are alive, (3) all conditions used to determine your insurability remain as stated in the application, and (4) the mortgage loan to which the proposed insurance applies is in effect. No one except the Company's Home Office officers can make, change or discharge any insurance contract, or bind the Company by making any promises about any policy benefits applied for. You acknowledge you have been provided and understand the consumer information, disclosures, and notices that follow or accompany this application.

Authorization to Obtain and Disclose Information - I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other health care provider, pharmacy or pharmacy benefit manager, insurance company or reinsurer, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer, mortgage loan broker, financial institution, or other organization, institution or person to give to the Company's insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers the following information about me: information on my mortgage loan; past and present physical, mental, drug and/or alcohol conditions; other insurance coverage; prescribed drugs; employment; avocations; general reputation; and other personal characteristics. I understand that the Company will collect this information for the purpose of determining eligibility for insurance. I further understand and agree that the Company may disclose all or some of my information to the MIB and the Company's insurance administrators, reinsurers, agents, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months and a photographic copy is as valid as the original. I understand that I am entitled to receive a copy of this authorization upon request and that I have the right to revoke this authorization by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation might cause the Company to reject this application.

NOTICE: 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.

FIRST APPLICANT'S SIGNATURE	DATE
<i>X John Doe</i>	10/1/2009

SECOND APPLICANT'S SIGNATURE	DATE
<i>X</i>	

Agent: Does the Proposed Insured have any existing life insurance or annuity contracts? Yes No
(If "yes", complete the required state replacement form.)

AGENT'S SIGNATURE	DATE
RBC Liberty	10/1/2009

AGENT'S PRINTED NAME

Application ID:

Marketing ID:



Liberty Life Insurance Company
Decreasing Term Life Insurance Application

[PO Box 19099, Greenville, SC 29602-9099]

Questions? Contact us at: [1-800-845-9265]

[Name of Mortgage Company]

MORTGAGE INFORMATION

Reference Number	CIDN	Insurance Term	Mortgage Amount \$	Initial Insurance Amount \$	Loan Term	Loan Interest Rate	Loan Closing Date
Loan Officer/Agent		Loan Officer/Agent ID		Product []		1	
Mortgage Property Address Street			City			State	Zip

FIRST APPLICANT (Please Print)				SECOND APPLICANT (Please Print)			
First Name	Middle Initial	Last Name		First Name	Middle Initial	Last Name	
Date of Birth	Social Security Number	<input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth	Social Security Number	<input type="checkbox"/> Female <input type="checkbox"/> Male	
Residence Address Street				Residence Address Street			
City		State	Zip	City		State	Zip
Mailing Address (if different) Street				Mailing Address (if different) Street			
City		State	Zip	City		State	Zip
Home Phone Number		Business Phone Number		Home Phone Number		Business Phone Number	
Email Address		State of Birth		Email Address		State of Birth	
First Applicant's Beneficiary				Second Applicant's Beneficiary			
Relationship of First Applicant's Beneficiary				Relationship of Second Applicant's Beneficiary			

	FIRST APPLICANT		SECOND APPLICANT	
	YES	NO	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 1) In the past 12 months, have you used any form of tobacco or nicotine products? YES NO
- 2) In the past 5 years, have you received any treatment, medical advice, or consultation for; been diagnosed with; or required follow-up for:
 - any disease or disorder of the heart, coronary arteries, aorta, or peripheral arteries; stroke or TIA (transient ischemic attack); diabetes, borderline diabetes, elevated blood sugar or any other disease or disorder of the pancreas; tumor or cancer (other than basal cell or squamous cell carcinoma of the skin); chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, or any other chronic lung disease; or
 - chronic renal (kidney) insufficiency or failure or any other chronic disease or disorder of the kidney; hepatitis or any other chronic disease or disorder of the liver; ulcerative colitis or Crohn's disease; any chronic blood disease or disorder; rheumatoid arthritis or any other chronic disease or disorder of the muscles, joints, connective tissues, or bones; or
 - alcohol or drug use or abuse; current use of 2 or more prescribed pain medications; major depression; bipolar disorder; schizophrenia or any other chronic mental disorder; or any chronic disease or disorder of the brain or nerves; seizures, multiple sclerosis, paralysis, or any form of dementia (including Alzheimer's disease)? YES NO
- 3) Have you been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or have you tested positive for HIV (Human Immunodeficiency Virus)? YES NO

First Name	Middle Initial	Last Name	Reference Number
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<u>FIRST</u>		<u>SECOND</u>	
<u>APPLICANT</u>		<u>APPLICANT</u>	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4) Do you have any existing life insurance or annuity contracts?

If "yes", give company name and amount:

First Applicant: _____

Second Applicant: _____

The Applicant(s) represent(s) that the following are the complete details to "Yes" answers in Questions 2 and 3:

Premium Payment Method:

- Checking / Savings Account
- Collect premiums with my/our Mortgage Payment

Premium Amount: _____ **Frequency:** _____

2

Acknowledgement - By signing below, each person applying for coverage represents and agrees to the following. The statements and answers made in this application are true and complete and are made to obtain the insurance applied for. It is understood that insurance will take effect only if Liberty Life Insurance Company (the "Company") accepts this application and issues a policy/certificate and if, on the date of issue, (1) the first premium has been paid, (2) you are alive, (3) all conditions used to determine your insurability remain as stated in the application, and (4) the mortgage loan to which the proposed insurance applies is in effect. No one except the Company's Home Office officers can make, change or discharge any insurance contract, or bind the Company by making any promises about any policy benefits applied for. [You acknowledge you have been provided and understand the consumer information, disclosures, and notices that follow or accompany this application.]

3

Authorization to Obtain and Disclose Information - I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other health care provider, pharmacy or pharmacy benefit manager, insurance company or reinsurer, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer, mortgage loan broker, financial institution, or other organization, institution or person to give to the Company's insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers the following information about me: information on my mortgage loan; past and present physical, mental, drug and/or alcohol conditions; other insurance coverage; prescribed drugs; employment; avocations; general reputation; and other personal characteristics. I understand that the Company will collect this information for the purpose of determining eligibility for insurance. I further understand and agree that the Company may disclose all or some of my information to the MIB and the Company's insurance administrators, reinsurers, agents, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months and a photographic copy is as valid as the original. I understand that I am entitled to receive a copy of this authorization upon request and that I have the right to revoke this authorization by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation might cause the Company to reject this application.

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4

FIRST APPLICANT'S SIGNATURE	DATE
✕	

SECOND APPLICANT'S SIGNATURE	DATE
✕	

Agent: Does the Proposed Insured have any existing life insurance or annuity contracts? Yes No
(If "yes", complete the required state replacement form.)

AGENT'S SIGNATURE	DATE

AGENT'S PRINTED NAME

Application ID:

Marketing ID:

READABILITY COMPLIANCE CERTIFICATION

1. Insurer: Liberty Life Insurance Company
PO Box 789
Greenville, South Carolina 29602-0789
2. Certification: I hereby certify that the forms listed below produce Flesch reading ease scores which meet the minimum score required in your state.

In addition, I certify that the forms, except for schedules and tables, are printed in 10 point type, one point leaded. The words and terminology exempted are: (a) all words and terms defined in the forms, (b) all captions and subcaptions, (c) all tables and schedules, and (d) all medical terms. All exempted items are permitted in your state.

READABILITY SCORE

<u>Name of Form</u>	<u>Form Number</u>	<u>Flesch Score</u>
Application	DTA300SEN (10-09)AR	51

09-21-09
Date



Dianne Harris
Compliance Specialist I Policy Forms/Compliance

Decreasing Term Life Insurance Application
DTA300SEN(10-09)
Explanation of Brackets

- **General Purpose Information** such as Company address and telephone number is bracketed to show variability due to changes. Mortgage Company name is bracketed to reflect variability based on account information.
1. **Product Name:** This item may be used to identify marketing name of product being sold.
 2. **Premium payment method, amount and frequency:** The payment authorization language will vary depending upon the payment election made by the applicant and the options available. In most situations, the payment authorization wording and personal account information will not appear on the application, but will appear on a separate document that will be signed by the insured. The premium payment method, frequency and amount will always appear on the application. In addition to the example shown on the application, the premium payment section may also appear as shown in Examples 2A-D as follows:

A. Premium Payment Method:

- Credit Card
 - Checking/Savings Account
 - Collect premiums with my/our Mortgage Payment Mortgage Payment
- Premium Amount : \$ _____ Frequency: _____

B. For EFT payments:

- Monthly Automatic deduction from my/our account.

I request and authorize my financial institution to pay and charge to my account electronic debits on my account, by and payable to Liberty Life Insurance Company, provided there are sufficient funds in my account at the time the debit is made. I understand and agree that the financial institution will not be liable for any payment that may not be honored, intentionally or inadvertently, even if such dishonor results in forfeiture of insurance. This authority is to remain in effect until revoked by me in writing, and until the financial institution actually receives such notice.

I understand that my premium due date will not change and the electronic debit drawn on my account will occur no earlier than the due date and no later than two business days after the due date.

Premium Amount: \$ _____ Full Name(s) on Account: _____

Bank Name: _____

Bank Routing Number: _____ Checking Savings Account Number: _____

C. For Credit Card payments:

- Charge to my credit card: Visa Master Card American Express Discover

I authorize the premium to be processed and remitted to Liberty Life Insurance Company through my credit card account as referenced herein. This authority is to remain in effect until I cancel it in writing and until the Company or my credit card company actually receives such notice.

Credit Card Number: _____ Expiration Date: ____ / ____

Name as it appears on the Credit Card: _____

Payment Frequency: Monthly Quarterly Semi-Annually Annually

Premium Amount: \$ _____

