

SERFF Tracking Number: *PHYS-126307816* State: *Arkansas*
 Filing Company: *Physicians Life Insurance Company* State Tracking Number: *43525*
 Company Tracking Number:
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
 Product Name: *LIFE APPLICATIONS WITH REPLACEMENT QUESTION*
 Project Name/Number: *LIFE APPLICATIONS WITH REPLACEMENT QUESTION/LIFE APPLICATIONS WITH REPLACEMENT QUESTION*

Filing at a Glance

Company: Physicians Life Insurance Company

Product Name: LIFE APPLICATIONS WITH REPLACEMENT QUESTION SERFF Tr Num: PHYS-126307816 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 43525

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Kathryn Gurnett

Disposition Date: 09/17/2009

Date Submitted: 09/16/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: LIFE APPLICATIONS WITH REPLACEMENT QUESTION

Status of Filing in Domicile: Not Filed

Project Number: LIFE APPLICATIONS WITH REPLACEMENT QUESTION

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/17/2009

Explanation for Other Group Market Type:

State Status Changed: 09/17/2009

Deemer Date:

Created By: Kathryn Gurnett

Submitted By: Kathryn Gurnett

Corresponding Filing Tracking Number:

Filing Description:

In response to recently revised Rule 97, the following applications are being filed to comply with the change in the replacement question:

New Form

Replaced Form

LA808-AR2

LA808-AR approved 2/1/98

LA826-2F

LA826-2FR approved 11/24/08

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ULA-18AR2 ULA-18AR approved 9/28/01
ULA41-1AF ULA41-F approved 9/6/07

The Flesch score of these applications when scored with the base policy will always be more than the minimum required by Arkansas law.

We reserve the right to alter the format of the form submitted without re-filing due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval.

Please contact me via SERFF, or at the e-mail address or phone number listed below if you have questions, or if additional information is needed.

Sincerely,

Kathryn R. Gurnett, MBA, CPCU, CLU, HIA, AAPA, LTCP, HIPAAP, AIRC, FLMI, CCP
Policy Approval and Compliance Coordinator
Government and Industry
Voice: (402) 633-1188
Fax: (402) 633-1096
E-mail: katie.gurnett@physiciansmutual.com

Company and Contact

Filing Contact Information

Kathryn Gurnett, Compliance Lead katie.gurnett@physiciansmutual.com
2600 Dodge Street 402-633-1188 [Phone]
Omaha, NE 68131 402-633-1096 [FAX]

Filing Company Information

Physicians Life Insurance Company CoCode: 72125 State of Domicile: Nebraska
2600 Dodge Street Group Code: 367 Company Type:
Omaha, NE 68131 Group Name: State ID Number:
(402) 633-1188 ext. [Phone] FEIN Number: 47-0529583

Filing Fees

SERFF Tracking Number: *PHYS-126307816* State: *Arkansas*
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Fee Required? *Yes*
Fee Amount: *\$80.00*
Retaliatory? *No*
Fee Explanation:
Per Company: *No*

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Life Insurance Company	\$80.00	09/16/2009	30598097

SERFF Tracking Number: *PHYS-126307816* State: *Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/17/2009	09/17/2009

SERFF Tracking Number: *PHYS-126307816* State: *Arkansas*
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Disposition

Disposition Date: 09/17/2009

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		Yes
Form	LIFE APPLICATION		Yes
Form	LIFE APPLICATION		Yes
Form	LIFE APPLICATION		Yes
Form	LIFE APPLICATION		Yes

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Form Schedule

Lead Form Number: LA808-AR2

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LA808-AR2	Application/	LIFE APPLICATION	Initial		40.000	LA808AR2.pdf
		Enrollment	Form				f
	LA826-2F	Application/	LIFE APPLICATION	Initial		40.000	LA826-2F.pdf
		Enrollment	Form				
	ULA-18AR2	Application/	LIFE APPLICATION	Initial		40.000	ULA18AR2.pdf
		Enrollment	Form				
	ULA41-1AF	Application/	LIFE APPLICATION	Initial		40.000	ULA41-1AF.pdf
		Enrollment	Form				

APPLICATION FOR LIFE INSURANCE
To Physicians Life Insurance Company
2600 Dodge Street
Omaha, Nebraska 68131

HOME OFFICE USE ONLY:	
Policy Kind	L-708
Policy #	_____

FOR: **PLAN A** OR **PLAN B**
 \$5,000 \$10,000

\$ _____ Submitted Premium

PERSON TO BE INSURED

(Name) _____
(First) (M.I.) (Last)

(Street Address) _____
(Apt. #)

(City) _____ (State) _____ (Zip) _____

Sex Male Female

Height _____
(Ft) (In)

Weight _____
(Lbs)

Age _____

Date of Birth _____
(MM/DD/YY)

1. Has the person to be insured ever had or received medical treatment or advice for: high blood pressure, heart trouble, cancer or tumor, kidney trouble, diabetes, epilepsy, birth defects, drug or alcohol use? Yes No
2. Does the person to be insured have any existing life insurance or annuities? Yes No If yes, please list policy number and company name.
- _____

BENEFICIARY INFORMATION (Complete only if different person from Applicant)

(Name) _____
(First) (M.I.) (Last)

RELATIONSHIP TO INSURED _____

APPLICANT INFORMATION (Please send policy and billings to:)

(Name) _____
(First) (M.I.) (Last)

(Street Address) _____
(Apt. #)

(City) _____ (State) _____ (Zip) _____

(Phone No.) () _____
(For Customer Service only)

Sex Male Female

Date of Birth _____
(MM/DD/YY)

RELATIONSHIP TO INSURED _____
(Must be parent, legal guardian, grandparent or self)

To the best of my knowledge and belief, the person to be insured is in good health. I understand that I am the policy's Owner and Beneficiary, unless another Beneficiary is named. I also understand the insurance is not effective until issued, and any premium will be refunded if the policy is not issued.

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.

Applicant Signature X _____ Date _____

Agent's Statement: I certify that I have accurately recorded in this application all information supplied by the applicant and [personally witnessed their signature]. To the best of my knowledge, the policy applied for will will not replace any existing life insurance or annuities. I certify that only company approved sales material was used in connection with this sale, and copies of all sales materials used were left with the applicant.

Agent Signature X _____ Date _____

PRINT or TYPE Agent's Name / Agent's State License ID Number _____

Please re-check application to be sure all information is complete.
 Make check or money order payable to Physicians Life Insurance Company

LA808-AR2

PHYSICIANS LIFE INSURANCE COMPANY

RECEIPT

(This does not create interim insurance)

2600 Dodge Street
Omaha, Nebraska 68131

Received from _____ on _____
month day year

the sum of \$ _____ check cash for an application for a life insurance policy offered by Physicians Life Insurance Company, Form LA-808. It is understood and agreed that the policy shall not be effective until the premium is received, the application approved and the policy issued, all at the Company's Home Office, during the lifetime and continued insurability of the proposed insured. If, after evaluation, it is determined that the proposed insured is insurable in accordance with the Company's usual rules and practices of selection, the policy will become effective according to its terms as of the date this application is approved. If the application is not approved, the Company agrees to refund the above amount to the applicant. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

Date _____ Agent Signature _____

POLICY KIND: L726

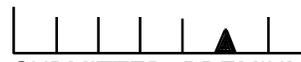
APPLICATION FOR WHOLE LIFE INSURANCE

Physicians Life Insurance Company
2600 Dodge Omaha, NE 68131

HOME OFFICE USE ONLY:

POLICY NO. _____

Amount of Insurance Applied For: \$10,000 \$5,000


SUBMITTED PREMIUM

Children To Be Insured (Proposed Insured(s))
(List children age 12 and under)

	First Name	Middle Initial	Last Name	Date of Birth			Sex
				Month	Day	Year	
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							

1. Has any Proposed Insured ever had or received medical treatment or advice for: Heart or Circulatory Disease, Birth or Genetic Defects, Mental Abnormality, Congenital Disease, or for any other existing impairments, diseases, health or medical conditions? Yes No
(If "Yes," please list the child's name and conditions below.)

Child's Name	Condition(s)	Date(s) Last Treated			Name(s) and Address(es) of Doctor(s) or Hospital(s)
		Month	Day	Year	

2. Does the Proposed Insured have any existing life insurance or annuities? Yes No
If "Yes," please list child's name, policy number and company. _____

Beneficiary: Unless otherwise requested, the Applicant shall be the Beneficiary.

Beneficiary's Name	Relationship

Applicant Information: (Parent/Grandparent/Legal Guardian)

Name _____
Address _____ Phone (____) _____
City _____ State _____ Zip _____
Date of Birth _____
Month Day Year
Check one: Male Female Parent Grandparent Legal Guardian

I am the Parent, Grandparent, or Legal Guardian of the Proposed Insured(s). To the best of my knowledge, the above answers are true and complete and each child to be insured is in sound physical and mental health. I understand that I am the policy's Owner and Beneficiary unless another Beneficiary is named. I understand the insurance is not effective until issued, and any premium paid will be refunded if the policy is not issued.

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

Applicant's Signature _____ Date _____
(Parent/Grandparent/Legal Guardian)

Agent's Statement: I certify that I have accurately recorded in this application all information supplied by the applicant and [personally witnessed their signature]. To the best of my knowledge, the policy applied for will will not replace any existing life insurance or annuities. I certify that only company approved sales material was used in connection with this sale, and copies of all sales materials used were left with the applicant.

Agent's Signature **X** _____ Date _____

PRINT or TYPE Agent's Name and Agent's State License I.D. Number

Please re-check application to be sure all information is complete.
Make check or money order payable to Physicians Life Insurance Company.

APPLICATION FOR LIFE INSURANCE

To Physicians Life Insurance Company ©
2600 Dodge Street Omaha, NE 68131-2671

\$, Face Amount Applied For

\$ Submitted Premium

HOME OFFICE USE ONLY

Policy Number _____

Proposed Insured's Name First Name _____ M.I. _____ Last Name _____		Birthdate		State of Birth	Age	Sex	Social Security Number	Height Ft. In.	Weight Lbs.
		Mo.	Day						
Spouse's Name (complete if Spouse to be insured by a Rider)									
Children's Names (complete if Children to be insured by a Rider)									
Address (Street) _____ (City) _____ (State) _____ (Zip) _____		Home Phone () - _____		Business Phone () - _____					
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, do you have a permanent visa? <input type="checkbox"/> Yes <input type="checkbox"/> No			Proposed Insured's Driver's Lic. # _____		State: _____		
Proposed Insured: <input type="checkbox"/> Yes <input type="checkbox"/> No		Proposed Insured: <input type="checkbox"/> Yes <input type="checkbox"/> No			Spouse's Driver's Lic. # _____		State: _____		
Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No							
Proposed Insured's Occupation? _____					(Title/Duties) _____				
Proposed Insured's Employer: _____					Annual Income: \$ _____				
Employer's Address: _____									
Spouse's Occupation? _____					(Title/Duties) _____				
Spouse's Employer: _____					Annual Income: \$ _____				
Employer's Address: _____									
Proposed Insured's Primary Beneficiary (Person to receive death benefits. Does not apply to Spouse and Children's Riders.)									
Name _____					Relationship to the Insured _____				
Contingent Beneficiary									
Name _____					Relationship to the Insured _____				
Owner (If Other than Proposed Insured)									
Name _____					Relationship to the Insured _____				
					Owner's Soc. Sec. No. or Tax I.D. No. _____				
(Street) _____		(City) _____		(State) _____		(Zip) _____			
Premium Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual					Optional Riders/Benefits				
<input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly					<input type="checkbox"/> _____ (Accidental Death) \$ _____				
<input type="checkbox"/> ABW					<input type="checkbox"/> _____ \$ _____				
Total Modal Premium \$ _____					<input type="checkbox"/> _____ \$ _____				
Plan of Insurance _____					<input type="checkbox"/> _____ \$ _____				
Automatic Premium Loan Option? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					<input type="checkbox"/> _____ \$ _____				
Has anyone to be insured used tobacco during the last 12 months? Proposed Insured <input type="checkbox"/> Yes <input type="checkbox"/> No									
Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No									
Does anyone to be insured have any existing life insurance or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes," give Insured's Name, company name, address and policy number: _____									

ULA-18AR2

Conditional Receipt

No agent is authorized to accept money with the application if any of the health questions are not answered. No one may waive or alter any part of this receipt. Please make all checks payable to Physicians Life Insurance Company. Do not make checks payable to the agent or leave the payee blank.

Received From _____ the sum of \$ _____ paid as the initial premium for the policy applied for above.

I understand and agree that no insurance will become effective until each and every one of the following requirements are met during the proposed insured's lifetime: 1) all questions on the application have been answered truthfully and completely; 2) the initial premium has been paid in full; 3) all medical requirements are received by Physicians Life Insurance Company within 60 days of the date of the application; and 4) the underwriting standards for the plan and amount applied for above have been satisfied.

I also understand that if these requirements are met, the amount of insurance provided by the receipt will be the lesser of the amount of insurance applied for or \$100,000. Any insurance provided by this receipt will end on the earliest of: 1) 60 days after the date of the application; 2) the date that a refund of premium is sent; or 3) the date the policy issued goes into effect. If Physicians Life Insurance Company offers to issue a policy other than as applied for, the amount shown in the receipt will be applied toward that policy if the applicant accepts the policy as issued.

Date _____ Signature of Owner/Applicant X _____

Date _____ Signature of Agent X _____

	YES	NO
1) Is anyone to be insured currently confined to a bed, hospital, nursing home, or other medical facility; or totally disabled due to illness?	<input type="checkbox"/>	<input type="checkbox"/>
2) Within the past 2 years, has anyone to be insured been diagnosed or treated (including prescription medication) by a member of the medical profession for:		
a) Internal Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
b) Heart Disease or Disorder (except High Blood Pressure)?	<input type="checkbox"/>	<input type="checkbox"/>
c) Terminal Illness or Injury (diagnosed as having a life expectancy of 12 months or less)?	<input type="checkbox"/>	<input type="checkbox"/>
d) Chronic Lung Disease?	<input type="checkbox"/>	<input type="checkbox"/>
e) Liver Disease?	<input type="checkbox"/>	<input type="checkbox"/>
f) Kidney Failure?	<input type="checkbox"/>	<input type="checkbox"/>
g) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered "Yes" to any question, please give the <u>name of the person</u> diagnosed or treated.		

Important - Please Read

I represent that the statements on this application are true and complete and shall be the basis for issue of the policy and will become part of it. I understand that the policy shall not become effective until the premium is received, the application approved, and the policy issued, all at the Company's Home Office, during my lifetime and continued insurability. I also acknowledge I have received the Notice to Applicant.

I authorize the Medical Information Bureau to give Physicians Life Insurance Company or its reinsurers, any records or knowledge of me or my health. This information will be used solely for insurance purposes. This authorization or a photocopy of same is valid for twenty-four (24) months from the date it is signed, and I have a right to a photocopy.

I represent that the Proposed Insured's signature below is the original, personal signature of the Proposed Insured. The Proposed Insured must personally sign. **Signatures under power of attorney will not be accepted.**

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

Proposed Insured's Signature _____ Date _____

Signature of Owner
(if other than Proposed Insured) _____ Date _____

Agent's Statement: I certify that I have accurately recorded in this application all information supplied by the applicant [and personally witnessed their signature.] To the best of my knowledge, the policy applied for will will not replace any existing life insurance or annuities. I certify that only company approved sales material was used in connection with this sale, and copies of all sales materials used were left with the applicant.

Agent's Signature

Print or Type Agent's [License] Number

Date

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Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

READCERT LIFE APPLICATIONS.pdf

Ar reg 19 cert.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

Please see filing description under General Information tab.

PHYSICIANS LIFE INSURANCE COMPANY

OMAHA, NEBRASKA

Certification of Flesch

These form(s) have the following Flesch Readability Score:

<u>Form</u>	<u>Flesch Score</u>
LA808-AR2	40*
LA826-2F	40*
ULA-18AR2	40*
ULA41-1AF	40*

*When scored with the base policy Flesch score will always be above that required by law.



Vice President
Physicians Life Insurance Company

September 16, 2009

Date

CERTIFICATION

RE: LA808-AR2, LA826-2F, ULA-18AR2, ULA41-1AF

This is to certify that the above captioned filing complies with Arkansas Regulation 19 and all other applicable requirements of the Arkansas Insurance Department.

A handwritten signature in black ink that reads "Shawn Pollock". The signature is written in a cursive style and is positioned to the left of a vertical red line.

Date: September 16, 2009

Shawn Pollock
Vice President
Government and Industry