

SERFF Tracking Number: UNAM-126297183 State: Arkansas
Filing Company: Constitution Life Insurance Company State Tracking Number: 43471
Company Tracking Number: CL-LDBAPP (1/09) AR
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Insurance Application
Project Name/Number: /

Filing at a Glance

Company: Constitution Life Insurance Company

Product Name: Life Insurance Application

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate
Premium - Single Life

Filing Type: Form

SERFF Tr Num: UNAM-126297183 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 43471

Co Tr Num: CL-LDBAPP (1/09) AR State Status: Approved-Closed

Author: Mary Reichert

Date Submitted: 09/10/2009

Reviewer(s): Linda Bird

Disposition Date: 09/15/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: This filing is being
done only in Arkansas, in order to comply with
the replacement regulation to take effect
January 1, 2010.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/15/2009

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/15/2009

Deemer Date:

Submitted By: Mary Reichert

Filing Description:

Created By: Mary Reichert

Corresponding Filing Tracking Number:

We submit this form for review and approval. A similar form is being submitted for our sister companies under SERFF Tracking #UNAM-126297182 and UNAM-126297184.

The form replaces previously approved form CLA-038 SSL (10/02) AR (CLIC)

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We will begin using the new form no later than January 1, 2010, when the new replacement regulation takes effect.

The form was revised to change the format and clarify some questions. We also revised the replacement question to comply with Arkansas Regulation ..A copy of the existing application with changes marked is included for reference.

This application will be used by our licenses agents during face-to-face contact with clients applying for our level and graded death benefit whole life insurance policies.

In the future, we may offer these plans in a variety of ways including via telephone with licensed agents completing the application form and potentially through the use of web-based application completion.

Company and Contact

Filing Contact Information

Mary Reichert, mreichert@universalamerican.com
 P.O. Box 958465 407-995-8000 [Phone] 8355 [Ext]
 Lake Mary, FL 32795-8465

Filing Company Information

Constitution Life Insurance Company	CoCode: 62359	State of Domicile: Texas
1001 Heathrow Park Lane	Group Code: 953	Company Type:
Suite 5001	Group Name:	State ID Number:
Lake Mary, FL 32746	FEIN Number: 36-1824600	
(407) 995-8000 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	Texas charges \$50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Constitution Life Insurance Company	\$50.00	09/10/2009	30465908

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/15/2009	09/15/2009

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Disposition

Disposition Date: 09/15/2009

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
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Application for Life Insurance		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	CL-LDBAPP (1/09) AR	Application/ Enrollment Form Application for Life Insurance	Initial		40.100	CL-LDBAPP 1-09 AR.pdf



HOME OFFICE: [Houston, Texas]
 EXECUTIVE OFFICE:
 [P.O. Box 958465, Lake Mary, FL 32795-8465]
 [(800) 882-1054]

APPLICATION FOR INSURANCE

Proposed Insured _____ Address _____ City _____ State _____ Zip _____ Social Security Number _____ Birth Date _____ Age _____ Birth State _____ Sex _____ Marital Status _____ Occupation _____ Height _____ Weight _____ Phone: Day (____) _____ Evening (____) _____	Complete only if Owner is not Proposed Insured <i>Owner</i> _____ <i>Relationship</i> _____ <i>Birth date</i> _____ <i>Address</i> _____ <i>City</i> _____ <i>State</i> _____ <i>Zip</i> _____ <i>Social Security/Tax ID Number</i> _____
Secondary Addressee Information When the insured or owner is age 64 or older, a copy of any notification of possible lapse will be sent to this person. Name & Address: _____	
Send premium notices to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Give name/address in Special Requests)	
Face Amount \$ _____ Plan _____ Accidental Death <input type="checkbox"/> Yes <input type="checkbox"/> No	Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC <input type="checkbox"/> Credit Card <input type="checkbox"/> Visa <input type="checkbox"/> MC (Check one) Modal Premium Amount \$ _____ Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No
Beneficiary of the Proposed Insured (If split, please indicate percentages) Primary _____ Birth Date _____ Relationship _____ Contingent _____ Birth Date _____ Relationship _____	
Does the applicant own existing, in-force policies or contracts on the Proposed Insured? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete the required replacement form.	
Do you now or have you within the last year used tobacco products in any form? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," please explain: _____	
Section 1 - No Coverage Available If the applicant answers "Yes" to any question in this section, the Proposed Insured is not eligible for coverage.	
1. Is the Proposed Insured currently: a) hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, confined to a wheel chair or awaiting an organ transplant? Yes <input type="checkbox"/> No <input type="checkbox"/> b) diagnosed with or being treated for a terminal illness? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for: a) Alzheimer's Disease or other Dementia? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes <input type="checkbox"/> No <input type="checkbox"/> 4. In the past 5 years, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for: a) Congestive Heart Failure? Yes <input type="checkbox"/> No <input type="checkbox"/> b) Internal Cancer, Malignant Melanoma, or Leukemia? Yes <input type="checkbox"/> No <input type="checkbox"/> 5. Has the Proposed Insured had an application for life insurance declined in the past 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Special Requests _____	Administrative Office Use Only: _____

6. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for:
- a) Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Chronic Asthma, Chronic Bronchitis or any other Chronic Respiratory Disorder? Yes No
- b) Parkinson's Disease, Kidney Disease, Kidney Failure, Cirrhosis, or other Liver Disease? Yes No
7. In the past 2 years, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for Diabetes requiring insulin or Diabetic Coma?
- a) Heart Attack, Angina (chest pain), Stroke, Aneurysm or other Heart or Circulatory disorder? Yes No
- b) Alcohol or Drug Dependency? Yes No
- c) Diabetes requiring insulin or Diabetic Coma? Yes No
8. Is the Proposed Insured currently Paralyzed or has the Proposed Insured had an Amputation due to disease or disorder? Yes No
9. In the past 12 months has the Proposed Insured used Oxygen Therapy to assist in breathing? Yes No

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on the application are true to the best of my knowledge and belief. I understand that my policy will be effective on the date it is issued by the company except as stated in the conditional receipt. I personally completed the questions in Section 1 & 2 above.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the MIB, Inc., a pharmaceutical database or any other organization, institution, or person that has any records or knowledge of me or my health or that of any member of my family to give to Constitution Life Insurance Company or its reinsurers any such information. A photographic copy of the authorization shall be valid as the original. This authorization is valid for 24 months from the date of signature. It may be revoked at any time by sending written request to the Executive Office of Constitution Life Insurance Company. Revocation is subject to the rights of any person that acted in reliance on the authorization prior to receiving the revocation. **I the undersigned applicant acknowledge that I have read, or had read to me, the completed application. I realize that any false statement or misrepresentation made therein, that is material to the risk or hazard assumed, 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.

Cash paid with application \$ _____.

Dated at _____, this _____ day of _____, _____.

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

Instructions to agents - This statement must be completed with application.

1. Submit all applications and business transmittals within 7 days of application date.
2. Do not solicit business on any individual currently hospitalized or confined to a nursing home.
3. Do not solicit business on any individual you have reason to believe is suffering from a terminal illness.
4. All premium checks must be made payable to Constitution Life Insurance Company.
5. The full initial premium must be submitted with application.

Agent's Statement

By signing below, I the agent, hereby certify that all the information contained on this application has been truly and accurately recorded as supplied by the Proposed Insured. To the best of my knowledge all the answers are complete and true, and the applicant is not currently hospitalized or confined to a nursing home, nor do I have reason to believe the applicant is suffering from a terminal illness. The applicant has read or had read to him/her the entire application. To the best of my knowledge and belief the applicant does does not own existing, in-force policies or contracts on the Proposed Insured. I personally did see did not see the applicant at the time of the application.

Agent Printed Name _____ Agent Signature _____

Agent Number: _____ Agent State ID Number: _____

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: redlined version of application		
Attachment: cl redlined.pdf		

We certify that these forms comply with the provision of 19 ss 10 b and all applicable requirements of the Department.

We also certify that both the Life and Health Guaranty Association Notice and agent contact information will be delivered with the policy in compliance with Regulation 49 and Arkansas Insurance Code 23-79-138.

In addition, we certify that the form submitted has a Flesch Reading Ease score of 40.1

Proposed Insured _____ Address _____ City _____ State _____ Zip _____ Social Security Number _____ Birth Date _____ Age _____ Birth State _____ Sex _____ Marital Status _____ Occupation _____ Height _____ Weight _____ Phone: Day (____) _____ Evening (____) _____	Complete only if Owner is not Proposed Insured Owner _____ Relationship _____ Birth date _____ Address _____ City _____ State _____ Zip _____ Social Security/Tax ID Number _____
Secondary Addressee Information When the insured or owner is age 64 or older, a copy of any notification of possible lapse will be sent to this person. Name & Address: _____	
Send premium notices to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Give name/address in Special Requests)	
Face Amount \$ _____ Plan _____ Accidental Death <input type="checkbox"/> Yes <input type="checkbox"/> No	Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC <input type="checkbox"/> Credit Card ___ Visa ___ MC (Check one) Modal Premium Amount \$ _____ Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No
Beneficiary of the Proposed Insured (If split, please indicate percentages) Primary _____ Birth Date _____ Relationship _____ Contingent _____ Birth Date _____ Relationship _____	
Will this insurance replace or change any other insurance policies or annuities? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," please provide the complete details of the insurance to be replaced, including amount, company and plan of insurance.	
Do you now or have you within the last year used tobacco products in any form? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," please explain: _____	
Section 1 - No Coverage Available If the applicant answers "Yes" to any question below (1-8), the proposed insured is not eligible for coverage.	
1. Is the Proposed Insured currently: a) hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, confined to a wheel chair or awaiting an organ transplant? Yes <input type="checkbox"/> No <input type="checkbox"/> b) diagnosed or treated with a terminal illness? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Has the proposed insured ever: a) had or been treated for Alzheimer's Disease or other Dementia? Yes <input type="checkbox"/> No <input type="checkbox"/> b) been tested positive for exposure to the Human Immunodeficiency Virus or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.... Yes <input type="checkbox"/> No <input type="checkbox"/> 3. In the past 5 years, has the Proposed Insured had or ever been treated for: a) Congestive Heart Failure? Yes <input type="checkbox"/> No <input type="checkbox"/> b) Internal Cancer, Malignant Melanoma, or Leukemia? Yes <input type="checkbox"/> No <input type="checkbox"/> 4. In the past 12 months, has the Proposed Insured had: a) Heart Attack, Angina (chest pain), Heart Surgery, Stroke, Aneurysm? Yes <input type="checkbox"/> No <input type="checkbox"/> b) Kidney Dialysis, treatment or counseling for alcohol or drug dependency or used oxygen therapy to assist breathing? Yes <input type="checkbox"/> No <input type="checkbox"/> 5. Has the proposed insured had an application for life insurance declined in the past 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Special Requests _____	Home Office Use Only: _____

Replaced

revised

Revised

- 6. Has the Proposed Insured ever had or been treated for or taken medication for:
 - a) Chronic Obstructive Pulmonary Disease (COPD) which includes Emphysema, Chronic Asthma, Chronic Bronchitis or other Chronic Respiratory Disorder? Yes No
 - b) Parkinson's Disease, Kidney Disease, Kidney Failure Cirrhosis, or Liver Disease? Yes No
- 7. In the past 2 years, has the Proposed Insured:
 - a) had, been diagnosed, treated for or taken medication for Heart Attack, Angina (chest pain), Stroke, Aneurysm or other heart or circulatory disorder? Yes No
 - b) received treatment or counseling for alcohol or drug dependency? Yes No
 - c) taken insulin injections for diabetes or treated for diabetic coma? Yes No
- 8. Is the Proposed Insured currently paralyzed or had an amputation due to disease or disorder? Yes No

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on the application are true to the best of my knowledge and belief. I understand that my policy will be effective on the date it is issued by the company. I personally completed the questions on pages 1 and 2.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or any other organization, institution, or person that has any records or knowledge of me or my health or that of any member of my family to give to Constitution Life or its reinsurers any such information. A photographic copy of the authorization shall be valid as the original. I the undersigned applicant acknowledge that I have read, or had read to me, the completed application. I realize that any false statement or misrepresentation made therein, that is material to the risk or hazard assumed, 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.

Cash paid with application \$ _____.

Dated at _____, this _____ day of _____, _____.

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

Instructions to agents - This statement must be completed with application.

1. Submit all applications and business transmittals within 7 days of application date.
2. Do not solicit business on any individual currently hospitalized or confined to a nursing home.
3. Do not solicit business on any individual you have reason to believe is suffering from a terminal illness.
4. All premium checks must be made payable to Constitution Life Insurance Company.
5. The full initial premium must be submitted with application.

Agent's Statement

By signing below, I the agent, hereby certify that all the information contained on this application has been truly and accurately recorded as supplied by the proposed insured. To the best of my knowledge all the answers are complete and true, and the applicant is not currently hospitalized or confined to a nursing home, nor do I have reason to believe the applicant is suffering from a terminal illness. The applicant has read or had read to him/her the entire application. To the best of my knowledge and belief the insurance applied for is is not intended to replace any existing life insurance or annuity coverage. I personally did see did not see the applicant at the time of the application.

Replaced

Agent Printed Name _____ Agent Signature _____

Agent Number: _____ Agent State ID Number: _____