

SERFF Tracking Number: HULI-126438906 State: Arkansas
Filing Company: Heritage Union Life Insurance Company State Tracking Number: 44445
Company Tracking Number: HU-TL-CR100A
TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other
Product Name: Conditional Receipt
Project Name/Number: HU-TL-CR100A/HU-TL-CR100A

Filing at a Glance

Company: Heritage Union Life Insurance Company

Product Name: Conditional Receipt

TOI: L04I Individual Life - Term

Sub-TOI: L04I.500 Other

Filing Type: Form

SERFF Tr Num: HULI-126438906

SERFF Status: Closed-Approved-
Closed

Co Tr Num: HU-TL-CR100A

Author: Kim Hiar

Date Submitted: 01/03/2010

State: Arkansas

State Tr Num: 44445

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 01/06/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: HU-TL-CR100A

Project Number: HU-TL-CR100A

Requested Filing Mode: File & Use

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 01/06/2010

Deemer Date:

Submitted By: Kim Hiar

Filing Description:

The attached conditional receipt will be used with application, HU-TL-APP320A, which was approved for use in Arkansas on 04/02/2009. It will be used by a field agent to bind coverage when premium is collected with an application. Coverage will be provided as specified in the attached conditional receipt.

Should you have any questions, please contact me.

Company and Contact

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: This form is
exempt from filing in Arizona.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 01/06/2010

Created By: Kim Hiar

Corresponding Filing Tracking Number:

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Filing Contact Information

Kim Hiar, Compliance Manager kimberly.hiar@heritageunion.com
 1805 Monument Avenue 804-212-2818 [Phone]
 Suite 201 804-213-0051 [FAX]
 Richmond, VA 23220

Filing Company Information

Heritage Union Life Insurance Company CoCode: 62421 State of Domicile: Arizona
 1805 Monument Avenue Group Code: 181 Company Type: Life & Health
 Insurer
 Suite 201 Group Name: State ID Number: 2058
 Richmond, VA 23220 FEIN Number: 41-0880965
 (804) 212-2818 ext. [Phone]

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Heritage Union Life Insurance Company	\$20.00	01/03/2010	33220934

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/06/2010	01/06/2010

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Disposition

Disposition Date: 01/06/2010

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	Conditional Receipt		Yes

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Form Schedule

Lead Form Number: HU-TL-CR100A

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	HU-TL-CR100A	Application/Conditional Receipt Enrollment Form	Initial		42.100	CONDITIONAL RECEIPT.pdf



HERITAGE UNION LIFE INSURANCE COMPANY

Executive Offices: 1805 Monument Avenue, Suite 201
Richmond, Virginia 23220

CONDITIONAL RECEIPT

Leave with Applicant only if money is submitted with application. If within the past 12 months any proposed Insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with an application. Do not accept money unless all required signatures below are obtained.

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the Conditional Receipt.

Make all checks payable to the Heritage Union Life Insurance Company. Do not make checks payable to the agent or leave the payee blank.

Received from _____ the sum of _____ for the insurance application dated _____ with _____ as the proposed Insured. The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of the application and (2) the date of the last medical examination, tests, or other screenings required by Heritage Union Life Insurance Company, if any (the Effective Date). Such conditional insurance will take effect as of the Effective Date, so long as the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with Heritage Union Life Insurance Company's underwriting rules and standards, without modifications as to plan, amount or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by Heritage Union Life Insurance Company are completed and results received at our Administrative Office within 60 days of the date that the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly; or if a proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, Heritage Union Life Insurance Company's liability will be limited to returning any payment(s) you have made upon return Receipt to the Company.

The aggregate amount of conditional coverage under this Receipt, if any, and any other Conditional Receipt issued by Heritage Union Life Insurance Company shall be limited to the lesser of the amount(s) applied for or the sum of monthly benefit payments not to exceed a total of \$300,000 of life insurance. Any conditional coverage payable under this rider will be paid in monthly payments. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

Authorizations (Signatures Required)

I certify that I have read and reviewed the Conditional Receipt and the acknowledgement of the applicant and proposed Insured in the application. The terms and conditions of the conditional receipt have been explained to me fully by the agent and I understand them.

Dated at _____ on _____

Signature of Agent or Authorized
Company Rep

Signature of proposed Insured

Signature of Applicant
(if other than proposed Insured)

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Certificate of Readability.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: The application was approved for use in Arkansas on 04/02/2009. Attachment: HU-TL-APP320A.pdf		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo Bypass Reason: This filing does not require an actuarial memorandum Comments:		

CERTIFICATE OF READABILITY

I certify the forms listed below meet the minimum reading requirements required in Arkansas ACA 23-80-206.

<u>FORM NUMBER</u>	<u>SCORE</u>
HU-TL-CR100A	42.1


Signature

December 28, 2009
Date

Julie Roper

Name

President

Title

ABOUT PROPOSED INSURED (Please answer each question completely)

First Name _____

Last Name _____

Street _____

City _____ State _____ Zip _____

Primary Phone _____
 Best time to call: Morning Afternoon Early Evening

Alternate Phone _____
 Best time to call: Morning Afternoon Early Evening

Email Address _____

Current Occupation _____

Annual Salary \$ _____ Male Female

Product _____

Monthly Benefit Amount \$ _____

Payout Period _____

Rider(s)/Amount _____

Date of Birth _____ Age _____ Birthplace _____
 month day year state or country

Height ____ feet _____ inches Weight _____ pounds

SS# _____

Driver's License # _____ State Issued _____

Are you a citizen of the United States? Yes No

If no, do you have a permanent Visa (green card)? Yes No

POLICY OWNER'S INFORMATION (If different from Proposed Insured)

Policy Owner's Name: _____

Policy Owner's Street: _____

Policy Owner's City _____ State _____ Zip _____

Policy Owner's SS# or Tax Payer ID#: _____

BENEFICIARY INFORMATION

Name, Relationship and Designated %:

APPLICANT HISTORY (Check YES or NO for each question. If yes, provide details.)

1. a. Do you have other life insurance applications pending with any other company? Yes No
 - b. By applying for the proposed policy do you intend to replace, discontinue or change an existing policy or contract? Yes No
- If yes, provide details as follows. Attach a separate sheet if more space is needed (*Indicate Type of Coverage: I=Individual; B=Business; or G=Group)

INSURED NAME	INSURANCE COMPANY	POLICY NO.	AMOUNT	*TYPE	PENDING	ISSUE DATE
					<input type="checkbox"/>	
					<input type="checkbox"/>	

2. Have you, in the past 2 years, used tobacco or nicotine products in any form? Yes No
3. Within the past 3 years, have you been refused life insurance or been issued a policy on a modified or rated basis? Yes No
4. Have you, in the past 3 years, participated in or do you plan to participate in any of the following activities: aeronautics, including hang gliding, sky diving, parachuting, or ballooning; racing, including car, motorcycle, or boat; scuba/skin diving; hiking, including mountain/trail climbing or rock climbing; or any similar hazardous activities? Yes No
5. Have you, in the past 3 years, piloted an aircraft, or do you have any intention of flying in the future other than as a passenger on a scheduled airline? Yes No
6. Do you contemplate residence or travel, including military deployment, outside the US during the next 2 years? Yes No
7. Have you, in the past 3 years, had your driver's license suspended, revoked, cancelled, or withdrawn, had 3 or more moving violations, or in the past 5 years pled guilty or no contest to or been convicted of driving under the influence (DUI/DWI) or reckless driving? Yes No
8. Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, or been on probation or parole for a felony offense, or are felony charges currently outstanding against you? Yes No
9. Have you, in the past 10 years, used illegal drugs, or consulted a physician or other healthcare provider or been treated, hospitalized, or taken medication for abuse of alcohol or drugs (including prescription drugs)? Yes No

- 10.** Have you, in the past 10 years, consulted a physician or other healthcare provider, or been treated, hospitalized or taken medication for: any diseases or disorders of the heart including rheumatic fever, circulatory system, diabetes/endocrine/thyroid, blood, kidneys, liver, digestive system, lungs including allergies, sleep apnea, respiratory disorder, emphysema, or chronic asthma; any mental or nervous disorders, including depression or anxiety; muscular, spinal, joint, or bone disorders or injuries; including concussions; high blood pressure; high cholesterol; cancer; stroke; epilepsy/seizures, including dizziness or fainting; arthritis; congenital defects or physical impairments; or sexually transmitted diseases? Yes No
- 11.** Have you ever tested positive for, or been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) antibodies or antigens or AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder? Yes No
- 12.** Have you, in the past 12 months, been confined to a hospital or medical facility of any kind for more than 24 hours? Yes No
- 13.** In the past 12 months have you scheduled or been advised to have surgery, a diagnostic test, an x-ray, electrocardiogram, blood test or any other laboratory tests, or evaluation of any kind? Yes No
- 14.** In the last 5 years, have you:
- a. Been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities? Yes No
- b. Taken prescription drugs for longer than 15 days? Yes No
- 15.** Have any of your immediate family members (parents or siblings) been diagnosed or died from coronary artery disease, cancer or diabetes prior to age 60? Yes No

PAYMENT OPTIONS (Choose One):

Payer: Proposed Insured Policy Owner (if different than proposed insured) Choose a billing frequency: Monthly Quarterly Semi-annually Annually

Agreement/Authorization to Obtain and Disclose Information: I have read all the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance contract. Any insurance issued as a result of this application will not take effect until the full first premium is paid and a policy is delivered to and accepted by the Proposed Insured during his/her lifetime and while such person is in the state of health described in all parts of this application. I acknowledge receiving the "NOTIFICATION" regarding MIB, Inc. and Fair Credit Reporting Act in the enclosed materials. For use in determining insurability, research, or any other purpose not prohibited by law, I authorize any licensed physician, medical practitioner, MIB, Inc., any pharmacy related service organization, or consumer reporting agency that has any records or knowledge of the Proposed Insured's medical history to give any such information to Heritage Union Life Insurance Company, its representatives, or reinsurers. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. 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 re-disclosed by the Company except as authorized by me or as required by law. I understand that I or any authorized representative will receive a copy of this authorization upon request. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. All applications are subject to underwriting approval which may include, but is not limited to, income verification, medical examination, laboratory testing, MVR, prescription records, and telephone interview.

Fraud Warning: 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. **CO Residents:** 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. **DC Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include, imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **KY Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files and 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. **MD Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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. **OH Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud. **OK Residents:** 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. **OR Residents:** Fraud Warning: 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 and may be subject to fines and confinement in prison. **TN Residents:** 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.

Signed at City _____ State _____ Date _____
 Signature of Proposed Insured (Required – Do not print) _____
 Policy Owner Signature (If Different than Proposed Insured) _____

FOR AGENT USE

To the best of my knowledge, replacement of an existing life insurance policy or annuity contract is is not involved in this transaction.

Agent Signature _____
 Agent Name (Printed) _____
 Agent Number _____
 Signed at City _____ State _____ Date _____

ADDITIONAL APPLICATION INFORMATION BELOW

Authorization For Payment by Electronic Funds Transfer or Credit Card

POLICY OWNER INFORMATION

First Name _____ MI _____

Last Name _____ Suffix _____

Street _____

City _____ State _____ Zip _____

SS# _____

PAYMENT OPTIONS (Choose One):

Choose a billing frequency: Monthly Quarterly Semi-annually Annually

Automatically Deduct Premium from: Savings Checking

Bank Name _____

Account Holder (Payer) Name (Please Print) _____

Account Number: _____

Routing Transit No.: _____

Example of routing/transit and account numbers found on the bottom of your personal check



OR Charge Premium to: Visa MasterCard Discover American Express

Credit Card Number: _____ Expiration Date: _____

BILLING ADDRESS

Same as Mailing Address Above

Street _____

City _____ State _____ Zip _____

I authorize Heritage Union Life Insurance Company to deduct from my account indicated above and I authorize the above named financial institution to honor the withdrawal. I understand that this authorization is to remain in effect until cancelled by me, Heritage Union Life Insurance Company or the Financial Institution named above. To terminate or change this service, I must notify Heritage Union Life Insurance Company at least 30 business days prior to the day that my premium is due to prevent electronic payment drafting.

Signature (Required – Do not print) _____