

SERFF Tracking Number: PHYS-126856324 State: Arkansas  
Filing Company: Physicians Life Insurance Company State Tracking Number: 47107  
Company Tracking Number:  
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Application for Term Life Insurance  
Project Name/Number: /

## Filing at a Glance

Company: Physicians Life Insurance Company

Product Name: Application for Term Life Insurance SERFF Tr Num: PHYS-126856324 State: Arkansas

TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- Closed State Tr Num: 47107

Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird  
Author: Sonja Morton Disposition Date: 10/26/2010  
Date Submitted: 10/21/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval  
State Filing Description:

Implementation Date:

## General Information

Project Name: Status of Filing in Domicile: Authorized  
Project Number: Date Approved in Domicile: 10/15/2010  
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: 10/26/2010 Explanation for Other Group Market Type:  
State Status Changed: 10/26/2010  
Deemer Date: Created By: Sonja Morton  
Submitted By: Sonja Morton Corresponding Filing Tracking Number:  
Filing Description:  
RE: Physicians Life Insurance Company – NAIC No. 72125; FEIN 47-0529583  
Individual Term Life Insurance  
ULA-46 – Application for Term Life Insurance & Variables

The above captioned form is enclosed for your review and approval. The form is new and does not replace any currently approved forms. To the best of my knowledge, the form complies with all state laws and regulations.



SERFF Tracking Number: *PHYS-126856324* State: *Arkansas*  
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Fixed/Indeterminate Premium*  
Product Name: *Application for Term Life Insurance*  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: The filing fee is \$50.00 per form. We are filing one form, so the filing fee is \$50.00.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Life Insurance Company	\$50.00	10/21/2010	41020035

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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved- Closed	Linda Bird	10/26/2010	10/26/2010

*SERFF Tracking Number:*      *PHYS-126856324*                      *State:*                      *Arkansas*  
*Filing Company:*              *Physicians Life Insurance Company*              *State Tracking Number:*      *47107*  
*Company Tracking Number:*  
*TOI:*                      *L04I Individual Life - Term*                      *Sub-TOI:*                      *L04I.103 Renewable - Single Life -*  
*Fixed/Indeterminate Premium*  
  
*Product Name:*              *Application for Term Life Insurance*  
*Project Name/Number:*      */*

## **Disposition**

Disposition Date: 10/26/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *PHYS-126856324* State: *Arkansas*  
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Supporting Document</b>	ULA-46 Variables		Yes
<b>Form</b>	Application for Term Life Insurance		Yes

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## Form Schedule

**Lead Form Number: ULA-46F**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ULA-46F	Application/ Enrollment Form	Application for Term Life Insurance	Initial		46.800	ULA-46F.pdf

**1 Applicant Name** (Person to be Insured)  
 Sample A. SampleXXXXXXXXXXXXXXXXXXXXXXXXXXXX  
 Address1XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXAddress2XXXX  
 City, State ZIP +4  
**Email Address:**  
 (for service and product updates from us) \_\_\_\_\_  
**Phone Number:** (Including Area Code) (\_\_\_\_) \_\_\_\_\_

**2 Date of Birth:** month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_  
**Place of Birth:** (State or Country) \_\_\_\_\_  
**Age:** \_\_\_\_ **Gender:**  Male  Female  
**Height:** feet \_\_\_\_\_ inches \_\_\_\_\_ **Weight:** pounds \_\_\_\_\_  
**Are you a U.S. Citizen or have you been a permanent resident of the U.S. for 2 years?**  YES  NO

**3 Term Period** (Check One)  **10 Year** (XXXX)  **20 Year** (XXXX)  
**Coverage Amount:** (Check One)  \$XX,XXX  \$XX,XXX  
**Add Optional [Accidental Death] Coverage:** (Check One)  \$XX,XXX  \$XX,XXX  \$XX,XXX (LRXXX)

**4 By applying for this insurance, do you intend to replace, discontinue or change any existing life insurance or annuities?**  YES  NO  
 If "Yes," list company name and policy number: \_\_\_\_\_

**5 Choose Your Method of Payment** (Make Check or Money Order Payable to PHYSICIANS LIFE INSURANCE COMPANY)  
 variable pay option copy here

**6 Beneficiary Name** **Relationship To Applicant**  
 First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

**7 [Please Answer The Questions Below:]**

- In the past 12 months**, have you used any form of tobacco or nicotine product?.....  YES  NO
- Are you currently** bedridden; confined to a hospital, nursing home, or other medical facility; confined to a wheelchair; or receiving or applying for disability benefits due to illness? .....  YES  NO
- In the past 5 years**, have you been convicted of a felony; been convicted of or pleaded "guilty" or "no contest" to driving under the influence (DUI/DWI); or used illicit drugs?.....  YES  NO
- Have you ever** tested positive for the Human Immunodeficiency Virus (HIV), or have you been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? .....  YES  NO
- In the past 5 years**, have you had or been diagnosed or treated (including prescription medications) by a member of the medical profession for any of the following: heart or coronary artery disease; stroke; cancer (except basal cell skin cancer); chronic kidney, liver or lung disease; drug or alcohol abuse; insulin dependent diabetes; or disease or disorder of the brain or central nervous system?.....  YES  NO
- In the past 12 months, have you:**  
 a) consulted a member of the medical profession, received medical or surgical care, or taken prescription medication for any condition other than those noted above?.....  YES  NO  
 b) for any condition, been advised to have medical tests which you have not yet completed or have results pending?.....  YES  NO  
**If "yes," please provide the type of condition, dates of treatment, and doctor's name and address:**  
*(If needed, attach, sign and date a separate sheet.)*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8 [Read and Sign]**

I represent the answers in this application are true and complete to the best of my knowledge and belief and understand that the answers will be relied upon to determine my insurability. I understand that the policy will 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 as stated in the application.

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, pharmacy, pharmacy benefit manager, any insurance company, reinsurer, the Medical Information Bureau (MIB), or consumer reporting agency to give to Physicians Life Insurance Company or its reinsurer, information regarding my physical or mental health (except psychotherapy notes), driving record, avocations, finances, insurance history and occupation, for the purpose of underwriting. I understand Physicians Life Insurance Company may disclose this information to entities not covered by federal privacy rules, and if information is redisclosed, it may no longer be protected by those rules.

This authorization, or a copy of it, is valid for 24 months from the date below. I have a right to a copy. I may revoke this authorization, except to the extent it has already been relied upon, by sending written notice to Physicians Life Insurance Company. I understand if I refuse to sign this authorization, Physicians Life Insurance Company will not be able to process my application. I have received the Notice to Applicant regarding the MIB and Fair Credit Reporting Act. I represent that the Applicant's signature below is the original, personal signature of the Applicant. The Applicant 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.

**Applicant Sign Here** \_\_\_\_\_ **Date Signed** \_\_\_\_\_  
 (Do Not Print)

To the best of my knowledge and belief the policy applied for  will  will not replace, cause to be discontinued, or change any existing life insurance or annuities.  
**Agent's Signature** \_\_\_\_\_ **Date Signed** \_\_\_\_\_  
 (Do Not Print)

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> ULA-46F Readability Cert.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application <b>Comments:</b> <b>Attachment:</b> ULA-46F.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> ULA-46 Variables <b>Comments:</b> <b>Attachment:</b> ULA-46 Variables.pdf		

**PHYSICIANS LIFE INSURANCE COMPANY**

**OMAHA, NEBRASKA**

**Certification of Flesch**

The form has the following Flesch Readability Score:

<u>Form</u>	<u>Flesch Score</u>
ULA-46F	46.8

The entire form was analyzed. The following was excluded in the text: name and address of the insurer; name, number and title of the form; captions and sub-captions; medical terminology; defined terms.



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Shawn Pollock  
Vice President  
Government and Industry

10-11-10  
Date

1 Applicant Name (Person to be Insured)
Sample A. Samplexxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Address1xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxAddress2xxxx
City, State ZIP +4
Email Address:
(for service and product updates from us)
Phone Number: (Including Area Code) ( )

2 Date of Birth: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_
Place of Birth: (State or Country) \_\_\_\_\_
Age: \_\_\_\_\_ Gender:  Male  Female
Height: feet \_\_\_\_\_ inches \_\_\_\_\_ Weight: pounds \_\_\_\_\_
Are you a U.S. Citizen or have you been a permanent resident of the U.S. for 2 years?  YES  NO

3 Term Period (Check One)  10 Year (XXXX)  20 Year (XXXX)
Coverage Amount: (Check One)  \$XX,XXX  \$XX,XXX
Add Optional [Accidental Death] Coverage: (Check One)  \$XX,XXX  \$XX,XXX  \$XX,XXX (LRXXX)

4 By applying for this insurance, do you intend to replace, discontinue or change any existing life insurance or annuities?  YES  NO
If "Yes," list company name and policy number: \_\_\_\_\_

5 Choose Your Method of Payment (Make Check or Money Order Payable to PHYSICIANS LIFE INSURANCE COMPANY)
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6 Beneficiary Name Relationship To Applicant
First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

7 [Please Answer The Questions Below:]
1. In the past 12 months, have you used any form of tobacco or nicotine product?.....  YES  NO
2. Are you currently bedridden; confined to a hospital, nursing home, or other medical facility; confined to a wheelchair; or receiving or applying for disability benefits due to illness? .....  YES  NO
3. In the past 5 years, have you been convicted of a felony; been convicted of or pleaded "guilty" or "no contest" to driving under the influence (DUI/DWI); or used illicit drugs?.....  YES  NO
4. Have you ever tested positive for the Human Immunodeficiency Virus (HIV), or have you been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? .....  YES  NO
5. In the past 5 years, have you had or been diagnosed or treated (including prescription medications) by a member of the medical profession for any of the following: heart or coronary artery disease; stroke; cancer (except basal cell skin cancer); chronic kidney, liver or lung disease; drug or alcohol abuse; insulin dependent diabetes; or disease or disorder of the brain or central nervous system?.....  YES  NO
6. In the past 12 months, have you:
a) consulted a member of the medical profession, received medical or surgical care, or taken prescription medication for any condition other than those noted above?.....  YES  NO
b) for any condition, been advised to have medical tests which you have not yet completed or have results pending?.....  YES  NO
If "yes," please provide the type of condition, dates of treatment, and doctor's name and address:
(If needed, attach, sign and date a separate sheet.)

8 [Read and Sign ]
I represent the answers in this application are true and complete to the best of my knowledge and belief and understand that the answers will be relied upon to determine my insurability. I understand that the policy will 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 as stated in the application.
I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, pharmacy, pharmacy benefit manager, any insurance company, reinsurer, the Medical Information Bureau (MIB), or consumer reporting agency to give to Physicians Life Insurance Company or its reinsurer, information regarding my physical or mental health (except psychotherapy notes), driving record, avocations, finances, insurance history and occupation, for the purpose of underwriting. I understand Physicians Life Insurance Company may disclose this information to entities not covered by federal privacy rules, and if information is redisclosed, it may no longer be protected by those rules.
This authorization, or a copy of it, is valid for 24 months from the date below. I have a right to a copy. I may revoke this authorization, except to the extent it has already been relied upon, by sending written notice to Physicians Life Insurance Company. I understand if I refuse to sign this authorization, Physicians Life Insurance Company will not be able to process my application. I have received the Notice to Applicant regarding the MIB and Fair Credit Reporting Act. I represent that the Applicant's signature below is the original, personal signature of the Applicant. The Applicant must personally sign. Signatures under power of attorney will not be accepted.
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Applicant Sign Here \_\_\_\_\_ Date Signed \_\_\_\_\_
(Do Not Print)

To the best of my knowledge and belief the policy applied for  will  will not replace, cause to be discontinued, or change any existing life insurance or annuities.
Agent's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_
(Do Not Print)

## Overall Variables:

- May change the dimensions of the form to varying horizontal format, or vertical format.
  - May change the font style in the layout. May rearrange the layout and format.
  - May add/change/delete/move boxes and heading boxes.
  - May add/change/delete/move a reply by date (ie: Please Respond Within 10 Days).
  - May add/change/delete/move the premium rates.
  - May add/change/delete/move the plan name, client logo, and/or company logo.
  - May add/change/delete/move copy above signature line in application: "I ACKNOWLEDGE THIS INSURANCE IS NOT A DEPOSIT OR OTHER OBLIGATION OF, OR GUARANTEED BY CITIBANK, OR ITS AFFILIATES AND IS NOT FDIC INSURED, AND NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY, OR "XYZ" BANK OR ITS AFFILIATES."
1. May add/change/delete/move the layout, format and copy pertaining to the Insured: Name, Address, Phone #, Email Address, etc.
  2. May add/change/delete/move the layout, format and copy pertaining to the Insured: Date of Birth, Age, Height, Weight, State of Birth, Female/Male, etc.
  3. May add/change/delete/move formatting of the heading { Coverage Amount (check one)}, dollar amount, number of options offered and rider combinations with varying dollar amounts and may move, rearrange and change format.
  4. May change/move formatting of the insurance replacement question area. The wording of the question, as filed, will never change.
  5. May add/change/delete/move/ or substitute applicable language for Variable Pay Options copy. Variable Payment Options will include monthly, quarterly, semiannual, annual, credit card billing (where available), electronic fund transfer, and direct billing. These may be used singularly or in combination. This would include adding/changing/deleting/moving copy for account numbers, expiration dates, (Make check or money order payable to PHYSICIANS LIFE INSURANCE COMPANY), account/client name/financial institute, combining two different payment options, credit card number/expiration date, credit card holders signature line and (\*Direct billing available), as appropriate.
  6. May add/change/delete/move formatting of the Beneficiary area or add address area.
  7. May add/change/delete/move formatting of the heading that is instructional copy.
  8. May add/change/delete/move payment copy for credit card, electronic file transfer (automatic bank withdrawal), & Third Party pay copy in the attestation as needed. May add/change/delete/move the format of the internal coding. May change/move the signature line, credit card signature line, and date depending on varying format.
- May add/change/delete/move the format of the agent signature line and date depending on varying format. The agent's signature line will be only if the solicitation involves telemarketing via a licensed agent.