

SERFF Tracking Number: AAMC-126929070 State: Arkansas
Filing Company: Pioneer American Insurance Company State Tracking Number: 47491
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Additional Insured Life Insurance Application - 9901
Project Name/Number: /

Filing at a Glance

Company: Pioneer American Insurance Company

Product Name: Additional Insured Life SERFF Tr Num: AAMC-126929070 State: Arkansas

Insurance Application - 9901

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 47491
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Author: Traci Baty

Reviewer(s): Linda Bird

Date Submitted: 12/08/2010

Disposition Date: 12/13/2010

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 in Texas, our
State of Domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 12/13/2010

Explanation for Other Group Market Type:

State Status Changed: 12/13/2010

Deemer Date:

Created By: Traci Baty

Submitted By: Traci Baty

Corresponding Filing Tracking Number:

Filing Description:

Cover Letter under Supporting Documentation.

Company and Contact

Filing Contact Information

Clara Keel, Product Filing Manager and
Assistant Secretary

ckeel@aatx.com

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425 Austin Avenue 254-297-2794 [Phone]
 Waco, TX 76701 254-297-2138 [FAX]

Filing Company Information

Pioneer American Insurance Company	CoCode: 67873	State of Domicile: Texas
425 Austin Avenue	Group Code: 1327	Company Type: LAH
Waco, TX 76701	Group Name:	State ID Number:
(254) 297-2777 ext. [Phone]	FEIN Number: 75-0914374	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pioneer American Insurance Company	\$50.00	12/08/2010	42757344

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/13/2010	12/13/2010

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Disposition

Disposition Date: 12/13/2010

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		No
Supporting Document	Cover Letter		Yes
Form	Additional Insured Life Insurance Application		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
	Form No. PA9901	Application/ Additional Insured Enrollment Life Insurance Form Application	Initial		64.000	STD PA9901 Life Insurance Application.pdf

PIONEER AMERICAN INSURANCE COMPANY
P.O. BOX 240, WACO, TX 76703-0240 • (254) 297-2776

ADDITIONAL INSURED
LIFE INSURANCE APPLICATION (Please print in black ink)

Proposed Additional Insured: _____ <small>(First) (Middle) (Last)</small>					_____ <input type="checkbox"/> am <input type="checkbox"/> pm <small>Phone Best time to call</small>	
Address: (No. & Street) _____					E-mail Address _____ @ _____	
City: _____		State: _____		Zip Code: _____		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Mo. Day Yr / /	Age	State of Birth	SS# — — DL#	Height: _____ ft _____ in Weight: _____ lbs	Occupation: _____ Annual Salary: \$ _____
Additional Primary Beneficiary _____			SS# _____	Relationship _____		
Insured: Contingent Beneficiary _____			SS# _____	Relationship _____		
Plan: _____ Face Amount \$ _____ (Not to exceed 3X the face amount of the base policy) (Minimum \$10,000)						
<input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Preferred Have you used tobacco or nicotine products in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No.....or during the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Do you have any existing life or disability insurance or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No				Company _____		
Will you replace an existing life or disability insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No				Policy # _____		Coverage Amount \$ _____

SECTION A: Answer Questions 1 through 3 for Proposed Additional Insured. (circle all conditions that apply)

1. **Within the past 10 years**, have you taken medication or been treated for, or been diagnosed by a medical professional with:
 - a. high blood pressure, heart attack, angina, arrhythmia, stroke, aneurysm, or any heart or circulatory disease or disorder? Yes No
 - b. diabetes, cirrhosis, hepatitis, pancreatitis, Crohn's disease, ulcerative colitis, or any digestive or liver disease or disorder? Yes No
 - c. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea or any respiratory disease or disorder? Yes No
 - d. cancer in any form, migraine headaches, anemia, seizure, bi-polar disorder, schizophrenia, or mental or nervous disorder? Yes No
 - e. any disease or disorder of the kidneys, urinary bladder, prostate, breast, reproductive organs, or sexually transmitted disease? Yes No
 - f. connective tissue disease, systemic lupus (SLE), arthritis, or any disorder of the back, joints, muscles, or nervous system? Yes No
 - g. any other disease or disorder, injury, surgery, birth defect, or deformity? Yes No
 - h. Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? Yes No
2. **Within the past 5 years**, have you:
 - a. been convicted of any misdemeanor or felony charge (including DUI or DWI), had a driver's license suspended or revoked or is currently suspended or revoked, or any motor vehicle violations or is currently on probation or parole? Yes No
 - b. used illegal drugs, or been recommended by a medical professional or a licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs? Yes No
 - c. participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving? Yes No
 - d. made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? Yes No
 - e. had application (including a reinstatement application) for life or health insurance declined, rated, modified, or postponed? Yes No
3. **Within the past 12 months**, have you:
 - a. consulted a medical professional, had surgery, been hospitalized, or had diagnostic tests such as EKG, Xray, MRI, CAT scan? Yes No
 - b. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? Yes No
4. **Complete only if the Proposed Additional Insured is a minor**
 - a. Are all siblings being insured? Yes No
 - b. Sum of existing life insurance on each parent: \$ _____ \$ _____ None
 - c. If (a.) is "No" or (b.) is "None", provide reason: _____

SECTION B: Give details to all "Yes" answers in Section A and list current medications (use COMMENTS section on back for additional space).

Condition	Dates	Treatment	Name/Address/Phone No. of Physician/Hospital
	/ /		
	/ /		
	/ /		
	/ /		

Form No. PA9901

NOTICE

Printed in compliance with Public Law 91-508

Thank you for considering Pioneer American Insurance Company for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Pioneer American Insurance Company, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Pioneer American Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

COMMENTS:

AGREEMENT—I agree with Pioneer American Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the Medical Information Bureau or other organization that has knowledge or records of me and my health to give such information to: (a) Pioneer American Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the Medical Information Bureau, are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Pioneer American Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the Medical Information Bureau; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

CERTIFICATION—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

I acknowledge receiving the Fair Credit Reporting Act Notice and the MIB Pre-Notice.

Signed at (City) _____ (State) _____ Date of Application (MM/DD/YY) _____

SIGNATURE OF PROPOSED ADDITIONAL INSURED
(Parent or legal guardian if proposed additional insured is under 16)

SIGNATURE OF OWNER (IF OTHER THAN PROPOSED ADDITIONAL INSURED)

AGENT ACKNOWLEDGEMENT

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.

Are you aware of any existing life insurance or annuity contract on the life of the Proposed Insured, except as noted in this application? Yes No

Are you aware of this policy replacing any existing life insurance policies or annuity contracts with this or any other company? Yes No

Agent Signature _____ Agent Printed Name _____ No: _____ % _____

Agent Signature _____ Agent Printed Name _____ No: _____ % _____

Form No. PA9901

PIONEER AMERICAN INSURANCE COMPANY
P.O. BOX 240, WACO, TX 76703-0240

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT. THIS RECEIPT SHALL BE INVALID AND MAY NOT BE ISSUED WITH RESPECT TO PROPOSED PAYMENT OF THE INITIAL PREMIUM TENDERED BY MEANS OF A POST-DATED CHECK.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Received from _____ the sum of \$ _____ as first payment on this application for Proposed Insured _____ Date _____ Agent _____

If (1) an amount equal to the first full premium is submitted or a payroll deduction authorization, a government allotment authorization, or a bank draft authorization has been fully implemented in an amount sufficient to pay the first full monthly premium, (2) any check or bank draft authorization given in payment of the initial premium is honored when first presented, (3) all underwriting requirements, including any medical examinations required by the Company's rules, are completed, and (4) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date the payroll deduction authorization or government allotment authorization is submitted for processing, or (c) the requested draft date specified in the bank draft authorization, or (d) the date of the latest medical exam required by the Company. THE TOTAL AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED \$150,000.00. (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met exactly, the liability of the Company shall be limited to the return of any amount paid.

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Supporting Document Schedules

Item Status:

**Status
Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR PA9901 Readability Certification.pdf

Item Status:

**Status
Date:**

Satisfied - Item: Cover Letter

Comments:

Cover Letter attached.

Attachment:

AR PA9901 Cover Letter.pdf

ARKANSAS

PIONEER AMERICAN INSURANCE COMPANY

CERTIFICATION

This is to certify that the attached Additional Insured Life Insurance Application, Form Number PA9901, has achieved a Flesch Reading Ease Score of 64 and complies with the requirements of Arkansas Statue 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Simplification Act.



Signature

Clara Keel, FLMI
Product Filing Manager & Assistant Secretary

December 6, 2010

Pioneer American Insurance Company

P.O. Box 240 • Waco, Texas 76703-0240 • 254-297-2776

December 8, 2010

NAIC No. 67873

Mr. Joe Musgrove
Policy and Other Form Filings
State of Arkansas
Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-1904
Attention: Compliance - Life and Health

Re: Form No. PA9901, Additional Insured Life Insurance Application

Dear Mr. Musgrove:

The above referenced application is being submitted for your consideration and review. This application is new and will not replace any application approved by your department. The Flesch readability score is 64.

Application, Form No. PA9901, will be used when applying for the Additional Insured Benefit Rider, Form No. PA9885, approved by your department on October 7, 2010.

The above referenced submission meets the provisions of Arkansas Rule and Regulation 19 (Unfair Sex Discrimination in the Sale of Insurance) as well as all applicable requirements of the department.

If I may be of assistance in your review, please contact me at 1-800-736-7311, extension 3216 or ckeel@aatx.com.

Sincerely,



Clara Keel, FLMI
Product Filing Manager & Assistant Secretary

CJK:tad
Enc.

