

SERFF Tracking Number: BFLI-126931618 State: Arkansas
 Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 47489
 Company Tracking Number: AR 0209 SM AP2010
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Application for Life Insurance
 Project Name/Number: /

Filing at a Glance

Company: Bankers Fidelity Life Insurance Company

Product Name: Application for Life Insurance SERFF Tr Num: BFLI-126931618 State: Arkansas
 TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- State Tr Num: 47489
 Closed

Sub-TOI: L071.101 Fixed/Indeterminate Co Tr Num: AR 0209 SM AP2010 State Status: Approved-Closed
 Premium - Single Life
 Filing Type: Form

Reviewer(s): Linda Bird
 Disposition Date: 12/10/2010
 Authors: Jill Jones, Bridgett
 Williams, Tina Cunningham, Lyn
 Ezell, Sharon White
 Date Submitted: 12/08/2010

Disposition Status: Approved-Closed
 Implementation Date:

Implementation Date Requested: On Approval
 State Filing Description:

General Information

Project Name:
 Project Number:
 Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending
 Date Approved in Domicile:
 Domicile Status Comments: submitted to GA
 DOI 12-03-2010

Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 12/10/2010

Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 12/10/2010
 Created By: Jill Jones
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Tina Cunningham
 Filing Description:

This application is new and will not replace any previously approved form. It will be used to underwrite our previously approved life products, detailed on the form use document attached to the Supporting Documentation tab.

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Company and Contact

Filing Contact Information

Tina Cunningham, Compliance Analyst L1 tcunningham@atlam.com
 4370 Peachtree Road NE 404-266-5723 [Phone]
 Atlanta, GA 30319 404-926-4092 [FAX]

Filing Company Information

Bankers Fidelity Life Insurance Company CoCode: 61239 State of Domicile: Georgia
 4370 Peachtree Rd NE Group Code: 587 Company Type: Life & Health
 Atlanta, GA 30319 Group Name: 61239 State ID Number:
 (404) 266-5600 ext. [Phone] FEIN Number: 58-0658963

Filing Fees

Fee Required? Yes
 Fee Amount: \$25.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Bankers Fidelity Life Insurance Company	\$25.00	12/08/2010	42756071
Bankers Fidelity Life Insurance Company	\$25.00	12/10/2010	42826205

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/10/2010	12/10/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	12/08/2010	12/08/2010	Tina Cunningham	12/10/2010	12/10/2010

SERFF Tracking Number: BFLI-126931618 *State:* Arkansas
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Product Name: Application for Life Insurance
Project Name/Number: /

Disposition

Disposition Date: 12/10/2010

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 - Actuarial Memo		No
Supporting Document	Forms Use List		Yes
Supporting Document	Statement Variability		Yes
Form	Application for Life Insurance		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 12/08/2010
Submitted Date 12/08/2010
Respond By Date 01/10/2011

Dear Tina Cunningham,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$25.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 12/10/2010
Submitted Date 12/10/2010

Dear Linda Bird,

Comments:

Thank you for informing me of the fee increase. I have submitted and addition \$25.00.

Response 1

Comments: Additonal \$25.00 has been submitted.

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$25.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you.

Sincerely,

Bridgett Williams, Jill Jones, Lyn Ezell, Sharon White, Tina Cunningham

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Form Schedule

Lead Form Number: B 0209 SM AP2010

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	B 0209 SM AP2010	Application/ Enrollment Form	Application for Life Insurance	Initial		47.240	B 0209 SM AP2010 john doe.pdf

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, GA 30348-5146

APPLICATION FOR LIFE INSURANCE

PLEASE PRINT

Agent/Broker Name	Agent #
Joe Agent	00001

Proposed Insured	Social Security No.	Sex	Place (State) of Birth	Age	Born			Height & Weight		
					Mo.	Day	Yr.	Ft.	In.	Lbs.
John D. Doe	000000000	M	GA	45	01	01	65	6	2	180
Residence Address (Street or Route & Box No.)		City	County	State	Zip Code					
#1 Main Street		City	County	ST	00000-0001					
Mailing Address (if different than Residence Address)		City	State	Zip Code						
Same										
Telephone Number	Occupation:	Proposed Insured E-mail Address:			Mail Policy To:					
(404) 123-4567	manager	johndoe@email.com			<input checked="" type="checkbox"/> Insured <input type="checkbox"/> Agent					

PRINT—To whom should premium notices be sent? Same address as Proposed Insured, or:

Payor name (If other than Insured) _____ Social Security No: _____
 Relationship to Insured _____ Phone Number: () _____
 Complete Address: _____

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

LIFE INSURANCE: <input checked="" type="checkbox"/> Level Whole Life <input type="checkbox"/> Modified Whole Life** Requested Face Amount: \$ <u>25,000</u> Automatic Premium Loan: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No **Not available in AR, KS, MD, MO, NC, ND, WA, WV or WI.	PREMIUM MODE: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Monthly Bank Draft* <input type="checkbox"/> Monthly Credit Card* *Requested Draft Date <u>1st</u>	BILLING TYPE: <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Family* *Complete Family Billing Form B 0129 FB/LB	MODAL PREMIUM COMPUTATION: Total Amount Paid \$ <u>xxx-xx</u> <input type="checkbox"/> Check/money order included. <input type="checkbox"/> Charge credit card for initial premium. <input checked="" type="checkbox"/> Draft initial premium* *Initial draft date <u>today</u>
OPTIONAL RIDER(S): <input checked="" type="checkbox"/> Accidental Death Benefit <input checked="" type="checkbox"/> Children's Insurance (answer questions 9 & 10) <u>10,000.00</u> Requested Benefit	REQUESTED EFFECTIVE DATE: <u>01-01-2011</u>		

IF THE ANSWER TO ANY PART OF QUESTION 1 THROUGH 3 IS "YES," COVERAGE IS NOT AVAILABLE.

- In the last 5 years, has the Proposed Insured had or been medically diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
- In the last 3 years, has the Proposed Insured had or been medically diagnosed with or treated for:
 - cirrhosis, liver disease, hepatitis (excluding Type A), kidney/renal failure or insufficiency, chronic kidney disease, or been advised to have or had dialysis? Yes No
 - Alzheimer's disease, dementia or organic brain syndrome? Yes No
 - muscular dystrophy, Lou Gehrig's disease (ALS) or sickle cell anemia? Yes No
- In the past year, has the Proposed Insured:
 - been confined to a hospital 3 or more times or to a nursing facility or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring, or toileting? Yes No
 - been confined to a wheelchair or require the use of a wheelchair or motorized mobility aid due to a medical condition or on the advice of a physician? Yes No
 - been medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? Yes No
 - had any heart or circulatory surgery? Yes No

IF THE ANSWER TO ANY PART OF QUESTION 4 IS "YES," LEVEL WHOLE LIFE IS NOT AVAILABLE. ONLY THE MODIFIED WHOLE LIFE* MAY BE AVAILABLE. *Not available in AR, KS, MD, MO, NC, ND, WA, WV or WI.

- In the last 3 years, has the Proposed Insured had, been medically diagnosed with, or treated for:
 - heart attack, stroke, congestive heart failure, or amputation due to disease? Yes No
 - emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, or used supplemental oxygen? Yes No
 - internal cancer, leukemia, malignant melanoma, or Hodgkin's disease? Yes No
 - Schizophrenia or delusional or psychotic disorder, alcoholism or drug addiction? Yes No
 - Parkinson's or Huntington's disease, multiple sclerosis, or systemic lupus? Yes No
 - complications of diabetes, diabetic coma, or insulin shock? Yes No
 - testing or surgery for the transplanting of any organ or tissue (excluding corneal transplants)? Yes No

5. Please provide complete name, address and telephone number of the Proposed Insured's primary care physician:

Physician's name: Dr. Bob Physician Telephone number 404-234-5678
 Physician's address: #1 Medical Ct, City, ST 00001-0000

(Application continued on reverse side)

6. Is the Proposed Insured a legal citizen of the United States or its possessions? Yes No
 If "No," is the Proposed Insured a Permanent Resident? Yes No If "No," coverage is not available.
 If "Yes," provide the following information as shown on the Permanent Resident Card:
 I.N.S. # _____ CATEGORY _____ RESIDENT SINCE _____ CARD EXPIRES _____

7. (a) Does the Proposed Insured currently have any life insurance policies or annuity contracts in force or pending?.... Yes No
 If "Yes": Name of company(ies) _____ Face Amount \$ _____ Policy No. _____
attach additional sheets if necessary (if known)
 (b) Will any life insurance or annuities be replaced with this policy of whole life insurance? Yes No
 If the answer to either question is "Yes", complete Replacement Notice(s) as required.

8. Name of Primary Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
Jane D. Doe	wife	000-00-0002	Same	Same
Name of Contingent Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
John D. Doe Jr.	son	00000-0003	Same	Same
Name of Owner (If other than Insured)	Relationship	Social Security No. (If known)	Address	Telephone No.

COMPLETE THIS SECTION IF THE CHILDREN'S INSURANCE RIDER IS BEING APPLIED FOR:

DEPENDENT CHILDREN PROPOSED FOR COVERAGE: <small>All children must be listed, attach additional sheet if necessary (First Name, Middle Initial, Last Name)</small>	Social Security Number	Sex	Place (State) of Birth	Age	Born			Height & Weight		
					Month	Day	Year	Feet	Inches	Lbs.
John D. Doe, Jr.	000-00-0003	M	GA	10	01	01	00	5	0	100

9. (a) Is any child proposed for insurance medically prohibited or prevented from participating in the daily activities normally associated with a child of their age due to injury, illness, disease or deformity, including but not limited to attending school? Yes No
 (b) Has any child proposed for insurance been hospitalized in the last 120 days?..... Yes No
 (c) Has any child proposed for insurance been medically diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)?.... Yes No
 10. Has any child proposed for insurance been medically diagnosed with or treated for or taken prescription medication for asthma, cerebral palsy, congenital heart defects, cystic fibrosis, Down's syndrome, hemophilia, insulin-dependent diabetes, internal cancer, leukemia, Muscular Dystrophy or seizure disorder? Yes No

11. I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein. I have received a "Life Insurance Buyer's Guide."

The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or contest your policy, subject to the "Incontestability" provision of the Policy.

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

Dated at Citrus ST, on 12-01-10 X [Signature]
(City and State) (Month, Day, Year) Proposed Insured's signature. Please read item 9 before signing.
*The Proposed Insured is the Applicant and Owner unless otherwise indicated.
X _____ X _____ X [Signature] 00001
Owner-Life only (if other than Proposed Insured) Applicant (if other than Proposed Insured) Agent's signature Agent's number

WRITING AGENT COMPLETE

Does the Proposed Insured currently have any life insurance policies or annuity contracts in force or pending? Yes No
Is any of this insurance being purchased to replace or change any existing life insurance policies or annuity contracts? Yes No

If the answer to either question above is "Yes", complete Replacement Notice(s) as required.

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured a "Life Insurance Buyers Guide:"

Is the Proposed Insured related to you? Yes No If "Yes," explain relationship: Self _____
If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insured's identity as required by the USA Patriot Act (PL 107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:
 Drivers License Passport Government-issued identification card Other _____

Dated at Citrus ST, on 12-01-10 X [Signature] 00001
(City and State) (Month, Day, Year) Agent's signature Agent's number
X _____
Co-signature (if required)

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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

B 0209 SM AP2010 Flesch Cert.pdf
 Guaranty Association Notice B 0076 AR.pdf
 Consumer Notice B 0034 AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Attachment:

B 0209 SM AP2010 john doe.pdf

Item Status: **Status Date:**

Satisfied - Item: Forms Use List

Comments:

Attachment:

AR B 0209 SM AP2010 Forms Use List.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement Variability

Comments:

Attachment:

B 0209 SM AP2010 Statement of Variability.pdf

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319

(404) 266-5657

FLESCH SCORE CERTIFICATION

B 0209 SM AP2010 – Application

Words:	369
Sentences:	12
Syllables:	560
Score:	47.24

I hereby certify that the Flesch reading ease score of the above forms is as shown.



Sharon A. White
Vice President; Legal/Compliance



Date

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are member of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting the insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

The Arkansas Life and Health Insurance Guaranty Association
C/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72202

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different type of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

BANKERS FIDELITY LIFE INSURANCE COMPANY

Atlanta, Georgia

The following information is being provided to you in accordance with Act 197 of the Arkansas Department of Insurance Regulations:

Bankers Fidelity Life Insurance Company

Policyholder Service Department

4370 Peachtree Road, N.E.

Atlanta, Georgia 30319

Toll-Free: 866-458-7500

Fax: (404) 926-4033

bflphs@atlam.com

If we at Bankers Fidelity Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Department of Insurance

Consumer Service Division

1200 West Third Street

Little Rock, Arkansas 72201-1904

(510) 371-2640, (800) 852-5494

Fax: (501) 371-2749

insurance.consumers@arkansas.gov

Your Agent:

{FId0240}

{FId0241} {FId0242}

{FId0243} {FId0244}

{FId0245}

This notice is for information only and does not become a part or condition of your policy.

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, GA 30348-5146

APPLICATION FOR LIFE INSURANCE

PLEASE PRINT

Agent/Broker Name	Agent #
Joe Agent	00001

Proposed Insured	Social Security No.	Sex	Place (State) of Birth	Age	Born			Height & Weight			
John D. Doe	000000000	M	GA	45	Mo.	Day	Yr.	Ft.	In.	Lbs.	
					01	01	65	6	2	180	
Residence Address (Street or Route & Box No.)	City	County	State	Zip Code							
#1 Main Street	City	County	ST	00000-0001							
Mailing Address (if different than Residence Address)	City	State	Zip Code								
Same											
Telephone Number	Occupation:	Proposed Insured E-mail Address:					Mail Policy To:				
(404) 123-4567	manager	johndoe@email.com					<input checked="" type="checkbox"/> Insured <input type="checkbox"/> Agent				

PRINT—To whom should premium notices be sent? Same address as Proposed Insured, or:

Payor name (If other than Insured) _____ Social Security No: _____

Relationship to Insured _____ Phone Number: () _____

Complete Address: _____

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

LIFE INSURANCE: <input checked="" type="checkbox"/> Level Whole Life <input type="checkbox"/> Modified Whole Life** Requested Face Amount: \$ <u>25,000</u> Automatic Premium Loan: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <small>**Not available in AR, KS, MD, MO, NC, ND, WA, WV or WI.</small>	PREMIUM MODE: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Monthly Bank Draft* <input type="checkbox"/> Monthly Credit Card* *Requested Draft Date <u>1st</u>	BILLING TYPE: <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Family* <small>*Complete Family Billing Form B 0129 FB/LB</small>	MODAL PREMIUM COMPUTATION: Total Amount Paid \$ <u>xxx-xx</u> <input type="checkbox"/> Check/money order included. <input type="checkbox"/> Charge credit card for initial premium. <input checked="" type="checkbox"/> Draft initial premium* *Initial draft date <u>today</u>
OPTIONAL RIDER(S): <input checked="" type="checkbox"/> Accidental Death Benefit <input checked="" type="checkbox"/> Children's Insurance (answer questions 9 & 10) <u>10,000.00</u> Requested Benefit	REQUESTED EFFECTIVE DATE: <u>01-01-2011</u>		

- IF THE ANSWER TO ANY PART OF QUESTION 1 THROUGH 3 IS "YES," COVERAGE IS NOT AVAILABLE.**
- In the last 5 years, has the Proposed Insured had or been medically diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
 - In the last 3 years, has the Proposed Insured had or been medically diagnosed with or treated for:
 - cirrhosis, liver disease, hepatitis (excluding Type A), kidney/renal failure or insufficiency, chronic kidney disease, or been advised to have or had dialysis? Yes No
 - Alzheimer's disease, dementia or organic brain syndrome? Yes No
 - muscular dystrophy, Lou Gehrig's disease (ALS) or sickle cell anemia? Yes No
 - In the past year, has the Proposed Insured:
 - been confined to a hospital 3 or more times or to a nursing facility or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring, or toileting? Yes No
 - been confined to a wheelchair or require the use of a wheelchair or motorized mobility aid due to a medical condition or on the advice of a physician? Yes No
 - been medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? Yes No
 - had any heart or circulatory surgery? Yes No

- IF THE ANSWER TO ANY PART OF QUESTION 4 IS "YES," LEVEL WHOLE LIFE IS NOT AVAILABLE. ONLY THE MODIFIED WHOLE LIFE* MAY BE AVAILABLE.** *Not available in AR, KS, MD, MO, NC, ND, WA, WV or WI.
- In the last 3 years, has the Proposed Insured had, been medically diagnosed with, or treated for:
 - heart attack, stroke, congestive heart failure, or amputation due to disease? Yes No
 - emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, or used supplemental oxygen? Yes No
 - internal cancer, leukemia, malignant melanoma, or Hodgkin's disease? Yes No
 - Schizophrenia or delusional or psychotic disorder, alcoholism or drug addiction? Yes No
 - Parkinson's or Huntington's disease, multiple sclerosis, or systemic lupus? Yes No
 - complications of diabetes, diabetic coma, or insulin shock? Yes No
 - testing or surgery for the transplanting of any organ or tissue (excluding corneal transplants)? Yes No

5. Please provide complete name, address and telephone number of the Proposed Insured's primary care physician:

Physician's name: Dr. Bob Physician Telephone number 404-234-5678

Physician's address: #1 Medical Ct, City, ST 00001-0000

(Application continued on reverse side)

6. Is the Proposed Insured a legal citizen of the United States or its possessions? Yes No
 If "No," is the Proposed Insured a Permanent Resident? Yes No If "No," coverage is not available.
 If "Yes," provide the following information as shown on the Permanent Resident Card:
 I.N.S. # _____ CATEGORY _____ RESIDENT SINCE _____ CARD EXPIRES _____

7. (a) Does the Proposed Insured currently have any life insurance policies or annuity contracts in force or pending?.... Yes No
 If "Yes": Name of company(ies) _____ Face Amount \$ _____ Policy No. _____
attach additional sheets if necessary (if known)
 (b) Will any life insurance or annuities be replaced with this policy of whole life insurance? Yes No
 If the answer to either question is "Yes", complete Replacement Notice(s) as required.

8. Name of Primary Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
Jane D. Doe	wife	000-00-0002	Same	Same
Name of Contingent Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
John D. Doe Jr.	son	00000-0003	Same	Same
Name of Owner (If other than Insured)	Relationship	Social Security No. (If known)	Address	Telephone No.

COMPLETE THIS SECTION IF THE CHILDREN'S INSURANCE RIDER IS BEING APPLIED FOR:

DEPENDENT CHILDREN PROPOSED FOR COVERAGE: All children must be listed, attach additional sheet if necessary (First Name, Middle Initial, Last Name)	Social Security Number	Sex	Place (State) of Birth	Age	Born			Height & Weight		
					Month	Day	Year	Feet	Inches	Lbs.
John D. Doe, Jr.	000-00-0003	M	GA	10	01	01	00	5	0	100

9. (a) Is any child proposed for insurance medically prohibited or prevented from participating in the daily activities normally associated with a child of their age due to injury, illness, disease or deformity, including but not limited to attending school? Yes No
 (b) Has any child proposed for insurance been hospitalized in the last 120 days?..... Yes No
 (c) Has any child proposed for insurance been medically diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)?.... Yes No
 10. Has any child proposed for insurance been medically diagnosed with or treated for or taken prescription medication for asthma, cerebral palsy, congenital heart defects, cystic fibrosis, Down's syndrome, hemophilia, insulin-dependent diabetes, internal cancer, leukemia, Muscular Dystrophy or seizure disorder? Yes No

11. I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein. I have received a "Life Insurance Buyer's Guide."

The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or contest your policy, subject to the "Incontestability" provision of the Policy.

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

Dated at Citrus ST, on 12-01-10 X [Signature]
(City and State) (Month, Day, Year) Proposed Insured's signature. Please read item 9 before signing.
*The Proposed Insured is the Applicant and Owner unless otherwise indicated.
X _____ X _____ X [Signature] 00001
Owner-Life only (if other than Proposed Insured) Applicant (if other than Proposed Insured) Agent's signature Agent's number

WRITING AGENT COMPLETE

Does the Proposed Insured currently have any life insurance policies or annuity contracts in force or pending? Yes No
Is any of this insurance being purchased to replace or change any existing life insurance policies or annuity contracts? Yes No

If the answer to either question above is "Yes", complete Replacement Notice(s) as required.

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured a "Life Insurance Buyers Guide:"

Is the Proposed Insured related to you? Yes No If "Yes," explain relationship: Self _____
If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insured's identity as required by the USA Patriot Act (PL 107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:
 Drivers License Passport Government-issued identification card Other _____

Dated at Citrus ST, on 12-01-10 X [Signature] 00001
(City and State) (Month, Day, Year) Agent's signature Agent's number
X _____
Co-signature (if required)

**Application for Life Insurance: B 0209 SM AP2010
FORMS TO BE USED WITH**

ARKANSAS

The Application for Life Insurance may be issued with the following policy forms and riders:

<u>Form Number</u>	<u>Description / Title</u>	<u>Approved by State</u>
B 20604	Endowment at Age 100	07-10-2006
B 20801	Level Whole Life Insurance	10-06-2008
B 20802	Modified Whole Life Insurance	12-02-2008
B 0109 TI ADB 50 (R09)	Accelerated Death Benefit Rider	11-09-2010
B 0108 WP NHC	Waiver of Premium Rider	07-01-1997
BFL-CIR	Children's Insurance Rider	01-18-1988
BFL-WPD	Waiver of Premium for Disability Rider	01-18-1988

STATEMENT OF VARIABILITY

Application for Life Insurance

Form: B 0209 SM AP2010

ITEM

Checkboxes for Life Insurance Plans

VARIABILITY

ability to remove plans that are no longer offered or offer additional that are later approved by the state; the options are shown on the Forms Use document attached to the filing

Checkboxes for Optional Rider(s)

ability to remove riders that are no longer offered or offer additional that are later approved by the state; the options are shown on the Forms Use document attached to the filing