

SERFF Tracking Number: LSVX-126493991 State: Arkansas
 Filing Company: USAbLe Life State Tracking Number: 44804
 Company Tracking Number: ICIAR0010001F01
 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
 Limited Benefit
 Product Name: Critical Illness Applications, CIP2-APP
 Project Name/Number: Critical Illness Applications, CIP2-APP/ICIAR0010001F01

Filing at a Glance

Company: USAbLe Life

Product Name: Critical Illness Applications, CIP2-APP SERFF Tr Num: LSVX-126493991 State: Arkansas

TOI: H071 Individual Health - Specified Disease - Limited Benefit SERFF Status: Closed-Approved-Closed State Tr Num: 44804

Sub-TOI: H071.001 Critical Illness Co Tr Num: ICIAR0010001F01 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI Life and Specialty Ventures Disposition Date: 02/12/2010

Date Submitted: 02/09/2010 Disposition Status: Approved-Closed

Implementation Date Requested: 02/12/2010
 State Filing Description:

Implementation Date:

General Information

Project Name: Critical Illness Applications, CIP2-APP

Project Number: ICIAR0010001F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/12/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 02/12/2010

Created By: SPI Life and Specialty Ventures

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI Life and Specialty Ventures

Filing Description:

This application will replace the previously approved CIP2-APP (7-07) application which was approved on June 29, 2007. We made the following revisions to the application: (1) In the authorization section, added the phrase "(f) know that I or my authorized representative may revoke this authorization at any time;" (2) In the signature section, added an agent's statement that states, "I have truly and accurately recorded the information supplied by the applicant." (3) Item 9 in Section 5 - Medical Information was reworded so details can be captured on all items where the applicant answers Yes to a medical question. This change does not affect the rates.

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The list below shows forms previously approved by your department that will be also be used with this form:

APP-NOTICE (9-08) - Application Notice - 12/03/2008

The application may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document, but we assure that its content will not change and its readability compliance will not be affected. Also, at some point, we anticipate utilizing electronic signatures in a form compliant with your laws and regulations.

Company and Contact

Filing Contact Information

Leslie Thomas, Senior Compliance Analyst lthomas@usablelife.com
 320 West Capitol Avenue 501-212-8874 [Phone] 8874 [Ext]
 Suite 700 501-235-8484 [FAX]
 Little Rock, AR 72201

Filing Company Information

USable Life CoCode: 94358 State of Domicile: Arkansas
 PO Box 1650 Group Code: 876 Company Type: Life & Health
 Little Rock, AR 72203-1650 Group Name: Life and Speciality State ID Number:
 Ventures (LSV)
 (501) 375-7200 ext. [Phone] FEIN Number: 71-0505232

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
USable Life	\$50.00	02/09/2010	34087078

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/12/2010	02/12/2010

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Disposition

Disposition Date: 02/12/2010

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	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Critical Illness Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CIP2-APP (2-10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/12/2010	CIP2-APP (2-10)	Application/Enrollment Form	Critical Illness Enrollment Application	Initial		44.900	CIP2-APP (2-10).PDF



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

CRITICAL ILLNESS APPLICATION

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc	

New Application Change Form Replaces Policy No. _____

SECTION 1 - APPLICANT INFORMATION

Name (First, MI, Last)						Social Security No.	
Home Address			City	State	Zip	County	
Occupation (Be Exact)	Date of Birth	Age	Birth State or Country		Sex	Height (ft-in.)	Weight (lbs.)
					<input type="checkbox"/> Male <input type="checkbox"/> Female		
Employer	Date Employed Full-time	Work Phone ()	Home Phone ()		Have you used any tobacco products within the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 2 - SPOUSE & CHILDREN INFORMATION

Full Name	Occupation	Sex	Date of birth			Birth State or Country	Ht. Ft. Ins.	Wt. lbs.
			mo.	day	yr.			
(spouse)								
(child)								
(child)								
(child)								

Has your spouse used any tobacco products within the past 36 months? Yes No

SECTION 3 - PLAN SELECTION

New Applicant

Application for Change

Select Type of Policy/Optional Rider:	Face Amount Applying For (Increments of \$5,000)	Number of Units (\$5,000 per Unit)	Rate	Monthly Premium
<input type="checkbox"/> CRITICAL ILLNESS WITH CANCER				
<input type="checkbox"/> CRITICAL ILLNESS WITHOUT CANCER				
<input type="checkbox"/> OPTIONAL RECURRENT BENEFIT RIDER				
I hereby apply for the following coverage:	Applicant		X	= \$
<input type="checkbox"/> Applicant Only	Spouse*		X	= \$
<input type="checkbox"/> Applicant & Spouse	Children**	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	X	= \$
<input type="checkbox"/> Applicant & Children				
<input type="checkbox"/> Applicant, Spouse & Children				

* Spouse's signature required if amount exceeds \$25,000.

** The maximum amount of Children's coverage is \$10,000.

TOTAL PREMIUM AMOUNT \$

- Does any person applying for coverage currently have a Critical Illness or Cancer Policy with us or any other insurance company? Yes No If yes, give name of company, list type of policy and amount of coverage. _____
- REPLACEMENT: Is this insurance to replace or change other insurance? Yes No If "Yes", give details including name of company. _____
- OUTLINE: Have you received the Outline of Coverage (in those states where required by law)? Yes No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" on page 2 of this application; (c) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to US Able Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (d) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (e) agree that this authorization shall be valid for two (2) years from the application date; (f) know that I or my authorized representative may revoke this authorization at any time; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (h) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand no person to be insured is also covered by any Title XIX program - Medicaid or any similar name (Not applicable to residents of AZ, MO, NC, OR, or SC). I understand failure to disclose a proposed insured person's true health condition may void this policy.

Be sure to complete the Medical Information on page 2/reverse side.

Page 1 of 2

Signed at: _____ (City and State)	Date of Application _____ (Month, Day, Year)	Date Received Home Office _____
I have truly and accurately recorded the information supplied by the applicant.		
X _____ Agent's Signature	X _____ Applicant's Signature	
CIP2-APP (2-10)	X _____ Spouse's Signature (if required)	

NOTIFICATION FOR THE PROPOSED INSURED— Please read carefully and detach for your records.

Notice of Insurance Information Practices - In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

US Able Life
Little Rock, Arkansas

Employee's Name (Last, First, M.I.)	Social Security #	Employer
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CRITICAL ILLNESS — MONTHLY PREMIUMS PER \$5,000 UNIT

CRITICAL ILLNESS WITH CANCER					CRITICAL ILLNESS WITHOUT CANCER				
Issue Age	INCLUDES RECURRENT BENEFIT		WITHOUT RECURRENT BENEFIT		Issue Age	INCLUDES RECURRENT BENEFIT		WITHOUT RECURRENT BENEFIT	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco		Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
All Children	\$1.66	\$1.66	\$1.46	\$1.46	All Children	\$1.00	\$1.00	\$0.82	\$0.82
18 - 29	2.50	5.22	2.22	4.58	18 - 29	1.76	3.06	1.48	2.52
30 - 39	4.08	9.56	3.62	8.38	30 - 39	2.74	5.72	2.30	4.68
40 - 49	6.44	16.92	5.68	14.80	40 - 49	4.20	10.06	3.50	8.18
50 - 59	9.92	27.10	8.74	23.68	50 - 59	6.30	15.82	5.20	12.82
60 - 64	13.36	34.06	11.74	29.74	60 - 64	8.36	19.96	6.88	16.16

SECTION 4 – BENEFICIARY

■ Name Beneficiary

■ Change of Beneficiary

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Relationship	Date of Birth	Primary or Secondary	Indicate % Distribution
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	

SECTION 5 – MEDICAL INFORMATION

NOTE: If Spouse or Children coverage IS NOT being requested answer questions only as applies to applicant.

- Has any person to be insured ever been diagnosed with or advised to take a diagnostic test, been treated by a member of the medical profession, or taken medication for:

Yes	No	Yes	No
-----	----	-----	----

 - Any form of internal cancer, carcinoma in-situ, malignant melanoma, or other precancerous findings? Yes No
 - Any chronic or progressive disease or disorder of the heart, kidneys, liver, lungs, pancreas, or bone marrow? Yes No
 - Quadriplegia, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease? Yes No
 - Alcohol or substance abuse (in the last 5 years)? Yes No
 - Heart Attack or heart disease, stroke or transient ischemic attack (TIA), or been advised to have coronary bypass surgery, stent insertion, or laser treatment to coronary arteries? Yes No
 - Diabetes (except during a pregnancy), or any blood pressure reading recorded in the last three months exceeding 149/94? Yes No
 - Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)? Yes No
- Has any person to be insured ever been diagnosed by a member of the medical profession with, or does anyone currently have:

Yes	No	Yes	No
-----	----	-----	----

 - Any abnormal cancer screening tests currently being followed by your doctor? Yes No
 - Any cysts, growths, lumps, or any mole or freckle that has bled, become painful, changed color, increased in size, required medical attention or evaluation for which you have not yet sought medical advice? Yes No
 - Carotid artery stenosis, peripheral vascular disease, chronic atrial fibrillation, or chest pain not evaluated by a medical doctor and determined to be non-cardiac? Yes No
 - Multiple sclerosis, memory loss, schizophrenia, systemic lupus erythematosus, pulmonary or cystic fibrosis? Yes No
- Has any person to be insured had any two or more natural parents, brothers, or sisters diagnosed with coronary artery disease, diabetes, or the same cancer (other than skin cancer) prior to age 55? Or, has any person to be insured had one or more natural parents, brothers, or sisters diagnosed with coronary artery disease or colorectal cancer prior to age 45? Yes No
- Is any person to be insured currently taking any prescription medicine(s) or have they taken prescription medicine(s) in the last three (3) years? Yes No
- Has any person to be insured had any abnormal tests (including blood test, urinalysis, X-ray, MRI, ultrasound, stress test, echocardiogram) not found to be normal or benign on further testing, or requiring follow-up by a physician? Yes No
- Does any person to be insured have any consultation, surgery, or test scheduled or anticipated? Yes No
- Has any person to be insured ever been diagnosed by a member of the medical profession with a benign tumor, disorder of blood or autoimmune disorder, digestive disorder, urinary system or reproduction organs disorder, heart or circulatory disorder, hypertension (list last two blood pressure readings and dates), mental or nervous disorder, neurological disorder, or respiratory disorder? Yes No
- Has any person to be insured had any application for critical illness, disability, health, or life insurance modified, rated, or declined in the last 5 years? Yes No
- Give details to any "Yes" answers, including name of person, prescription medicine(s), diagnosis, and dates of treatment: _____
- Name, address, and phone number of the personal physician(s) of all applicants with date last seen, reason for visit, and results: _____

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application. I understand that my policy will be dated and become effective on the first day of the month following the effective date (anniversary date for rescission) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

Insurance 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 subject to fines and confinement in prison.

Medical Information Bureau Disclosure Notice - Information regarding your insurability will be treated as confidential. US Able Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-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, the MIB will arrange disclosure of any information it may have 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, Braintree, Massachusetts 02184-8734. US Able Life or its reinsurers may also release information in its file to other life 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.

Federal Fair Credit Reporting Act Notice - In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	02/12/2010
Comments:	See Forms Tab		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	02/12/2010
Bypass Reason:	N/A - This application change did not affect the actuarial.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	02/12/2010
Bypass Reason:	N/A - This is an application revision filing only.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/12/2010
Comments:			
Attachment:	AR - READABILITY CERTIFICATION.PDF		

		Item Status:	Status Date:
Satisfied - Item:	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	02/12/2010
Comments:			

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Attachments:

AR - NAIC TRANSMITTAL DOCUMENT.PDF
AR - NAIC FORM FILING ATTACHMENT.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: USAble Life

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
CIP2-APP (2-10)	44.9

Signed: 
Name: Connie Phillips
Title: Assistant General Counsel & Assistant Secretary
Date: 2/9/10

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
USable Life PO Box 1650 Little Rock AR 72203-1650	AR		876	94358	71-0505232	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Leslie M. Thomas, AIRC, ACP 320 West Capitol Avenue, Suite 700 Little Rock AR 72201	800-648-0271 Ext. 8874	501-235-8484	lthomas@usablelife.com

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	ICIAR0010001F01
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8. Market	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9. Type of Insurance	H07I Individual Health - Specified Disease - Limited Benefit
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10. Product Coding Matrix Filing Code	H07I.001 Critical Illness
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11. Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	2/9/10
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	
15.	Filing Description:	
<p>This application will replace the previously approved CIP2-APP (7-07) application which was approved on June 29, 2007. We made the following revisions to the application: (1) In the authorization section, added the phrase "(f) know that I or my authorized representative may revoke this authorization at any time;" (2) In the signature section, added an agent's statement that states, "I have truly and accurately recorded the information supplied by the applicant." (3) Item 9 in Section 5 - Medical Information was reworded so details can be captured on all items where the applicant answers Yes to a medical question. This change does not affect the rates.</p> <p>The list below shows forms previously approved by your department that will be also be used with this form:</p> <p>APP-NOTICE (9-08) - Application Notice - 12/03/2008</p> <p>The application may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document, but we assure that its content will not change and its readability compliance will not be affected. Also, at some point, we anticipate utilizing electronic signatures in a form compliant with your laws and regulations.</p>		

16.	Certification (If required)	
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
<p>Print Name <u>Leslie M. Thomas, AIRC, ACP</u> Title <u>Senior Compliance Analyst</u></p>		
<p>Signature <u></u> Date <u>2/9/10</u></p>		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	ICIAR0010001F01	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Critical Illness Application	CIP2-APP (2-10)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	CIP2-APP (7-07)
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	