

SERFF Tracking Number: BNLI-126516456 State: Arkansas
Filing Company: Brokers National Life Assurance Company State Tracking Number: 45129
Company Tracking Number: BNL-2010-28B
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002 Dread Disease
Limited Benefit
Product Name: Cancer Expense Benefits Insurance
Project Name/Number: Application for Reinstatement of Cancer Expense Benefits Insurance/BNL-2010-28B

Filing at a Glance

Company: Brokers National Life Assurance Company

Product Name: Cancer Expense Benefits Insurance SERFF Tr Num: BNLI-126516456 State: Arkansas

TOI: H071 Individual Health - Specified Disease - Limited Benefit SERFF Status: Closed-Approved- Closed State Tr Num: 45129

Sub-TOI: H071.002 Dread Disease Co Tr Num: BNL-2010-28B State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Amy Irby, Mandi Disposition Date: 03/10/2010

Rodriguez, Holly Harrison, Robin Salkowski

Date Submitted: 03/04/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Application for Reinstatement of Cancer Expense Benefits Status of Filing in Domicile: Pending Insurance

Project Number: BNL-2010-28B

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/10/2010

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 03/10/2010

Created By: Holly Harrison

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Holly Harrison

Filing Description:

Re: Company: Brokers National Life Assurance Company

Application for Reinstatement of Cancer Expense Benefits

NAIC #: 74900

FEIN #: 63-0483783

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Our Filing #: BNL-2010-28B

The following referenced form is being submitted for your review and approval:

Application for Reinstatement of Cancer Expense Benefits Insurance Policy Form #: RA-C(2010)

Once approved, this form will be used to allow the reinstatement of Individual Cancer Expense Benefit coverage.

If you have any questions, please contact me at 800-798-1125, extension 1404, or e-mail me at holly@bnlac.com.

Sincerely,

Holly Harrison
 Compliance Assistant

Company and Contact

Filing Contact Information

Holly Harrison, Compliance Assistant holly@bnlac.com
 7010 Hwy 71 West, Suite 100 512-383-0220 [Phone] 1404 [Ext]
 Austin, TX 78735 512-383-8502 [FAX]

Filing Company Information

Brokers National Life Assurance Company CoCode: 74900 State of Domicile: Arkansas
 7010 Hwy 71 West Group Code: Company Type:
 Suite 100 Group Name: State ID Number:
 Austin, TX 78735 FEIN Number: 63-0483783
 (800) 798-1125 ext. [Phone]

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Brokers National Life Assurance Company	\$50.00	03/04/2010	34619326

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/10/2010	03/10/2010

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application for Reinstatement of Cancer Expense Benefits Policy	Approved-Closed	Yes

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Form Schedule

Lead Form Number: RA-C(2010)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/10/2010	RA-C(2010)	Application/Enrollment Form	Application for Reinstatement of Cancer Expense Benefits Policy	Initial			RA-C(2010).pdf



BROKERS NATIONAL LIFE ASSURANCE COMPANY

Domiciled in the State of Arkansas
Administrative Office: 7010 Hwy 71 West, Suite 100, Austin, Texas 78735
Phone: 512-383-0220

Application to Brokers National Life Assurance Company for Reinstatement of Cancer Expense Benefits Policy

Policy Number: _____ Primary Insured Person: _____

Select one:

- I request to reinstate my insurance coverage on myself only.
- I request to reinstate my insurance coverage on myself and the following named spouse and/or dependent child(ren):

Spouse Name: _____

Child Name: _____

I hereby represent to the best of my knowledge, information, and belief, no insured person to be reinstated under this policy is now or has ever been diagnosed as a victim of Cancer, Carcinoma, Sarcoma, Hodgkin's Disease, Leukemia, Lymphoma or Malignancy, except **(list person and condition)**:

_____ who is to be excluded from such coverage of this cancer hospitalization insurance plan.

It is understood and agreed that: 1. The statements in this application are true and complete to the best of my knowledge and belief. 2. All agreements made by us must be signed by our president, vice president, secretary or assistant secretary; no agent can accept risks, modify policies or waive any rights or requirements of the Company. 3. No insurance will be reinstated until the policy has been approved for reinstatement and the premium due has been paid. It is agreed that this policy shall not be considered reinstated and the Company shall have no liability (other than to return payments made consequent to the application) until all amounts required for reinstatement of this policy have been paid and until this application has been approved by the Company during the lifetime and good health of all persons who would be insured under this policy if reinstated. It is further agreed that reinstatement of this policy, if granted by the Company, shall be contestable for fraud or misrepresentation of any material facts stated in this application for the same period after reinstatement as is provided in this policy with respect to the original date of issue.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **(Except in Colorado, D.C., Georgia, Kansas, Kentucky, Louisiana, Nebraska, Oregon, Pennsylvania & Utah)** In **Colorado**, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. In **D.C. & Louisiana**, any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. In **Georgia, Kansas, Nebraska, Oregon & Utah**, any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud (as determined by a court of law - in the state of Kansas). In **Kentucky**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. In **Pennsylvania**, 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Primary Insured **X** _____ Spouse Signature **X** _____

Witness **X** _____ Date _____

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	03/10/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	03/10/2010
Comments:	Approved 08/19/02		
Attachment:	CEA(2002).pdf		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	03/10/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	03/10/2010
Bypass Reason:	N/A		
Comments:			



BROKERS NATIONAL LIFE ASSURANCE COMPANY

Domiciled in the State of Arkansas

Administrative Office: 2100 West William Cannon, Suite L, Austin, Texas 78745

Phone: 512-383-0220

Cancer Expense Application

PLAN SELECTION				
Amount of Coverage <input type="checkbox"/> \$100 Daily Benefit <input type="checkbox"/> \$200 Daily Benefit	Level of Coverage <input type="checkbox"/> Applicant Only <input type="checkbox"/> Applicant & Child(ren) <input type="checkbox"/> Applicant & Family	Monthly Premium \$ _____	Payment Frequency <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	Form of Billing <input type="checkbox"/> Bank Draft <input type="checkbox"/> Payroll Deduction <input type="checkbox"/> Direct Bill <input type="checkbox"/> Credit Card Draft

	APPLICANT	SPOUSE (if applicable)
Applicant Name		
Social Security #	- -	- -
Birth Date, Sex	/ / M or F	/ / M or F
Home Address	STREET ADDRESS () -	
	CITY	STATE ZIP CODE PHONE

DEPENDENTS (if applying for Dependent Coverage)					
Child Name	Birth Date	Sex	Child Name	Birth Date	Sex
1.			4.		
2.			5.		
3.			6.		

I hereby represent to the best of my knowledge, information and belief no person to be insured under the policy is now or has ever been diagnosed as a victim of cancer, carcinoma, sarcoma, Hodgkin's disease, leukemia, lymphoma or malignancy, except (list person and condition): _____

_____ who is to be excluded from such coverage of this cancer hospitalization plan.

Will this insurance replace any other insurance? No Yes Give Company Name and Policy Number _____

REQUEST FOR CREDIT CARD PAYMENT

For Credit Card Payment, please complete the following: I authorize BNL to bill my VISA/MC account for the initial amount due and subsequent regular payments.

Visa List digits of Account # _____ Expiration Date _____
 MasterCard Signature _____ Date _____

REQUEST FOR AUTOMATIC MONTHLY BANK DRAFT / EFT (Attach a void check)

If Bank Draft is chosen, your monthly BNL premium will be automatically withdrawn from your checking account. Please complete the Authorization Form below and attach a void check from the account to be drafted:

To (*Print full name of bank or branch where account is maintained.*) _____

Street Address _____ City _____ State _____ Zip Code _____

I request that you pay and charge my account, debits drawn on my account by BNL to its own order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advance written notice to me and to BNL. You are to treat such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer _____

It is understood and agreed that: 1. The application includes any other underwriting questionnaires required by the Company. 2. The statements in this application: a) Are to form the basis of any policy issued; and b) Are true and complete to the best of my knowledge and belief. 3. All agreements made by us must be signed by our president, vice president, secretary or assistant secretary; no agent can accept risks, modify policies or waive any rights or requirements of the Company. 4. The acceptance by the proposed insured of a policy issued on this application will constitute ratification of any changes made by the Company (Except in Kentucky, Minnesota & Texas). 5. No insurance will be in force: a) Until the policy has been delivered and accepted during the continued insurability, as stated in the application, of the insured(s); and b) Unless nothing has happened since the date of the application that would require a different answer to any question; and c) Until the full first premium is paid, at which time the policy will take effect on its date of issue.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Except in Colorado, Florida, Georgia, Kansas, Louisiana, Nebraska, Oregon, Pennsylvania, Tennessee & Texas) In Colorado, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. In Florida, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. In Georgia, Kansas, Nebraska & Texas, any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. In Louisiana, any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. In Pennsylvania, 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 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. In Tennessee, it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Dated at (*city*) _____ (*state*) _____ Proposed Insured _____

Does the agent have knowledge this insurance will replace any other insurance? No Yes

Witnessed by: Licensed Agent _____ Date _____

Agent's Name _____ Agent's License ID Number _____