

SERFF Tracking Number: UFFL-126516123 State: Arkansas  
Filing Company: United Home Life Insurance Company State Tracking Number: 45005  
Company Tracking Number: 200-359  
TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other  
Product Name: 200-359  
Project Name/Number: /

## Filing at a Glance

Company: United Home Life Insurance Company

Product Name: 200-359

SERFF Tr Num: UFFL-126516123 State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-  
Closed State Tr Num: 45005

Sub-TOI: L04I.500 Other

Co Tr Num: 200-359

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Karen Hynes

Disposition Date: 03/01/2010

Date Submitted: 02/26/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/01/2010

Explanation for Other Group Market Type:

State Status Changed: 03/01/2010

Deemer Date:

Created By: Karen Hynes

Submitted By: Karen Hynes

Corresponding Filing Tracking Number:

Filing Description:

Attached please find the form noted below for your review and approval.

Form 200-359 1-10 (AR) is an application for a term life child rider. This form is new and replaces form 200-359 3-02 (AR) approved by your department April 12, 2002. The main difference between the form enclosed and that previously approved is that we updated the insured's and agent's replacement questions to comply with Rule and Regulation 97.

We reserve the right to make typographical corrections or make minor revisions to the appearance of the form due to printing constraints.

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If you have any questions or need any additional information, please feel free to contact me at 317-692-7465 or by email at Karen.Hynes@infarmbureau.com.

## Company and Contact

### Filing Contact Information

Karen Hynes, karen.hynes@infarmbureau.com  
 225 S East 317-692-7465 [Phone]  
 Indianapolis, IN 46202

### Filing Company Information

United Home Life Insurance Company CoCode: 69922 State of Domicile: Indiana  
 225 S. East St. Group Code: Company Type: LAH  
 Indianapolis, IN 46202 Group Name: State ID Number:  
 (317) 692-7465 ext. [Phone] FEIN Number: 35-0841899  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: AR imposes a filing fee of \$50 per form.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Home Life Insurance Company	\$50.00	02/26/2010	34473715

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/01/2010	03/01/2010

*SERFF Tracking Number:*      *UFFL-126516123*                      *State:*                      *Arkansas*  
*Filing Company:*              *United Home Life Insurance Company*              *State Tracking Number:*      *45005*  
*Company Tracking Number:*      *200-359*  
*TOI:*                      *L041 Individual Life - Term*                      *Sub-TOI:*                      *L041.500 Other*  
*Product Name:*              *200-359*  
*Project Name/Number:*      */*

## **Disposition**

Disposition Date: 03/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:*      *UFFL-126516123*                      *State:*                      *Arkansas*  
*Filing Company:*              *United Home Life Insurance Company*              *State Tracking Number:*      *45005*  
*Company Tracking Number:*      *200-359*  
*TOI:*                      *L041 Individual Life - Term*                      *Sub-TOI:*                      *L041.500 Other*  
*Product Name:*              *200-359*  
*Project Name/Number:*      /

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Form</b>	Application for Child Rider		Yes

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## Form Schedule

### Lead Form Number: 200-359 1-10 (AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	200-359 1-10 (AR)	1-	Application/ Enrollment Form	Application for Child Rider	Initial	45.200	200-359ar (1-10).pdf



# APPLICATION for CHILD RIDER

**United Home Life Insurance Company**

P.O. Box 7192

Indianapolis, IN 46207-7192

1-800-428-3001

**United Home Life Insurance Company**

Child Rider Application

Application is hereby made for Child Rider to be provided by supplementary provision or agreement attached to and made part of

Any policy to be issued on application dated \_\_\_\_\_

Policy No. \_\_\_\_\_

} \_\_\_\_\_  
on the life of (hereinafter referred to as Insured)

1. Full name of children of Insured, including legally adopted children and stepchildren, who are under age 19	Relationship to Insured	Date of Birth*	Place of Birth (State or Country)	Ht.	Wt.

**\*PLEASE NOTE: No coverage is afforded infants under 30 days.**

2. Child Rider Amount  \$5,000  \$10,000  \$15,000  \$20,000 *Total amount of Child Rider coverages cannot exceed \$20,000*

3. In the past 5 years has any child named in Question 1 had: Any consultation or treatment by any physician or practitioner; examination in a clinic, hospital, dispensary, or sanitarium; any disease, ailment, injury or complaint which caused loss of time from school or work; any surgical operation, x-ray, electrocardiogram or other special tests, or been told there is a need for them?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
4. During entire lifetime has any child named in answer to Question 1 had any deformity, impairment, abnormality or ailment of eyes, ears, arms, legs, brain, nervous system, heart, blood pressure, circulation, chest, lungs, digestion, kidneys, bladder or any other part of body, or been treated for a mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any child named in answer to Question 1 been declined, postponed, limited, or had a policy issued other than as applied for on any life or health insurance or reinstatement thereof?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does any child named in Question 1 have any existing life insurance policies or annuity contracts? If "Yes." please complete any necessary replacement forms.	<input type="checkbox"/>	<input type="checkbox"/>
7. Give full details to questions requiring additional explanation.		

**Insured's Supplementary Statements and Certificate of Health**  
*(Complete only if this is an addition to an existing policy)*

1. Exact Height-Weight _____ Ft. _____ In. _____ Lbs. Has weight changed more than 10 lbs in past year? If yes, amount of increase _____ decrease _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Since the date of the original application has the Insured had: Any consultation or treatment by any physician or practitioner; examination in a clinic, hospital, dispensary, or sanitarium; any surgical operation, x-ray, electrocardiogram, or other tests, or been told there is a need for them?	<input type="checkbox"/>	<input type="checkbox"/>
3. Name of physician Insured last consulted: _____ Address _____ Why consulted _____ Give name and address of family physician if different from above _____		
4. Has Insured ever: Been exempted, or discharged as unfit, from military service; applied for or received any kind of disability compensation; or had an application for life or health insurance declined, postponed, limited, or issued other than as applied for?	<input type="checkbox"/>	<input type="checkbox"/>
5. Give full details to questions requiring additional explanation.		

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on this application are true to the best of my knowledge and belief. I understand that my policy will be effective on the date it is issued by the company.

I declare that I have read and received a copy of the Fair Credit Reporting Act/Medical Information Bureau Notice.

**AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

**\*\*\*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 is guilty of a crime and may be subject to fines and confinement in prison.

\$ \_\_\_\_\_ paid with application.

Dated \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City State Month Year

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

To the best of my knowledge and belief the applicant does  does not  have any existing life insurance policies or annuity contracts.

X \_\_\_\_\_ X \_\_\_\_\_  
Printed Agent Name Agent's Signature

Agent Code \_\_\_\_\_ Agent E-mail \_\_\_\_\_

Agent: Phone # \_\_\_\_\_ Fax# \_\_\_\_\_ License Identification Number ( ) \_\_\_\_\_  
State

*If you do not receive your Policy within 60 days from the date of your application, please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192*  
*\*Check or money order must accompany. All premium checks must be made payable to United Home Life Insurance Company.*  
*Do not make check or money order payable to the agent or leave the Payee blank.*

**PLEASE DETACH AND GIVE TO APPLICANT**  
**FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE**

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., formerly known as the 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 it may have in your file. 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, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) 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](http://www.mib.com).



UNITED  
HOME  
LIFE™

Insurance  
Company

*Simplified Products - Faster Results*

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## Supporting Document Schedules

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Readability - 1-10 - Signed.pdf

**Item Status:**

**Status  
Date:**

**Bypassed - Item:** Application

**Bypass Reason:** N/A - Submission does not include a policy.

**Comments:**



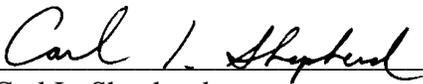
## CERTIFICATION

I hereby certify the following scores on the Flesch Reading Ease Test.

Form 200-359 1-10

Score 45.2

Date: 2/24/2010

A handwritten signature in black ink that reads "Carl L. Shepherd". The signature is written in a cursive style and is positioned above a horizontal line.

Carl L. Shepherd  
Senior Vice President  
United Home Life Insurance Company