

SERFF Tracking Number: AMMB-126534040 State: Arkansas  
Filing Company: Amica Life Insurance Company State Tracking Number: 45413  
Company Tracking Number: L251-1 AR  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Children's Insurance Benefit Application  
Project Name/Number: Children's Insurance Benefit Application/L251-1 AR

## Filing at a Glance

Company: Amica Life Insurance Company

Product Name: Children's Insurance Benefit Application SERFF Tr Num: AMMB-126534040 State: Arkansas

Application

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 45413

Sub-TOI: L08.000 Life - Other

Co Tr Num: L251-1 AR

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Laurie Clark

Disposition Date: 04/15/2010

Date Submitted: 04/14/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Children's Insurance Benefit Application

Status of Filing in Domicile: Authorized

Project Number: L251-1 AR

Date Approved in Domicile: 04/05/2010

Requested Filing Mode: Review & Approval

Domicile Status Comments: This application was filed through the Interstate Compact. Our domicile state of RI is part of the Interstate Compact.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/15/2010

Explanation for Other Group Market Type:

State Status Changed: 04/15/2010

Deemer Date:

Created By: Laurie Clark

Submitted By: Laurie Clark

Corresponding Filing Tracking Number:

Filing Description:

Attached is a copy of our new Children's Insurance Benefit Application, Form No. L251-1 AR. Please be advised that this application form was approved by our domiciliary (Rhode Island) on April 5, 2010 through the Interstate Insurance Commission.

This application will replace Form No. L251-1 which was approved by your department on November 4, 1996. There

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was no state tracking number available for this filing.

This application will be used when an insured is applying for our Children's Insurance Benefit, Form No. CI01-04, which was approved by your department on November 4, 1996. There was no state tracking number available for this filing.

The Children's Insurance Benefit can be added to the following policies:

Whole Life Policy. Form No. WL2006-01, approved January 18, 2007 (no tracking number found)  
XX Year Convertible Level Term Policy, Form No. FGCLT01-01, approved July 15, 2008 (SERFF Tracking No. AMMB-125718307)  
XX Year Convertible Level Term Policy. Form No. CLT01-01, approved October 2, 2008 (SERFF Tracking No. AMMB-125825097)  
Annual Renewable Term Policy, Form No. ART01-01 (09/2009), approved December 4, 2009 (SERFF Tracking No. AMMB-126322498)

Also attached is a complete list of all the possible drop down questions in the event that the applicant answers "yes" to the following questions: 4D, 4E, 4F, 4G and 4H. If any of those questions are answered "yes", the question number (for example, 4F); the specific issue (for example, "Scuba Diving"); if applicable, the additional drop down questions; and the responses will print in Section 6 – Additional Information, as shown in the sample John Doe application. If the information to be recorded in Section 6 exceeds the space allowed, an additional page will generate to accommodate the required information.

Every such application will be completed over the telephone by our employee during an interview process with the applicant. (Prior to such completion, a blank copy of this application form will be provided to the applicant for their reference.) Once the application is completed, the applicant will be given the option of signing such application using voice or digital signature. If the applicant prefers, we will mail the completed application to the client for their traditional "wet" signature. The applicant's identify will be verified prior to completing the application by confirmation of several "identifiers," such as social security number, date of birth, etc. Once the completed application has been signed by the applicant, either electronically or traditionally, we will send a photocopy to the applicant for their records. Additionally, a copy will be attached to and made a part of the issued policy.

Please be advised that we are in the process of implementing additional computer programming to accommodate this new application; thus, we will not begin using this application until all necessary programming has been completed.

Please advise if additional information and/or documentation is needed at this time regarding this matter. If necessary, I may be reached by telephone at (800) 234-5433, ext. 29729; or by email at lclark@amica.com. Thank you.

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## Company and Contact

### Filing Contact Information

Laurie A. Clark, Compliance Supervisor lclark@amica.com  
 10 Amica Center Boulevard 800-234-5433 [Phone] 29729 [Ext]  
 Lincoln, RI 02861 401-334-5146 [FAX]

### Filing Company Information

Amica Life Insurance Company CoCode: 72222 State of Domicile: Rhode Island  
 100 Amica Way Group Code: 28 Company Type: Life  
 Lincoln, RI 02865 Group Name: 72222 State ID Number:  
 (800) 234-5433 ext. 29729[Phone] FEIN Number: 05-0340166

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: The Rhode Island filing fee would have been \$100.00. Arkansas fee is \$50.00. Therefore, we are submitting the higher fee.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Amica Life Insurance Company	\$100.00	04/14/2010	35627419

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/15/2010	04/15/2010

### 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	04/15/2010	04/15/2010	Laurie Clark	04/15/2010	04/15/2010

*SERFF Tracking Number:*      *AMMB-126534040*                      *State:*                      *Arkansas*  
*Filing Company:*              *Amica Life Insurance Company*                      *State Tracking Number:*      *45413*  
*Company Tracking Number:*      *L251-1 AR*  
*TOI:*                      *L08 Life - Other*                      *Sub-TOI:*                      *L08.000 Life - Other*  
*Product Name:*              *Children's Insurance Benefit Application*  
*Project Name/Number:*      *Children's Insurance Benefit Application/L251-1 AR*

## **Disposition**

Disposition Date: 04/15/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Drop Down Questions		Yes
Form (revised)	Children's Insurance Benefit Application		Yes
Form	Children's Insurance Benefit Application		Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 04/15/2010  
Submitted Date 04/15/2010  
Respond By Date 05/17/2010

Dear Laurie A. Clark,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Please be advised the Children's Insurance Benefit Application was not submitted as an attachment to this filing.

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 04/15/2010  
 Submitted Date 04/15/2010

Dear Linda Bird,

### Comments:

This refers to your Objection letter.

I apologize for not attaching the application. Here it is.

### Response 1

Comments: Attached is a copy of the CIB application.

### Related Objection 1

Comment:

Please be advised the Children's Insurance Benefit Application was not submitted as an attachment to this filing.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Children's Insurance Benefit Application	L251-1 AR		Application/Enrollment Form	Initial		50.760	L251-1 AR.pdf
<b>Previous Version</b>							
Children's Insurance Benefit Application	L251-1 AR		Application/Enrollment Form	Initial		50.760	

No Rate/Rule Schedule items changed.

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Sincerely,  
Laurie Clark

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## Form Schedule

**Lead Form Number: L251-1 AR**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L251-1 AR	Application/Children's Insurance Enrollment Benefit Application Form	Initial		50.760	L251-1 AR.pdf

# CHILDREN'S INSURANCE BENEFIT APPLICATION

**AMICA LIFE INSURANCE COMPANY**  
PO Box 6008  
Providence, Rhode Island 02940-6008

Page 1 of 4

Please print in ink. (Do not use gel pen.) Initial all changes and corrections.

- **Section 1 applies to person insured under basic application or existing policy.**
- **Remainder of this application applies to children to be covered under this benefit.**
- **If you need more space in any section, use Section 6 or a separate sheet of paper. Sign, date and submit with this application.**

Please provide all information requested. Send no money with this application.

**COMPANY USE ONLY:**

Accompanies a Life Application for:

\_\_\_\_\_

To be attached to policy number:

\_\_\_\_\_

## 1 APPLICANT INFORMATION

Full Name (First, Middle, Last)

Social Security or Tax ID Number

## 2 PROPOSED INSURED CHILDREN

*Please provide the requested information for all Children to be covered. A Child must be under age 18 at time of application.*

Number of Units (Each Unit is equal to \$1,000 coverage per child; maximum of 10 Units): \_\_\_\_\_

	<input type="checkbox"/> M <input type="checkbox"/> F	ft.	in.	lbs.	
<b>Child 1</b> Full Name (First, Middle, Last)	Gender	Height	Weight	Social Security Number	
Place of Birth	Date of Birth	Relationship to Applicant	Total Life Insurance in Force		
	<input type="checkbox"/> M <input type="checkbox"/> F	ft.	in.	lbs.	
<b>Child 2</b> Full Name (First, Middle, Last)	Gender	Height	Weight	Social Security Number	
Place of Birth	Date of Birth	Relationship to Applicant	Total Life Insurance in Force		
	<input type="checkbox"/> M <input type="checkbox"/> F	ft.	in.	lbs.	
<b>Child 3</b> Full Name (First, Middle, Last)	Gender	Height	Weight	Social Security Number	
Place of Birth	Date of Birth	Relationship to Applicant	Total Life Insurance in Force		
	<input type="checkbox"/> M <input type="checkbox"/> F	ft.	in.	lbs.	
<b>Child 4</b> Full Name (First, Middle, Last)	Gender	Height	Weight	Social Security Number	
Place of Birth	Date of Birth	Relationship to Applicant	Total Life Insurance in Force		
	<input type="checkbox"/> M <input type="checkbox"/> F	ft.	in.	lbs.	
<b>Child 5</b> Full Name (First, Middle, Last)	Gender	Height	Weight	Social Security Number	
Place of Birth	Date of Birth	Relationship to Applicant	Total Life Insurance in Force		

## 3 BENEFICIARY

*Note: All beneficiaries in a class share equally unless otherwise noted.*

<b>PRIMARY</b> Beneficiary Full Name	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Social Security Number	Relationship to Child(ren)	%
Beneficiary Full Name	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Social Security Number	Relationship to Child(ren)	%
Beneficiary Full Name	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Social Security Number	Relationship to Child(ren)	%
Beneficiary Full Name	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Social Security Number	Relationship to Child(ren)	%

*Note: Sections 4 and 5 pertain to any Child listed in Section 2.*

## 4 PERSONAL HISTORY

*Please provide complete details for any "yes" answers in Section 6.*

- A.** Does any Child reside at a location other than with the Applicant named in Section 1?  YES  NO
- B.** Will this application replace or change any existing life insurance or annuity in force on any Child with any insurance company?  YES  NO
- C.** Are you applying for life insurance on the life of any Child with any other company at this time?  YES  NO
- D.** Has any company declined, postponed, rated, refused to reinstate, or modified any insurance on the life of any Child?  YES  NO
- E.** Does any Child age 12 or older currently, or does any such Child within the next 2 years expect to, fly as a pilot or a crew member?  YES  NO
- F.** Does any Child age 10 or older now participate in, or does any such Child intend to participate within the next 2 years in, mountain or rock climbing; bungee jumping; sky diving; scuba diving; or racing of powered air, water or land vehicles?  YES  NO
- G.** Has any Child age 14 or older ever received any type of motor vehicle violation?  YES  NO
- H.** Does any Child plan residence, travel or military service outside of the United States or Canada within the next year?  YES  NO

## 5 MEDICAL HISTORY

*Please provide complete details for any "yes" answers in Section 6.*

- A.** Does any Child receive routine annual pediatric exams or consults?  YES  NO
- B.** Has any Child ever received medical advice or treatment from a member of a medical profession for: chest pain; shortness of breath; tumor or cancer; brain, heart, lung, liver or kidney disorders; diabetes; stroke; high blood pressure; mental or nervous disorders (including ADD/ADHD, learning disabilities and behavioral issues); or use of alcohol or drugs?  YES  NO
- C.** Has any Child ever been diagnosed by a member of a medical profession with, or tested positive for, the Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?  YES  NO
- D.** Does any Child plan to consult a physician or be seen as a patient at a clinic or hospital within the next 30 days?  YES  NO
- E.** Is any Child now under medical observation by, or receiving treatment from, a member of a medical profession?  YES  NO



**7 ACKNOWLEDGEMENTS & SIGNATURES**

I acknowledge that I have read this application and all the statements and answers contained herein, and that they are complete and true to the best of my knowledge and belief. I understand that such statements and answers will be used by Amica Life to determine eligibility for insurance; and that no additional information regarding such statements and answers will be considered to have been given to Amica Life unless such information is stated in this application.

I understand: that no coverage is effective until this application has been approved; a benefit rider has been issued by Amica Life and accepted by the Owner; and the entire amount of the first modal premium has been received and accepted by Amica Life while the Insured Child(ren) is/are alive. I also understand that a sales representative does not have authorization to accept risk, rule on insurability, or make, void, waive or change any conditions or provisions of this application or of any receipt or coverage issued by Amica Life.

I acknowledge that I have read and received "How Your Amica Life Application is Processed to Protect Your Rights," required by the Federal Fair Credit Reporting Act and the Medical Information Bureau (MIB). I authorize any physician; medical professional; hospital, clinic or other medical care institution; the MIB; insurer consumer reporting agency; other insurance company; or any other organization, institution or person that has any records or knowledge of me and the Child(ren) named in this application and of their health; to provide information to Amica Life Insurance Company, its representative, or any consumer reporting agency acting on Amica Life's behalf. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Amica Life to collect and transmit such information.

I understand that a photographic copy or facsimile (or transmission by other electronic means) of this statement shall be as valid as the original. I know that my authorized representative or I have the right to receive a copy of this statement upon request. I agree this authorization is valid for two and one-half (2½) years from the date signed.

A consumer report may be obtained; if such a report is obtained, I know that my authorized representative or I have the right to receive a copy of this statement upon request. I (check one)  do  do not request to be interviewed if such a consumer report is obtained.

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.

Dated at: \_\_\_\_\_ on \_\_\_\_\_  
City State Month, Day, Year (MM/DD/YYYY)

\_\_\_\_\_  
Signature of Applicant (named in Section 1) Signature of Custodial Parent/Guardian (if other than Applicant)

REPRESENTATIVE'S STATEMENT

To the best of your knowledge and belief, does the purchase of this benefit by the above Applicant involve the replacement of any other life insurance or annuity contract(s) in force with a life insurance company?  YES  NO

\_\_\_\_\_  
Signature of Company Representative Date

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 Project Name/Number: Children's Insurance Benefit Application/L251-1 AR

## Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

AR - Contact Notice.pdf  
 AR - Guaranty Association Form.pdf  
 AR - Certification of Compliance.pdf  
 Flesch Cert (L251-1 AR).pdf

**Item Status:** **Status Date:**

**Bypassed - Item:** Application

**Bypass Reason:** N/A - We are not filing a policy.

**Comments:**

**Item Status:** **Status Date:**

**Satisfied - Item:** Drop Down Questions

**Comments:**

This list indicates all the possible drop down questions in the event that the applicant answers "yes".

Also attached is a sample John Doe application that indicates how a "yes" answer will display in Section 6 - Additional Information.

**Attachments:**

Drop down questions for L251-1 AR.pdf  
 AR - CIB App filled.pdf

AMICA LIFE INSURANCE COMPANY

*Thank you for entrusting Amica Life Insurance Company with your insurance needs!*

*If you ever need to contact us, please write to us at:*

*Amica Life Insurance Company  
Life Customer Services  
100 Amica Way  
Lincoln, RI 02865*

*We may be reached by telephone, toll-free, at (800) 234-5433, ext. 3400.*

*You may also communicate with us by visiting our Web site at [www.amica.com/life](http://www.amica.com/life).  
Once there, please point your cursor to the "Contact Us" menu selection near the top  
of the main screen, and click on the "How Are We Doing?" link provided.*

*If we at Amica Life Insurance Company fail to provide you with reasonable and  
adequate services, you should feel free to contact us:*

*Arkansas Department of Insurance  
1200 West 3rd Street  
Little Rock, AR 72201-1904  
800-852-5494  
or  
501-371-2640*

*Again, thank you! We look forward to serving you now and in the future.*

**AMICA LIFE INSURANCE COMPANY**

**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 members 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 policyowners 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 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 Disability  
Insurance Guaranty Association  
1023 West Capitol, Suite 2  
Little Rock, AR 72201**

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

(Continued on next page)

The state law that provides for this safety-net coverage 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 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 holding 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 an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- 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 nonaffiliate benefit plan or its trustees).

(Continued on next page)

## 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 types 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 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.

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STATE OF ARKANSAS  
CERTIFICATION OF COMPLIANCE

Form Number (s): L251-2 AR

As an officer of Amica Life Insurance Company, I hereby certify that the above-referenced policy form complies in all respects with the provisions, requirements and restrictions of Regulation 19 – Section 10(B). To the best of my knowledge, information and belief, it also complies with all applicable requirements of the Insurance Department

A handwritten signature in black ink that reads "James R. Ruegg". The signature is written in a cursive style with a large initial "J" and "R".

James R. Ruegg  
Senior Assistant Vice President

Dated: April 7, 2010

AMICA LIFE INSURANCE COMPANY

This is to certify that each form listed below is in compliance with the insurance policy form language simplification rules and readability standards of your state in accordance with the following test procedures:

A. Option Selected

1. The form(s) submitted with this filing and any related forms have been scored as one unit for the Flesch reading ease test. The combined score is \_\_\_\_\_.
2. Each form has been scored separately for the Flesch reading ease test. Scores for each form submitted with this filing are:

<u>Form Number</u>	<u>Title</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables</u>	<u>Flesch Score</u>
L251-1 AR	Children's Insurance Benefit Application	24	373	619	50.67

B. Test Option Selected

1. The test was applied to each entire form.
2. The test was applied on a sample basis since the form(s) contain(s) more than 10,000 words. A copy of the form(s) indicating the word samples tested is enclosed.

C. Standards for Certification

A checked line indicates the standard has been achieved:

1. The form text achieves your state's minimum score on the Flesch reading ease test in accordance with the option selected in Section A above.
2. Each form is printed in not less than 10-point type, 1-point leaded. (This does not apply to specification pages, schedules and tables.)
3. The layout and spacing of each form separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in boldface type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in any form.
6. The style, arrangement and overall appearance of each form give no undue prominence to any portion of any form submitted with this filing or to any related form.
7. A table of contents or index of the principal sections is included in the policy. (This applies only to a policy having more than 3,000 words or consisting of more than 3 pages.)



James R. Ruegg  
Sr. Assistant Vice President

Dated: March 12, 2010

**Drop Down Questions**  
**Children's Insurance Benefit Application**  
**Form No. L251-1 AR**

**4D. *Has any company declined, postponed, rated, refused to reinstate, or modified any insurance on the life of any Child?***

1. Name of Child to whom the following information applies.
2. What was the final action? (Declined, postponed, rated, etc.) – was an additional premium charged?
3. Date and reason for action – if health condition, get details
4. Name of company and type of insurance

**4E. *Does any Child age 12 or older currently, or does any such Child within the next 2 years expect to, fly as a pilot or a crew member?***

Private

1. Name of Child to whom the following information applies.
2. Does he/she currently have an active pilot's license?
3. Type of license (student or private)?
4. Total solo hours?
5. Expected annual flying hours?
6. Type of aircraft?
7. Instrument rating – yes or no?
8. Any restrictions?
9. Any violations/accidents?
10. Date of last flight?
11. Do he/she have a history of aviation activity? If not currently, does he/she have any intention to resume flying?

Paid

1. Name of Child to whom the following information applies.
2. Is he/she a pilot or crew member?
3. Type of flight (scheduled, non-scheduled, passenger, freight, military or other)?
4. Purpose of flying (i.e. banner towing, air ambulance/flight nurse, taxi, crop dusting, photography, search & rescue, sightseeing, exploration, test piloting, weather/traffic control etc.)?

5. Expected annual flying hours?
6. Total years/hours of experience?
7. Type of aircraft flown?
8. Type of certificate (IFR, ATR, Flight instruction)?
9. Any restrictions?
10. Any violations/accidents?
11. Geographical flight locations?
12. Any travel into hazardous terrain?

Crew member

1. Name of Child to whom the following information applies.
2. In what capacity does he/she fly? (air nurse, photographer, traffic control, weather person)
3. Type of aircraft
4. How often does he/she fly, or annual hours?
5. What geographic or locations of the flights?
6. Any flights into hazardous terrain or weather?

**4F. Does any Child age 10 or older now participate in, or does any such Child intend to participate within the next 2 years in, mountain or rock climbing; bungee jumping; sky diving; scuba diving; or racing of powered air, water or land vehicles?**

Mountain or Rock Climbing

1. Name of Child to whom the following information applies.
2. How long has he/she been climbing?
3. How often does he/she climb?
4. When was his/her last climb?
5. When is his/her next climb planned (month/year)?
6. Location?
7. Highest climb?
8. What equipment is used?
9. Does he/she climb for pleasure, occupation, competition or volunteer work?
10. Any accidents?
11. What classification/difficulty level? (Yosemite Decimal System, water ice, mix – If customer does not know level, input “don’t know”)

### Bungee Jumping

1. Name of Child to whom the following information applies.
2. Number of jumps per year?
3. Location of jumps?
4. How high are jumps?
5. Date of last jump?
6. When is his/her next jump planned (month/year)?
7. Any accidents?

### Sky Diving

1. Name of Child to whom the following information applies.
2. Amateur or professional? If professional, provide details (stunts, instruction training, etc.)
3. Club affiliation?
4. Number of jumps per year?
5. Any base jumping?
6. Date of last jump?
7. When is his/her next jump planned (month/year)?
8. Any accidents?

### Scuba Diving

1. Name of Child to whom the following information applies.
2. Number of dives per year?
3. Date of last dive?
4. When is his/her next dive planned (month/year)?
5. Average depth of dive?
6. Maximum depth?
7. Any certification?
8. Ever dive alone?
9. What type of diving (caves, caverns, wrecks, open water or rescue diving)?

### Racing of Powered Air Vehicles

1. Name of Child to whom the following information applies.
2. Type of aircraft?
3. Home or factory made?

4. Size of engine?
5. Number of races per year?
6. Date of last race?
7. When is his/her next race planned (month/year)?
8. How long racing?
9. Amateur or professional?
10. Max speed?
11. Any past accidents or injuries?
12. Total hours of experience?
13. Where does he/she participate in racing? (geographical location)
14. Does he/she hold any licenses or certifications?

#### Racing of Powered Water Vehicles

1. Name of Child to whom the following information applies.
2. Type of vehicle?
3. Racing classification?
4. Number of races per year?
5. Date of last race?
6. When is his/her next race planned (month/year)?
7. How long racing? Amateur or professional?
8. Max speed? Any past accidents or injuries?
9. Where do the races take place?

#### Racing of Powered Land Vehicles

1. Name of Child to whom the following information applies.
2. Type of vehicle?
3. Size of engine?
4. Type and size of track? (dirt, oval, motor cross, ¼ mile, mile, etc)
5. Racing classification? (grand prix, drag, stock, etc)
6. Number of races per year?
7. Date of last race?
8. When is his/her next race planned (month/year)?
9. How long racing?
10. Amateur or professional?
11. Max speed?
12. Any past accidents or injuries?
13. What organizations is he/she affiliated with?

**4G. Has any Child age 14 or older ever received any type of motor vehicle violation?**

Moving Violations

1. Name of Child to whom the following information applies.
2. Date (month/year)?
3. State?
4. Reason? (stop sign violation, speeding – need MPH over limit, accident)
  - If accident:
    - 1a. Was he/she at fault?
    - 2b. Any injuries to him/her? (details)
5. What were results? (paid fine, took class, dropped)

Suspensions, DWI, or DUI

1. Name of Child to whom the following information applies.
2. Date (month/year)?
3. State?
4. Was this the first suspension, DWI, DUI?
5. Length of suspension?
6. Any counseling, treatment, or classes? (inpatient or outpatient)

**4H. Does any Child plan residence, travel or military service outside of the United States or Canada within the next year?**

Foreign Residence

1. Name of Child to whom the following information applies.
2. Country and location in country?
3. Reason for living in foreign country?
4. How long does he/she plan on living outside of the U.S.?
5. Where else might he/she travel or live?

Foreign Travel

1. Name of Child to whom the following information applies.
2. What countries will he/she be travelling to (include cities/regions)?
3. Date?

4. Length of stay?
5. Reason for travel? (vacation or business)
6. If business, what will duties include?
7. How often does he/she travel outside the U.S.?
8. Will he/she engage in any hazardous activities (scuba diving, mountain climbing, etc)?
9. Are there any countries that he/she will likely visit in the future? If yes, complete # 1-7 above.

# CHILDREN'S INSURANCE BENEFIT APPLICATION

Page 1 of 4

**AMICA LIFE INSURANCE COMPANY**  
PO Box 6008  
Providence, Rhode Island 02940-6008

**COMPANY USE ONLY:**
 Accompanies a Life Application for:

 To be attached to policy number:

1-000123456

Please print in ink. (Do not use gel pen.) Initial all changes and corrections.

- **Section 1 applies to person insured under basic application or existing policy.**
- **Remainder of this application applies to children to be covered under this benefit.**
- **If you need more space in any section, use Section 6 or a separate sheet of paper. Sign, date and submit with this application.**

Please provide all information requested. Send no money with this application.

## 1 APPLICANT INFORMATION

John E. Doe

Full Name (First, Middle, Last)

123-45-6789

Social Security or Tax ID Number

## 2 PROPOSED INSURED CHILDREN

Please provide the requested information for all Children to be covered. A Child must be under age 18 at time of application.

Number of Units (Each Unit is equal to \$1,000 coverage per child; maximum of 10 Units): 10

<u>John E. Doe, Jr.</u> Child 1 Full Name (First, Middle, Last)	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<u>4</u> ft. <u>6</u> in.	<u>120</u> lbs.	<u>234-56-7890</u> Social Security Number
<u>Anytown, US</u> Place of Birth	<u>01-02-1998</u> Date of Birth	<u>son</u> Relationship to Applicant	<u>-0-</u> Total Life Insurance in Force	
<u>Mary A. Doe</u> Child 2 Full Name (First, Middle, Last)	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	<u>3</u> ft. <u>6</u> in.	<u>80</u> lbs.	<u>345-67-8901</u> Social Security Number
<u>Anytown, US</u> Place of Birth	<u>04-15-2001</u> Date of Birth	<u>daughter</u> Relationship to Applicant	<u>-0-</u> Total Life Insurance in Force	
<u>N/A</u> Child 3 Full Name (First, Middle, Last)	<input type="checkbox"/> M <input type="checkbox"/> F	ft. in.	lbs.	Social Security Number
<u>N/A</u> Place of Birth	<u>N/A</u> Date of Birth	<u>N/A</u> Relationship to Applicant	<u>N/A</u> Total Life Insurance in Force	
<u>N/A</u> Child 4 Full Name (First, Middle, Last)	<input type="checkbox"/> M <input type="checkbox"/> F	ft. in.	lbs.	Social Security Number
<u>N/A</u> Place of Birth	<u>N/A</u> Date of Birth	<u>N/A</u> Relationship to Applicant	<u>N/A</u> Total Life Insurance in Force	
<u>N/A</u> Child 5 Full Name (First, Middle, Last)	<input type="checkbox"/> M <input type="checkbox"/> F	ft. in.	lbs.	Social Security Number
<u>N/A</u> Place of Birth	<u>N/A</u> Date of Birth	<u>N/A</u> Relationship to Applicant	<u>N/A</u> Total Life Insurance in Force	

## 3 BENEFICIARY

Note: All beneficiaries in a class share equally unless otherwise noted.

<u>John E. Doe</u> PRIMARY Beneficiary Full Name	<input type="checkbox"/> Primary <input checked="" type="checkbox"/> Contingent	<u>123-45-6789</u> Social Security Number	<u>Father</u> Relationship to Child(ren)	<u>100</u> %
<u>Ellen A. Doe</u> Beneficiary Full Name	<input type="checkbox"/> Primary <input checked="" type="checkbox"/> Contingent	<u>567-89-0123</u> Social Security Number	<u>Mother</u> Relationship to Child(ren)	<u>100</u> %
<u>N/A</u> Beneficiary Full Name	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<u>N/A</u> Social Security Number	<u>N/A</u> Relationship to Child(ren)	<u>N/A</u> %
<u>N/A</u> Beneficiary Full Name	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<u>N/A</u> Social Security Number	<u>N/A</u> Relationship to Child(ren)	<u>N/A</u> %

*Note: Sections 4 and 5 pertain to any Child listed in Section 2.*

## 4 PERSONAL HISTORY

*Please provide complete details for any "yes" answers in Section 6.*

- A. Does any Child reside at a location other than with the Applicant named in Section 1?  YES  NO
- B. Will this application replace or change any existing life insurance or annuity in force on any Child with any insurance company?  YES  NO
- C. Are you applying for life insurance on the life of any Child with any other company at this time?  YES  NO
- D. Has any company declined, postponed, rated, refused to reinstate, or modified any insurance on the life of any Child?  YES  NO
- E. Does any Child age 12 or older currently, or does any such Child within the next 2 years expect to, fly as a pilot or a crew member?  YES  NO
- F. Does any Child age 10 or older now participate in, or does any such Child intend to participate within the next 2 years in, mountain or rock climbing; bungee jumping; sky diving; scuba diving; or racing of powered air, water or land vehicles?  YES  NO
- G. Has any Child age 14 or older ever received any type of motor vehicle violation?  YES  NO
- H. Does any Child plan residence, travel or military service outside of the United States or Canada within the next year?  YES  NO

## 5 MEDICAL HISTORY

*Please provide complete details for any "yes" answers in Section 6.*

- A. Does any Child receive routine annual pediatric exams or consults?  YES  NO
- B. Has any Child ever received medical advice or treatment from a member of a medical profession for: chest pain; shortness of breath; tumor or cancer; brain, heart, lung, liver or kidney disorders; diabetes; stroke; high blood pressure; mental or nervous disorders (including ADD/ADHD, learning disabilities and behavioral issues); or use of alcohol or drugs?  YES  NO
- C. Has any Child ever been diagnosed by a member of a medical profession with, or tested positive for, the Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?  YES  NO
- D. Does any Child plan to consult a physician or be seen as a patient at a clinic or hospital within the next 30 days?  YES  NO
- E. Is any Child now under medical observation by, or receiving treatment from, a member of a medical profession?  YES  NO

## 6 ADDITIONAL INFORMATION

Use the space below to provide any information that did not fit in the space provided on the application, or to provide details for any “yes” answers in Section 4 (Personal History) or in Section 5 (Medical History). Please include **section number, question letter and name of the Child** the response is for (where applicable). If you need additional space, use a separate sheet of paper. Sign, date and submit with this application.

When providing details for “yes” answers in Section 5 (Medical History), be sure to include:

*1) attending physician’s name, address and telephone number; 2) dates/durations; 3) diagnosis/treatment/result; 4) current status; and 5) medications (if applicable). For Question 1 in Section 5, include the date of the last exam and results.*

4F: Scuba Diving

1. Name of Child to whom the following information applies. **John Doe, Jr.**

2. Number of dives per year? **3-4**

3. Date of last dive? **12-15-2009**

4. When is his/her next dive planned (month/year)? **April 2010**

5. Average depth of dive? **50-60 ft.**

6. Maximum depth? **65 ft.**

7. Any certification? **Yes—Junior Conditional**

8. Ever dive alone? **No**

9. What type of diving (caves, caverns, wrecks, open water or rescue diving)? **Open water only.**

5A: **Routine exams—John Jr. and Mary; 11/15/2009; William Jones, MD;**

**123 Main St., Anywhere, US; 401-345-6789; All OK—No problematic findings.**

5D: **John Jr. must have complete physical exam for diving certification test. Scheduled for 02/15/2010 with Dr. Jones—info above.**

**7 ACKNOWLEDGEMENTS & SIGNATURES**

I acknowledge that I have read this application and all the statements and answers contained herein, and that they are complete and true to the best of my knowledge and belief. I understand that such statements and answers will be used by Amica Life to determine eligibility for insurance; and that no additional information regarding such statements and answers will be considered to have been given to Amica Life unless such information is stated in this application.

I understand: that no coverage is effective until this application has been approved; a benefit rider has been issued by Amica Life and accepted by the Owner; and the entire amount of the first modal premium has been received and accepted by Amica Life while the Insured Child(ren) is/are alive. I also understand that a sales representative does not have authorization to accept risk, rule on insurability, or make, void, waive or change any conditions or provisions of this application or of any receipt or coverage issued by Amica Life.

I acknowledge that I have read and received "How Your Amica Life Application is Processed to Protect Your Rights," required by the Federal Fair Credit Reporting Act and the Medical Information Bureau (MIB). I authorize any physician; medical professional; hospital, clinic or other medical care institution; the MIB; insurer consumer reporting agency; other insurance company; or any other organization, institution or person that has any records or knowledge of me and the Child(ren) named in this application and of their health; to provide information to Amica Life Insurance Company, its representative, or any consumer reporting agency acting on Amica Life's behalf. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Amica Life to collect and transmit such information.

I understand that a photographic copy or facsimile (or transmission by other electronic means) of this statement shall be as valid as the original. I know that my authorized representative or I have the right to receive a copy of this statement upon request. I agree this authorization is valid for two and one-half (2½) years from the date signed.

A consumer report may be obtained; if such a report is obtained, I know that my authorized representative or I have the right to receive a copy of this statement upon request. I (check one)  do  do not request to be interviewed if such a consumer report is obtained.

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.

Dated at: \_\_\_\_\_ on \_\_\_\_\_  
City State Month, Day, Year (MM/DD/YYYY)

\_\_\_\_\_  
Signature of Applicant (named in Section 1)

\_\_\_\_\_  
Signature of Custodial Parent/Guardian (if other than Applicant)

REPRESENTATIVE'S STATEMENT

To the best of your knowledge and belief, does the purchase of this benefit by the above Applicant involve the replacement of any other life insurance or annuity contract(s) in force with a life insurance company?  YES  NO

\_\_\_\_\_  
Signature of Company Representative

\_\_\_\_\_  
Date

SERFF Tracking Number: AMMB-126534040 State: Arkansas  
 Filing Company: Amica Life Insurance Company State Tracking Number: 45413  
 Company Tracking Number: L251-1 AR  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Children's Insurance Benefit Application  
 Project Name/Number: Children's Insurance Benefit Application/L251-1 AR

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/09/2010	Form	Children's Insurance Benefit Application	04/15/2010	