

SERFF Tracking Number: BNLI-126565115 State: Arkansas  
Filing Company: Brokers National Life Assurance Company State Tracking Number: 45375  
Company Tracking Number: BNL-2010-28A  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Reinstatement Application  
Project Name/Number: Reinstatement Application/BNL-2010-28A

## Filing at a Glance

Company: Brokers National Life Assurance Company

Product Name: Reinstatement Application

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: BNLI-126565115

SERFF Status: Closed-Approved-Closed

Co Tr Num: BNL-2010-28A

Authors: Amy Irby, Mandi Rodriguez, Holly Harrison, Robin Salkowski

Date Submitted: 04/07/2010

State: Arkansas

State Tr Num: 45375

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 04/07/2010

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: Reinstatement Application

Project Number: BNL-2010-28A

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/07/2010

Deemer Date:

Submitted By: Robin Salkowski

Filing Description:

Re: Company: Brokers National Life Assurance Company

Reinstatement Application

NAIC #: 74900

FEIN #: 63-0483783

Project Number: BNL-2010-28A

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: AR is Domicile State.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 04/07/2010

Created By: Robin Salkowski

Corresponding Filing Tracking Number: BNL-2010-28A

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

- Reinstatement Application Form # RA-FP(2010)

Once approved, this form will be used to allow reinstatement of individual insurance coverage. This form will be used for our individual life and health products that have been approved by your state, or that receive future approval.

If you have any questions, please contact me at 800-798-1125, extension 1405, or email me at robin@bnlac.com.

Sincerely,

A. Robin Salkowski  
Compliance Department Representative

## Company and Contact

### Filing Contact Information

Robin Salkowski, Compliance Department      robin@bnlac.com  
Representative  
7010 HWY 71 West, Suite 100      512-383-0220 [Phone] 1405 [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]

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## Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Brokers National Life Assurance Company	\$50.00	04/07/2010	35459350

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/07/2010	04/07/2010

*SERFF Tracking Number:*      *BNLI-126565115*                      *State:*                      *Arkansas*  
*Filing Company:*              *Brokers National Life Assurance Company*      *State Tracking Number:*      *45375*  
*Company Tracking Number:*      *BNL-2010-28A*  
*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *Reinstatement Application*  
*Project Name/Number:*      *Reinstatement Application/BNL-2010-28A*

## **Disposition**

Disposition Date: 04/07/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *BNLI-126565115* State: *Arkansas*  
 Filing Company: *Brokers National Life Assurance Company* State Tracking Number: *45375*  
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 TOI: *H21 Health - Other* Sub-TOI: *H21.000 Health - Other*  
 Product Name: *Reinstatement Application*  
 Project Name/Number: *Reinstatement Application/BNL-2010-28A*

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Reinstatement Application	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: RA-FP(2010)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/07/2010	RA-FP(2010)	Application/Reinstatement Enrollment Form	Application	Initial			RA-FP(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 Insurance Policy**

Policy Number: \_\_\_\_\_ Primary Insured Person: \_\_\_\_\_

I request to reinstate my insurance coverage.

Primary Insured's Occupation: \_\_\_\_\_ Insured Spouse's Occupation: \_\_\_\_\_

Complete the following questions for all proposed insured(s) (Not required for AD&D)	Primary Insured	Insured Spouse	Child(ren)
1. Have you, in the past 3 years: Engaged in, or do you plan to engage in, any hazardous sports or aviation activities; or, been arrested for driving while intoxicated, or had a drivers license suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
2. Have you smoked any cigarettes in the past twelve months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
3. Have you ever had insurance declined, postponed or modified in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the past 10 years, been positively diagnosed or treated by a member of the medical profession for: a) heart trouble, high blood pressure, kidney disease, diabetes, liver disorder, cancer, cyst, tumor, abnormal lymph gland, ulcers, mental or nervous disorder? b) any immune deficiency disorder (AIDS), the AIDS-Related Complex (ARC) or tested positive for antibodies to the AIDS virus? c) alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been observed, treated, or hospitalized, or had any symptoms of, any disease not covered above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Full name and address of your personal physician. Give date and reason of last consultation with any treatment/medication. If none, state "None". Primary Insured _____ Insured Spouse _____			

Please explain any YES answers for questions 1, 3-5:

	Height	Weight		Height	Weight
Primary Insured			Child Name		
Insured Spouse			Child Name		
Child Name			Child Name		
Child Name			Child Name		

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, Oregon, Rhode Island, Tennessee & 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 & Rhode Island, 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, 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 Tennessee, it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

I certify that all persons insured under this Policy have not had a life threatening injury or an accident that causes loss of sight or limb(s) within a year of this application.

I authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or members of my family for whom insurance application is made on my health or their health, to give Brokers National Life Assurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. This authorization will be valid for 24 months from the date below. I understand that I may revoke the authorization at any time by submitting a written request. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

All statements in this application are deemed to be representations and not warranties.

I acknowledge receipt of the Fair Credit Reporting Act Notice and Notice Regarding Medical Information Bureau.

Signature of Primary Insured **X** \_\_\_\_\_ Insured Spouse Signature **X** \_\_\_\_\_

Witness **X** \_\_\_\_\_ Date \_\_\_\_\_

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	04/07/2010
<b>Comments:</b>		
<b>Attachment:</b> Compliance Certification.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	04/07/2010
<b>Comments:</b>		
<b>Attachment:</b> RA-FP(2010).pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Health - Actuarial Justification	Approved-Closed	04/07/2010
<b>Bypass Reason:</b> N/A.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	04/07/2010
<b>Bypass Reason:</b> N/A.		
<b>Comments:</b>		

# BROKERS NATIONAL LIFE ASSURANCE COMPANY

## Compliance Certification

This is to certify that the attached form(s) meet the provisions of **Regulation 19**;

That Brokers National Life Assurance Company is in compliance with **Regulation 49**, using the Life Health Guaranty Notice approved by your state on **July 21, 2009**;

That the attached **Reinstatement Application**, Form # **RA-FP(2010)**, has achieved the Flesch Reading Ease Score of **52**, meeting the standards provided in **Arkansas Insurance Code 23-80-206**;

And that Brokers National Life Assurance Company is in compliance with **Arkansas Insurance Code 23-79-138**, using the Important Information Notice approved by your state on **January 22, 2010**.



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Tammy Barr  
Vice President - Underwriting

Brokers National Life Assurance Company  
Compliance Department

04/05/2010

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Date



**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 Insurance Policy**

Policy Number: \_\_\_\_\_ Primary Insured Person: \_\_\_\_\_

I request to reinstate my insurance coverage.

Primary Insured's Occupation: \_\_\_\_\_ Insured Spouse's Occupation: \_\_\_\_\_

Complete the following questions for all proposed insured(s) (Not required for AD&D)	Primary Insured	Insured Spouse	Child(ren)
1. Have you, in the past 3 years: Engaged in, or do you plan to engage in, any hazardous sports or aviation activities; or, been arrested for driving while intoxicated, or had a drivers license suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
2. Have you smoked any cigarettes in the past twelve months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
3. Have you ever had insurance declined, postponed or modified in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the past 10 years, been positively diagnosed or treated by a member of the medical profession for: a) heart trouble, high blood pressure, kidney disease, diabetes, liver disorder, cancer, cyst, tumor, abnormal lymph gland, ulcers, mental or nervous disorder? b) any immune deficiency disorder (AIDS), the AIDS-Related Complex (ARC) or tested positive for antibodies to the AIDS virus? c) alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been observed, treated, or hospitalized, or had any symptoms of, any disease not covered above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Full name and address of your personal physician. Give date and reason of last consultation with any treatment/medication. If none, state "None". Primary Insured _____ Insured Spouse _____			

Please explain any YES answers for questions 1, 3-5:

	Height	Weight		Height	Weight
Primary Insured			Child Name		
Insured Spouse			Child Name		
Child Name			Child Name		
Child Name			Child Name		

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.

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I certify that all persons insured under this Policy have not had a life threatening injury or an accident that causes loss of sight or limb(s) within a year of this application.

I authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or members of my family for whom insurance application is made on my health or their health, to give Brokers National Life Assurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. This authorization will be valid for 24 months from the date below. I understand that I may revoke the authorization at any time by submitting a written request. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

All statements in this application are deemed to be representations and not warranties.

I acknowledge receipt of the Fair Credit Reporting Act Notice and Notice Regarding Medical Information Bureau.

Signature of Primary Insured **X** \_\_\_\_\_ Insured Spouse Signature **X** \_\_\_\_\_

Witness **X** \_\_\_\_\_ Date \_\_\_\_\_