

SERFF Tracking Number: HULI-126550959 State: Arkansas  
 Filing Company: Heritage Union Life Insurance Company State Tracking Number: 45386  
 Company Tracking Number: HU-TL-POL500  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium  
 Product Name: Salary Shield Silver-LF75  
 Project Name/Number: /

## Filing at a Glance

Company: Heritage Union Life Insurance Company

Product Name: Salary Shield Silver-LF75 SERFF Tr Num: HULI-126550959 State: Arkansas  
 TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- State Tr Num: 45386  
 Closed  
 Sub-TOI: L04I.313 Decreasing - Single Life - Co Tr Num: HU-TL-POL500 State Status: Approved-Closed  
 Fixed/Indeterminate Premium  
 Filing Type: Form Reviewer(s): Linda Bird  
 Authors: Kim Hiar, Teresa Lockette Disposition Date: 04/09/2010  
 Date Submitted: 04/08/2010 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: Exempt from Filing in Arizona.  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Group Market Size:  
 Overall Rate Impact: Group Market Type:  
 Filing Status Changed: 04/09/2010 Explanation for Other Group Market Type:  
 State Status Changed: 04/09/2010  
 Deemer Date: Created By: Teresa Lockette  
 Submitted By: Kim Hiar Corresponding Filing Tracking Number:  
 Filing Description:

This term life insurance product is marketed under the product name, SalaryShield Silver. It allows the applicant to select a monthly death benefit based on their currently salary to be paid to the named beneficiary. The issue age is from age 50 to age 70. The monthly benefit will be paid until the insured would have reached age 75.

This product will be marketed through both the agent channel and the direct response channel, including mail, radio and television. This product will not be marketed with an illustration.

<i>SERFF Tracking Number:</i>	<i>HULI-126550959</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Heritage Union Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45386</i>
<i>Company Tracking Number:</i>	<i>HU-TL-POL500</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Salary Shield Silver-LF75</i>		
<i>Project Name/Number:</i>	<i>/</i>		

The following forms will be used in the sales and administration of this product. These forms were previously approved as follows:

Form Number	Description	SERFF Tracking #	Approval Date
HU-TL-APP320A	Term Life Application	HULI-126094738	4/2/2009
HU-GHS100	Good Health Statement	HULI-126094738	4/2/2009
HU-TL-RDR100A	Decreasing Term Rider	HULI-126119897	5/5/2009
AL-TL-REP100A	Replacement Notice	HULI-125571367	4/7/2008
AL-TL-APP300A	Reinstatement Application	HULI-125571367	4/7/2008

We reserve the right to change layout and font type in the future. Should you have any questions or need additional information, please contact me at 804-201-4733 or email me at [teresa.lockette@heritageunion.com](mailto:teresa.lockette@heritageunion.com).

## Company and Contact

### Filing Contact Information

Kim Hiar, Compliance Manager	<a href="mailto:kimberly.hiar@heritageunion.com">kimberly.hiar@heritageunion.com</a>
1805 Monument Avenue	804-212-2818 [Phone]
Suite 201	804-213-0051 [FAX]
Richmond, VA 23220	

### Filing Company Information

Heritage Union Life Insurance Company	CoCode: 62421	State of Domicile: Arizona
1805 Monument Avenue	Group Code: 181	Company Type: Life & Health Insurer
Suite 201	Group Name:	State ID Number: 2058
Richmond, VA 23220	FEIN Number: 41-0880965	
(804) 212-2818 ext. [Phone]		

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No

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Project Name/Number: /  
Fee Explanation: 1 policy @ \$50.00/policy submission  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Heritage Union Life Insurance Company	\$50.00	04/08/2010	35497079

SERFF Tracking Number: HULI-126550959 State: Arkansas  
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Fixed/Indeterminate Premium  
Product Name: Salary Shield Silver-LF75  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	04/09/2010	04/09/2010

SERFF Tracking Number: HULI-126550959 State: Arkansas  
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Fixed/Indeterminate Premium  
Product Name: Salary Shield Silver-LF75  
Project Name/Number: /

## Disposition

Disposition Date: 04/09/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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 Filing Company: Heritage Union Life Insurance Company State Tracking Number: 45386  
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Product Name: Salary Shield Silver-LF75

Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variables		Yes
Form	Policy Form		Yes
Form	Schedule Pages		Yes
Form	Cost and Benefits Statement		Yes

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 Product Name: Salary Shield Silver-LF75  
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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	HU-TL-POL500B-AR	Policy/Contract/Fraternal Certificate	Policy Form	Initial		48.100	HU-TL-POL500B-AR LF75 Policy with LS-Final.pdf
	HU-TL-SCH500A-AR	Schedule Pages	Schedule Pages	Initial		47.100	HU-TL-SCH500A-AR Schedule Pages.pdf
	HU-TL-CBS500A	Other	Cost and Benefits Statement	Initial		47.200	HU-TL-CBS500A Cost Benefit Statement-Final.pdf



# HERITAGE UNION LIFE INSURANCE COMPANY

Executive Offices: 1805 Monument Avenue, Suite 201  
Richmond, Virginia 23220

We agree to pay the Policy Proceeds if the Insured dies before the Expiration Date while this policy is in force subject to all policy provisions. Payment will be made upon receipt at Our Administrative Office of due proof of the Insured's death that is satisfactory to Us.

This policy is issued in consideration of the application and payment of the first premium. While the Insured is alive, premiums must be paid as shown on the Policy Schedule until the Expiration Date.

## **THIS IS A LEGAL CONTRACT – READ IT CAREFULLY**

### **IMPORTANT NOTICE – RIGHT TO CANCEL**

**This policy may be cancelled within 30 days after You receive it by returning it to Our Administrative Office, or by mailing or returning it to the agent from whom it was purchased, if any. We will return all payments made for this policy and cancel the policy as of the Policy Date.**

Issued and signed for Heritage Union Life Insurance Company,  
an Arizona domestic life insurance company

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**[Philip G. Walker]**  
Chairman and CEO

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**[Julia Roper]**  
President

**LEVEL PREMIUM  
DECREASING TERM LIFE INSURANCE TO AGE 75  
PREMIUMS PAYABLE TO EXPIRATION DATE  
POLICY PROCEEDS PAYABLE UPON DEATH BEFORE EXPIRATION DATE  
NON-PARTICIPATING NON-CONVERTIBLE**

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Copies of applications, endorsements and/or riders.

This page is intentionally left blank for insertion of Policy Schedule page(s)  
Form HU-TL-SCH500A-AR

## **SECTION 1 – DEFINITIONS**

**Administrative Office** – means the office located at the address shown on the Policy Schedule.

**Assign** – means to transfer Your rights as the Owner of this policy. If You transfer all of Your rights irrevocably, the Assignment is absolute. If You transfer all or some of Your rights as the Owner of this policy as security for a loan, but on the condition that they return to You once the debt is paid, then the Assignment is collateral.

**Beneficiary** – means the person(s) or entity designated to receive Policy Proceeds at the time of the Insured's death.

**Discount Rate** – is the interest rate used to determine the present value of a stream of policy payments.

**Endorsement or Rider** – is a form which amends this policy or which provides additional benefits. When an Endorsement or Rider is attached to this policy it becomes a part of this policy and is subject to all of the policy terms unless We state otherwise in the Endorsement or Rider.

**Expiration Date** – is the date on which the insurance coverage under this policy ends. The Expiration Date is shown on the Policy Schedule.

**Grace Period** – is the period after a Premium Due Date during which We will accept premiums to keep the policy in force.

**He** – is used to mean "he" or "she."

**His** – is used to mean "his" or "hers."

**Insured** – is the person whose life is covered under this policy.

**Owner** – is the person who may exercise the rights of this policy.

**Policy Anniversary** – is the same day and month as the Policy Date for each subsequent year this policy is in force.

**Policy Anniversary Age** – is the Insured's age on his or her last birthday prior to the Policy Anniversary.

**Policy Date** – is the date on which this policy is issued and the insurance coverage becomes effective.

**Policy Issue Age** – is the Insured's age on his or her last birthday prior to the Policy Date.

**Policy Months and Policy Years** – refer to the months and years during which this policy is in force. Policy Months and Policy Years are measured from the Policy Date.

**Policy Proceeds** – is the amount payable to the Beneficiary upon due proof of the Insured's death that is satisfactory to Us.

**Premium Due Date** – is the date premiums, other than the first, must be paid. If the annual mode of premium payment is chosen, the Premium Due Dates are the Policy Anniversaries. If a monthly, quarterly, or semi-annual mode of premium payment is chosen, the Premium Due Dates are, respectively, every 1 month, 3 months, or 6 months from the Policy Date. The first Premium Due Date is measured from the Policy Date. All following Premium Due Dates are measured from the immediately preceding Premium Due Date.

**We, Us, Our, Ours** – means Heritage Union Life Insurance Company

**Written Notice** – means a written form satisfactory to Us and received by Us at Our Administrative Office.

**You, Your, Yours** – means the Owner.

## **SECTION 2 – GENERAL PROVISIONS**

**ENTIRE CONTRACT** – The entire contract consists of this policy, Endorsements or Riders, if any, the attached written application and supplemental written application(s), if any. Any statement made in any such written application, in the absence of fraud, is deemed a representation and not a warranty. We will not use any statement made by the Insured, or on his behalf, to challenge a claim under this policy unless it is contained in a written application.

**CHANGES TO CONTRACT** – This policy may be changed only if the change is approved in writing by Our President and Secretary.

**INCONTESTABILITY** – We cannot contest this policy, except for non-payment of premiums, after it has been in force during the Insured's lifetime for two years from the Policy Date or, if reinstated, for two years from the date of reinstatement. Reinstatements may be contested based on material misrepresentations only with respect to statements made in the application for reinstatement.

**SUICIDE** – If the Insured commits suicide, while sane or insane, within two years from the Policy Date, Our liability is limited to an amount equal to the total premiums paid. We will pay this amount to the Beneficiary in one sum.

**MISSTATEMENT OF AGE** – If the age of the Insured has been misstated, We will adjust the Policy Proceeds to the amount which the premiums paid would have purchased at the correct age.

**NON-PARTICIPATING** – This policy is not entitled to share in Our profits or surplus.

**CONFORMITY WITH STATE STATUTES** – Any provision of this policy, which on the Policy Date is in conflict with the statutes of the state in which the policy was issued on such date, is hereby amended to conform to the minimum requirements of such statutes.

**TERMINATION** – This policy will terminate and all coverage on the Insured's life shall end on the earliest of the following dates or events:

1. The Expiration Date, as set out on the Policy Schedule; or
2. The date the policy terminates, as set out in the Grace Period provision; or
3. The date We receive Your Written Notice to terminate Your policy; or
4. The date of the Insured's death.

## **SECTION 3 – PREMIUMS AND REINSTATEMENT**

**PAYMENT OF PREMIUMS** – Each premium must be paid to Us at Our Administrative Office on or before its Premium Due Date. You may change the mode of premium payment, by providing Written Notice satisfactory to Us. You may change to any mode of premium payment being offered by Us at the time of Written Notice.

**GRACE PERIOD** – Any premium, other than the first, which is not paid by the Premium Due Date must be paid and received by Us within 31 days after its Premium Due Date. The policy stays in force during the Grace Period. If the Insured dies during the Grace Period, We will deduct the unpaid premium from the Policy Proceeds. If the premium remains unpaid at the end of the Grace Period, this policy will terminate as of the unpaid Premium Due Date.

**REINSTATEMENT** – This policy may be reinstated, during the lifetime of the Insured, within 15 days after the end of the Grace Period by payment of the unpaid premium.

This policy may also be reinstated following the 15 day period after the end of the Grace Period. Such reinstatement must be made during the lifetime of the Insured and within 5 years after the Premium Due Date of the unpaid premium. For such reinstatement We require and must receive:

1. Written application for reinstatement satisfactory to Us;
2. Evidence of insurability satisfactory to Us; and
3. Payment of all past due premiums with interest at 6% per year compounded annually to the date of reinstatement.

The reinstated policy will be in force from the date We approve the reinstatement application.

#### **SECTION 4 – OWNERSHIP AND BENEFICIARY**

**OWNER’S RIGHTS** - You may without the Beneficiary's consent:

- Receive any benefit, exercise any right and use any privilege granted by the policy;
- Transfer ownership of the policy;
- Change any revocable Beneficiary during the Insured's lifetime; or
- Agree with Us to any change or amendment of the policy.

If You die while the Insured is alive, ownership will pass to Your estate.

**CHANGE OF OWNER** – On the Policy Date the Owner is as shown on the Policy Schedule. You may change the Owner by sending Us Written Notice. We must receive Written Notice informing Us of the change. The change will take effect as of the date the Written Notice was signed. However, We are not liable for any payment made by Us before We record the Written Notice.

**ASSIGNMENT** – You may Assign this policy. We are bound by an Assignment only if We receive a duplicate of the original Assignment at Our Administrative Office. We are not liable for any payment made by Us before We record the Assignment. We are not responsible for the validity of any Assignment.

You may revoke any Assignment prior to its effective date provided We receive Written Notice of revocation satisfactory to Us before the Assignment is recorded by Us.

An Assignment will not change or revoke the Beneficiary designation in effect at the time the Assignment is made. If an Assignment is absolute, Your rights and privileges, including any right to change the Beneficiary, vest in the Assignee. If any Assignment is collateral, the collateral Assignee has priority over the interest of any revocable Beneficiary or revocable payee.

**BENEFICIARY** – When we receive due proof of the Insured's death, unless You specify otherwise, any benefit for loss of life will be paid to the Insured's then living lawful spouse; otherwise equally to the Insured's then living lawful children, if any; otherwise equally to the Insured's then living parents or parent, otherwise to Your estate. Any payment made under this section will fully release us to the extent of the payment.

If a Beneficiary dies before the Insured, that Beneficiary's interest in this Policy ends with that Beneficiary's death. Only those Beneficiaries who survive the Insured will be eligible to share the Proceeds. If no Beneficiary survives the Insured, We will pay the Proceeds of this Policy to You, if living, otherwise to Your estate.

**CHANGE OF BENEFICIARY** – You may change a revocable Beneficiary. We must receive Written Notice satisfactory to Us informing Us of the change. The change will take effect as of the date the Written Notice was signed. However, We are not liable for any payment made by Us before We record the Written Notice.

If the Beneficiary designation is irrevocable, it may only be changed by submitting a Written Notice to Us which has been signed by You and the irrevocable Beneficiary.

**BENEFICIARY DEATH SIMULTANEOUS** – Unless You have directed otherwise, if any Beneficiary dies at the same time as the Insured or within ten (10) days after the death of the Insured, benefits will be paid as if the Beneficiary predeceased the Insured unless it is proved otherwise to Our satisfaction.

## **SECTION 5 – POLICY PROCEEDS**

**PROCEEDS** – If the Insured dies while this policy is in force, We will pay the Policy Proceeds to the Beneficiary when We receive due proof of the Insured's death satisfactory to Us. We may require return of this policy.

The Policy Proceeds will consist of:

- The Benefit Amount as shown on the Policy Schedule; plus
- Benefits provided by Endorsement or Rider, if any, which are payable on the Insured's death; plus
- An amount equal to the premium already paid to Us for each Policy Month following the Policy Month of the Insured's death. We will not pay this amount if We are waiving premiums for this policy under a Rider or Endorsement.

If the Insured dies during the Grace Period, We will deduct the unpaid premium from the Policy Proceeds for the Policy Month in which the Insured dies.

The Policy Proceeds will be paid in monthly installments unless the Beneficiary elects to receive a lump sum or there is no Beneficiary designation in effect. If the Beneficiary elects a lump sum, we must receive a Written Notice of such election before any monthly installments have been paid. If there is no beneficiary designation in effect a lump-sum benefit amount may be paid to Your estate.

The lump-sum benefit amount is a one-time payment of the present value of the monthly installments of Policy Proceeds from the date of the Insured's death until the Insured's age 75.

The present value is determined by discounting each monthly installment of Policy Proceeds from the date it would have been paid to the date of the Insured's death. The Discount Rate is determined by Us, but not to exceed the 30-year Treasury rate (CMT), plus 6%.

If the Beneficiary survives the Insured but dies prior to all monthly installments of Policy Proceeds having been paid to such Beneficiary, the present value of the remaining unpaid monthly installments of the Policy Proceeds will be paid to the Beneficiary's estate in a lump-sum amount in lieu of future monthly installments of the Policy Proceeds. The present value is determined by discounting each monthly installment of Policy Proceeds from the date it would have been paid to the date of the Beneficiary's death. The Discount Rate is determined by Us, but not to exceed the 30-year Treasury rate (CMT), plus 6%.

If the Policy Proceeds are not paid within 30 days of Our receipt of due proof of death, We will pay interest at the rate required by law in the state in which this policy is delivered from the date of death until the date of the first payment.

Any payment is subject to the terms of this policy.

**PROTECTION AGAINST CREDITORS** - Policy Proceeds are exempt from the claims of creditors and from legal process to the extent permitted by law.

**LEVEL PREMIUM  
DECREASING TERM LIFE INSURANCE TO AGE 75  
PREMIUMS PAYABLE TO EXPIRATION DATE  
POLICY PROCEEDS PAYABLE UPON DEATH BEFORE EXPIRATION DATE  
NON-PARTICIPATING    NON-CONVERTIBLE**

## Policy Schedule

Owner: [Jane Doe]	Policy Date: [01/01/2010]
Insured: [John Doe]	
Insured's Policy Issue Age: [60]	Policy Number: [1234567890]
Sex: [M]	Expiration Date: [01/01/2025]
Premium Class: [Preferred Non-Tobacco]	Mode of Premium Payment: [Monthly]
Premium: \$[14.22]	

### Benefit Amount

**[\$500.00] Per Month until Policy Anniversary Age 75**

**[Rider(s)]**

[Rider 1]	[Rider Benefit]
[Rider 2]	[Rider Benefit]
[Rider 3]	[Rider Benefit]
[Rider 4]	[Rider Benefit]

	<u>Annual Premium</u>	<u>Semi-Annual Premium</u>	<u>Quarterly Premium</u>	<u>Monthly Premium</u>
<b>Base Policy</b>	<b>[152.64]</b>	<b>[76.32]</b>	<b>[38.16]</b>	<b>[12.72]</b>
<b>[Rider 1]</b>	<b>[10.80]</b>	<b>[5.40]</b>	<b>[2.70]</b>	<b>[0.90]</b>
<b>[Rider 2]</b>	<b>[10.80]</b>	<b>[5.40]</b>	<b>[2.70]</b>	<b>[0.90]</b>
<b>[Rider 3]</b>	<b>[10.80]</b>	<b>[5.40]</b>	<b>[2.70]</b>	<b>[0.90]</b>
<b>[Rider 4]</b>	<b>[10.80]</b>	<b>[5.40]</b>	<b>[2.70]</b>	<b>[0.90]</b>

Please contact our Administrative Office for questions or information regarding your policy.

**Heritage Union Life Service Center**  
**[P.O. BOX 2918**  
**Jacksonville, FL 32202-2918]**  
**[TOLL FREE – 866-438-9404**

If We fail to provide you with reasonable and adequate service, you should feel free to contact:

**Arkansas Insurance Department**  
**Consumer Services Division**  
**400 University Tower Building**  
**Little Rock, AR 72204**  
**(501) 371-1811**



# Heritage Union Life Insurance Company

Executive Offices: 1805 Monument Avenue, Suite 201  
Richmond, Virginia 23220

**STATEMENT PREPARATION DATE: [03/19/2010]**

## **STATEMENT OF POLICY COST AND BENEFIT INFORMATION TERM LIFE INSURANCE TO AGE 75**

Insured: [John Doe]

Age: [60]

Class: [Non-tobacco]

Policy Date: [3/19/2010]

Policy Number: [ 12345678]

<u>Year</u>	<u>Annual Premium</u>	<u>Monthly Benefit Amount*</u>
1	[\$180.00]	[\$2,500.00]
2	[\$180.00]	[\$2,500.00]
3	[\$180.00]	[\$2,500.00]
4	[\$180.00]	[\$2,500.00]
5	[\$180.00]	[\$2,500.00]
10	[\$180.00]	[\$2,500.00]
20	[\$180.00]	[\$2,500.00]

\*The Monthly Benefit Amount that will be paid to the beneficiary beginning from the date of the Insured's death until the date the Insured would have attained Policy Anniversary Age 75. Policy Proceeds will be paid in monthly installments unless there is no Beneficiary designation in effect. If there is no Beneficiary designation in effect, a lump sum benefit amount may be paid to Your estate. The lump sum benefit amount is a one-time payment of the present value of the monthly installments of Policy Proceeds from the date of the Insured's death until the Insured's age 75. The present value is determined by discounting each monthly installment of Policy Proceeds from the date it would have been paid to the date of the Insured's death. The Discount Rate used in this calculation will be the Discount Rate in effect at the time of the Insured's death. The Discount Rate is determined by Us.

**[Premiums shown above include \$75 annual policy fee.]**

	<u>10<sup>th</sup> Year</u>	<u>20<sup>th</sup> Year</u>
Surrender Cost Index	[0.99]	[0.99]
Net Payment Cost Index	[0.99]	[0.99]

EXPLANATION OF THE INTENDED USE OF THE COST INDEXES IS INCLUDED IN THE LIFE INSURANCE BUYER'S GUIDE.

**For additional information or questions, contact the following:**

**Heritage Union Life Service Center**

**[PO Box 1439**

**Deerfield, IL 60015-1439]**

**[TOLL FREE – 866-893-6771]**

SERFF Tracking Number: HULI-126550959 State: Arkansas  
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TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Salary Shield Silver-LF75  
Project Name/Number: /

## Supporting Document Schedules

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

**Satisfied - Item:** Flesch Certification  
**Comments:**  
**Attachment:**  
Certification of Compliance HU-TL-POL500B-AR.pdf

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

**Satisfied - Item:** Application  
**Comments:**  
The application to be used with this filing was previously approved under SERFF Filing number HULI-126094738 on 4/2/2009. The form number for this application is HU-TL-APP320A.  
**Attachment:**  
HU-TL-APP320A.pdf

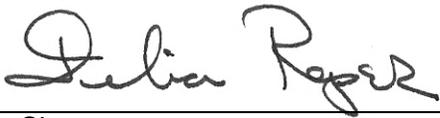
**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Statement of Variables  
**Comments:**  
**Attachment:**  
STATEMENT OF VARIABLES FOR HU-TL-SCH500A.pdf

CERTIFICATION OF COMPLIANCE

I certify that in preparation of this filing all statutes, regulations, rules and bulletins have been reviewed, including Rule 19 and Rule 49.

I also certify that all forms contained in this filing comply with the minimum flesch score of 40 as required in Arkansas ACA 23-80-206.



\_\_\_\_\_  
Signature

March 24, 2010

\_\_\_\_\_  
Date

Julie Roper

\_\_\_\_\_  
Name

President

\_\_\_\_\_  
Title

### ABOUT PROPOSED INSURED (Please answer each question completely)

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone \_\_\_\_\_  
 Best time to call:  Morning  Afternoon  Early Evening

Alternate Phone \_\_\_\_\_  
 Best time to call:  Morning  Afternoon  Early Evening

Email Address \_\_\_\_\_

Current Occupation \_\_\_\_\_

Annual Salary \$ \_\_\_\_\_  Male  Female

Product \_\_\_\_\_

Monthly Benefit Amount \$ \_\_\_\_\_

Payout Period \_\_\_\_\_

Rider(s)/Amount \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Birthplace \_\_\_\_\_  
 month day year state or country

Height \_\_\_\_ feet \_\_\_\_\_ inches Weight \_\_\_\_\_ pounds

SS# \_\_\_\_\_

Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_

Are you a citizen of the United States?  Yes  No

If no, do you have a permanent Visa (green card)?  Yes  No

#### POLICY OWNER'S INFORMATION (If different from Proposed Insured)

Policy Owner's Name: \_\_\_\_\_

Policy Owner's Street: \_\_\_\_\_

Policy Owner's City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Owner's SS# or Tax Payer ID#: \_\_\_\_\_

#### BENEFICIARY INFORMATION

Name, Relationship and Designated %:

### APPLICANT HISTORY (Check YES or NO for each question. If yes, provide details.)

1. a. Do you have other life insurance applications pending with any other company? .....  Yes  No
  - b. By applying for the proposed policy do you intend to replace, discontinue or change an existing policy or contract? .....  Yes  No
- If yes, provide details as follows. Attach a separate sheet if more space is needed (\*Indicate Type of Coverage: I=Individual; B=Business; or G=Group)

INSURED NAME	INSURANCE COMPANY	POLICY NO.	AMOUNT	*TYPE	PENDING	ISSUE DATE
					<input type="checkbox"/>	
					<input type="checkbox"/>	

2. Have you, in the past 2 years, used tobacco or nicotine products in any form? .....  Yes  No
3. Within the past 3 years, have you been refused life insurance or been issued a policy on a modified or rated basis? .....  Yes  No
4. Have you, in the past 3 years, participated in or do you plan to participate in any of the following activities: aeronautics, including hang gliding, sky diving, parachuting, or ballooning; racing, including car, motorcycle, or boat; scuba/skin diving; hiking, including mountain/trail climbing or rock climbing; or any similar hazardous activities? .....  Yes  No
5. Have you, in the past 3 years, piloted an aircraft, or do you have any intention of flying in the future other than as a passenger on a scheduled airline? .....  Yes  No
6. Do you contemplate residence or travel, including military deployment, outside the US during the next 2 years? .....  Yes  No
7. Have you, in the past 3 years, had your driver's license suspended, revoked, cancelled, or withdrawn, had 3 or more moving violations, or in the past 5 years pled guilty or no contest to or been convicted of driving under the influence (DUI/DWI) or reckless driving? .....  Yes  No
8. Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, or been on probation or parole for a felony offense, or are felony charges currently outstanding against you? .....  Yes  No
9. Have you, in the past 10 years, used illegal drugs, or consulted a physician or other healthcare provider or been treated, hospitalized, or taken medication for abuse of alcohol or drugs (including prescription drugs)? .....  Yes  No

- 10.** Have you, in the past 10 years, consulted a physician or other healthcare provider, or been treated, hospitalized or taken medication for: any diseases or disorders of the heart including rheumatic fever, circulatory system, diabetes/endocrine/thyroid, blood, kidneys, liver, digestive system, lungs including allergies, sleep apnea, respiratory disorder, emphysema, or chronic asthma; any mental or nervous disorders, including depression or anxiety; muscular, spinal, joint, or bone disorders or injuries; including concussions; high blood pressure; high cholesterol; cancer; stroke; epilepsy/seizures, including dizziness or fainting; arthritis; congenital defects or physical impairments; or sexually transmitted diseases? .....  Yes  No
- 11.** Have you ever tested positive for, or been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) antibodies or antigens or AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder? .....  Yes  No
- 12.** Have you, in the past 12 months, been confined to a hospital or medical facility of any kind for more than 24 hours? .....  Yes  No
- 13.** In the past 12 months have you scheduled or been advised to have surgery, a diagnostic test, an x-ray, electrocardiogram, blood test or any other laboratory tests, or evaluation of any kind? .....  Yes  No
- 14.** In the last 5 years, have you:
- a. Been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities? .....  Yes  No
- b. Taken prescription drugs for longer than 15 days? .....  Yes  No
- 15.** Have any of your immediate family members (parents or siblings) been diagnosed or died from coronary artery disease, cancer or diabetes prior to age 60? .....  Yes  No

## PAYMENT OPTIONS (Choose One):

Payer:  Proposed Insured  Policy Owner (if different than proposed insured) Choose a billing frequency:  Monthly  Quarterly  
 Semi-annually  Annually

**Agreement/Authorization to Obtain and Disclose Information:** I have read all the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance contract. Any insurance issued as a result of this application will not take effect until the full first premium is paid and a policy is delivered to and accepted by the Proposed Insured during his/her lifetime and while such person is in the state of health described in all parts of this application. I acknowledge receiving the "NOTIFICATION" regarding MIB, Inc. and Fair Credit Reporting Act in the enclosed materials. For use in determining insurability, research, or any other purpose not prohibited by law, I authorize any licensed physician, medical practitioner, MIB, Inc., any pharmacy related service organization, or consumer reporting agency that has any records or knowledge of the Proposed Insured's medical history to give any such information to Heritage Union Life Insurance Company, its representatives, or reinsurers. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the Company except as authorized by me or as required by law. I understand that I or any authorized representative will receive a copy of this authorization upon request. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. All applications are subject to underwriting approval which may include, but is not limited to, income verification, medical examination, laboratory testing, MVR, prescription records, and telephone interview.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **CO Residents:** 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. **DC Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include, imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **KY Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files and 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. **MD Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **OH Residents:** 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 false or deceptive statement is guilty of insurance fraud. **OK Residents:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **OR Residents:** Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. **TN Residents:** 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 insurance benefits.

Signed at City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Proposed Insured (Required – Do not print) \_\_\_\_\_  
 Policy Owner Signature (If Different than Proposed Insured) \_\_\_\_\_

## FOR AGENT USE

To the best of my knowledge, replacement of an existing life insurance policy or annuity contract  is  is not involved in this transaction.

Agent Signature \_\_\_\_\_  
 Agent Name (Printed) \_\_\_\_\_  
 Agent Number \_\_\_\_\_  
 Signed at City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

## **ADDITIONAL APPLICATION INFORMATION BELOW**

# Authorization For Payment by Electronic Funds Transfer or Credit Card

## POLICY OWNER INFORMATION

First Name \_\_\_\_\_ MI \_\_\_\_\_

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_

## PAYMENT OPTIONS (Choose One):

Choose a billing frequency:  Monthly  Quarterly  Semi-annually  Annually

Automatically Deduct Premium from:  Savings  Checking

Bank Name \_\_\_\_\_ Account Holder (Payer) Name (Please Print) \_\_\_\_\_

Account Number: \_\_\_\_\_ Routing Transit No.: \_\_\_\_\_

*Example of routing/transit and account numbers found on the bottom of your personal check*



**OR** Charge Premium to:  Visa  MasterCard  Discover  American Express

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

## BILLING ADDRESS

Same as Mailing Address Above

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize Heritage Union Life Insurance Company to deduct from my account indicated above and I authorize the above named financial institution to honor the withdrawal. I understand that this authorization is to remain in effect until cancelled by me, Heritage Union Life Insurance Company or the Financial Institution named above. To terminate or change this service, I must notify Heritage Union Life Insurance Company at least 30 business days prior to the day that my premium is due to prevent electronic payment drafting.

Signature (Required – Do not print) \_\_\_\_\_

STATEMENT OF VARIABLES  
Forms: HU-TL-SCH500A and HU-TL-CBS500A

<u>VARIABLE</u>	<u>VALUE</u>
Owner	Policy owner's name
Policy Date	Calendar date showing policy effective date
Insured	Insured's name
Insured's Policy Issue Age	Insured's age at the time the policy is issued.
Policy Number	System generated number for each policy issued
Expiration Date	Policy anniversary following the insured's 75 <sup>th</sup> birthday.
Sex	Insured's sex; male or female
Mode of Premium Payment	Monthly, quarterly, semi-annually, or annually
Premium Class	Premium Class of the Insured (Preferred Non-Tobacco; Standard Non-Tobacco; Standard Tobacco; Substandard)
Premium	Premium amount based on the Mode of Payment. (default is Monthly).
Benefit Amount	\$500 to \$10,000
Riders	Include description of each optional rider selected by applicant.
Policy Modal Premiums	Amount of each modal premium. The base policy and each optional rider, if applicable, shown separately

Supplemental rider pages contain detailed information of optional benefits elected by the proposed insured. Subsequent pages will be added as more riders are made available. Page number of the policy specification pages will be advanced using a lower case alpha character following the page number, i.e. 3a, 3b, 3c, etc.

A revised statement of variables will be included with each new optional rider filing when submitted for approval.