

SERFF Tracking Number: UFFL-126578452 State: Arkansas
Filing Company: United Home Life Insurance Company State Tracking Number: 45390
Company Tracking Number: 200-638
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 200-638
Project Name/Number: /

Filing at a Glance

Company: United Home Life Insurance Company

Product Name: 200-638

SERFF Tr Num: UFFL-126578452 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 45390

Sub-TOI: L08.000 Life - Other

Co Tr Num: 200-638

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Karen Hynes

Disposition Date: 04/12/2010

Date Submitted: 04/09/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed concurrently
with IN, our state of domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/12/2010

Explanation for Other Group Market Type:

State Status Changed: 04/12/2010

Deemer Date:

Created By: Karen Hynes

Submitted By: Karen Hynes

Corresponding Filing Tracking Number:

Filing Description:

Attached please find the form referenced below for your review and approval. The requested implementation date of the form included in this submission is upon your approval.

Form 200-638 3-09 is an application for reinstatement that will be used to apply for reinstatement of coverage for products and riders currently on file with your department and those that may be filed at a later date. The application is new and does not replace any form currently on file with your department.

We reserve the right to make any typographical corrections or make minor revisions to the appearance of the form due

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to printing constraints.

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

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Home Life Insurance Company	\$50.00	04/09/2010	35532159

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/12/2010	04/12/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Reinstatement	Karen Hynes	04/09/2010	04/09/2010

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Disposition

Disposition Date: 04/12/2010

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
Form (revised)	Application for Reinstatement		Yes
Form	Application for Reinstatement	Replaced	Yes

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Amendment Letter

Submitted Date: 04/09/2010

Comments:

The form number shown in the Form Schedule tab had not been revised to reflect a state specific form number for Arkansas. I apologize for this oversight. The form number submitted for review is 200-638 3-09 (AR).

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
200-638 3-09 (AR)	Application/Enrollment Form	Application for Reinstatement	Initial				50.200	200-638 3-09 - AR.pdf

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Form Schedule

Lead Form Number: 200-638 3-09

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	200-638 3-09 (AR)	3-	Application/ Enrollment Form	Application for Reinstatement	Initial	50.200	200-638 3-09 - AR.pdf

Application for Reinstatement

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

Policy Number	Proposed Insured	Spouse (If spouse coverage)
Premium Collected	Mode/Method of Payment	Home Office Use Only

I hereby apply for Reinstatement.

As an inducement to the Company to approve this application, I agree that:

- a. The statements and answers in this application are true and complete.
- b. No insurance will be in force until this application is approved:
 1. during the lifetime and sound health of the proposed insured; and
 2. also during the lifetime and sound health of the spouse and the children, if they are covered under the policy or any rider being reinstated.
- c. Approval of this application will be void if at any time within two years from the approval date any of the statements or answers are found to be untrue.
- d. If approved:
 1. this application, along with the original application, will become part of the policy described above; and
 2. a copy will be returned to the policyowner to attach to the policy.

If Spouse coverage, complete 1a and 2a.

1. Proposed Insured's Occupation	2. Exact Height - Weight Ft. In. Lbs.	Has weight changed more than 10 lbs. in past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount of increase _____ decrease _____	Date of Birth
1. a. Spouse's Occupation	2. a. Exact Height - Weight Ft. In. Lbs.	Has weight changed more than 10 lbs. in past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount of increase _____ decrease _____	Date of Birth

The representations made below apply to **EACH PERSON** who would be insured under the policy, including any riders, if reinstated. These individuals include: the insured; any person other than the insured on whose death the premiums would be waived; the insured's spouse or children; and any other individual covered by the stated policy.

3. Since the date of the original application has any proposed insured:	
a. Had any consultation or treatment by a member of the medical profession, physician or practitioner, examination in a clinic, hospital, dispensary, or sanitarium; any surgical operation, x-ray, electrocardiogram, or other tests, or been told there is a need for them?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Had or been told they have any disease, illness, impairment or injury, either physical or mental, by a member of the medical profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Been exempted or discharged as unfit from military service; applied for any kind of disability compensation; or had an application for life or health insurance: declined; postponed; limited; or issued other than as applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Engaged in or contemplate engaging in scuba or sky diving, racing, or other hazardous sports; or made or contemplate making flights as a pilot or student pilot?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Had a driver's license revoked or suspended or been convicted of a felony; sought or received advice, counseling or treatment by a member of the medical profession for the abuse of alcohol or drugs; used (other than as prescribed by a member of the medical profession) narcotics, cocaine, heroin, amphetamines, barbiturates, hallucinogens, or marijuana; used alcohol to the point of intoxication on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Used any nicotine products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details of "Yes" answers to any questions:

*****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.

Dated at _____	this	_____	Month	_____	Day	_____	Year
<input checked="" type="checkbox"/>	Signature of Agent		<input checked="" type="checkbox"/>	Signature of Proposed Insured			
<input checked="" type="checkbox"/>	Signature of Witness, if Agent not Present		<input checked="" type="checkbox"/>	Signature of Spouse			
	Current Address of Payor		<input checked="" type="checkbox"/>	Signature of Owner – If Other Than Proposed Insured			
	City/State/Zip of Payor		<input checked="" type="checkbox"/>	Signature of Owner – If Other Than Proposed Insured			
	Social Security Number of Insured/Owner						

AUTHORIZATION

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

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

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

	<input checked="" type="checkbox"/>	
Date		Signature of Proposed Insured (Required on proposed insureds age 15 and up)

AUTHORIZATION

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

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	<input checked="" type="checkbox"/>	
Date		Signature of Owner

AUTHORIZATION

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

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	<input checked="" type="checkbox"/>	
Date		Signature of Spouse

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

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

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

I declare that I have read and understand the above notice.

Dated at _____	X
this _____	Signature of Proposed Insured
Month Day Year	(Required on proposed insureds age 15 and up.)
X	X
_____	Signature of Spouse
Signature of Agent	X
	Signature of Owner – If Other than Proposed Insured

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Readability - Signed.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: N/A - Submission does not include a policy. Comments:		



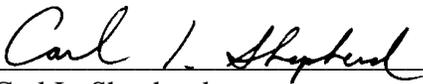
CERTIFICATION

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

Form 200-638 3-09

Score 50.2

Date: 4/9/10

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

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

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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)
04/09/2010	Form	Application for Reinstatement	04/09/2010	200-638 3-09 - AR.pdf