

SERFF Tracking Number: LBLI-126683916 State: Arkansas  
Filing Company: Liberty Life Insurance Company State Tracking Number: 46089  
Company Tracking Number: CFA3001PCR(07-10)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: CFA3001PCR(07-10)  
Project Name/Number: CFA3001PCR(07-10)/CFA3001PCR(07-10)

## Filing at a Glance

Company: Liberty Life Insurance Company

Product Name: CFA3001PCR(07-10)

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: LBLI-126683916 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 46089

Co Tr Num: CFA3001PCR(07-10) State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 06/30/2010

Authors: Julie Duncan, Dianne

Harris

Date Submitted: 06/29/2010

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: CFA3001PCR(07-10)

Project Number: CFA3001PCR(07-10)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/30/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/30/2010

Created By: Dianne Harris

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Dianne Harris

Filing Description:

RE: Form Number CFA3001PCR(07-10), Application for Policy Change or Reinstatement

Liberty Life Insurance Company, NAIC Co. No. 61492, Group 0000, FEIN 44-0188050

The above referenced form is being submitted for your review and approval.

This form will be used to make changes to existing insurance coverage or to reinstate lapsed coverage. This application will be used with previously approved products as well as any products approved for use in your state in the future.

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Please find attached a bracketed version completed in John Doe fashion. This application will be used in a paper environment. All bracketed sections are considered variable, and an Explanation of Brackets is enclosed to explain each variable section.

The form submitted is in final print and is subject to only minor modification in paper size and stock, formatting, ink, border, Company logo, and adaptation to computer printing.

To the best of my knowledge and belief, this form complies with the statutory and regulatory requirements of your state. This form contains no unusual or possible controversial items from normal company or industry standards. If you have questions or need additional information, please contact me at 864-609-1198 or by email at Dianne.k.harris@rbc.com.

## Company and Contact

### Filing Contact Information

Dianne Harris, Compliance Analyst dianne.k.harris@rbc.com  
 2000 Wade Hampton Blvd 864-609-1198 [Phone]  
 Greenville, SC 29615 864-609-1039 [FAX]

### Filing Company Information

Liberty Life Insurance Company CoCode: 61492 State of Domicile: South Carolina  
 2000 Wade Hampton Blvd Group Code: Company Type:  
 Greenville, SC 29602 Group Name: State ID Number:  
 (864) 609-1172 ext. [Phone] FEIN Number: 44-0188050

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: 1 filing x \$50 = \$50  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty Life Insurance Company	\$50.00	06/29/2010	37642023

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/30/2010	06/30/2010

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## Disposition

Disposition Date: 06/30/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *LBLI-126683916* State: *Arkansas*  
 Filing Company: *Liberty Life Insurance Company* State Tracking Number: *46089*  
 Company Tracking Number: *CFA3001PCR(07-10)*  
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*  
 Product Name: *CFA3001PCR(07-10)*  
 Project Name/Number: *CFA3001PCR(07-10)/CFA3001PCR(07-10)*

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Statement of Variability		Yes
<b>Form</b>	Application for Policy Change or Reinstatement		Yes

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## Form Schedule

### Lead Form Number: CFA3001PCR(07-10)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	CFA3001P CR(07-10)	Application/ Enrollment Form	Application for Policy Initial Change or Reinstatement		72.600	CFA3001PCR (07-10)Doe- Bracket.pdf



LIBERTY LIFE INSURANCE COMPANY [2000 Wade Hampton Blvd. Greenville, SC 29615-1064]

**General Instructions For Using This Form**

SUBMIT ONE FORM for each policy to be changed or reinstated. A separate Application for Insurance Part II must also be completed for each applicant except as noted below for Tobacco Class change for ExpressTERM.

- Reinstatement. Complete all of Section I, Section II.A., Section III, and the Application for Insurance Part II.
Face Amount Changes. Complete all of Section I, Section II.B., Section III, and the Application for Insurance Part II. Please consult your policy or product guide to determine the type of changes that can be requested, limitations may apply.
Benefit And Rider Changes. Complete all of Section I, Section II.C., Section III, and the Application for Insurance Part II. Please consult your policy or product guide to determine the type of changes that can be requested, limitations may apply.
Tobacco Class Change. Complete all of Section I, Section II.D., Tobacco Questionnaire and the Application for Insurance Part II. Agent collected saliva or a urinalysis is required for face amounts at \$100,000 and above, excluding ExpressTERM.
Rate Reduction. Complete all of Section I, Section II. E., Section III, and the Application for Insurance Part II.

Section I: Policy and Insured Information.

Policy Number AB12345
Insured's Name (Print First, Middle, Last) John Q. Doe
Date of Birth 01 / 01 / 1959 State of Birth SC Marital Status: Single
Height (ft/in) 6' 0" Weight (lbs) 180 SSN/Tax ID 123-45-6789 E-mail John.Doe@yahoo.com
Residence Address (No PO Box) 123 Any Street Mailing Address (if different)
City Anywhere State SC Zip 12345
Phone: Day (888) 111-1111 Evening (888) 222-2222 Best time to call: After 5:00 pm
Do you have a driver's license? Yes License Number 0123456 State of Issue SC
Are you employed? Yes Occupation/Duties Nurse Annual Income \$ 100,000
Have you ever used any tobacco or nicotine products? No

Policyowner Information (complete only if different than insured)

Owner's Name (Print First, Middle, Last)
Residence (No PO Box) Mailing Address (if different)
City State Zip City State Zip
Daytime Phone Evening E-mail
Relationship to Insured

**Section II.**

**A. Reinstate** *(Please indicate premium amount below and complete Application for Insurance Part II)*

Enclosed is \$ \_\_\_\_\_ premium due.

**B. Face Amount Change** *(If increasing Face Amount please complete Section III of this form and Application for Insurance Part II)*

Increase Base Policy by \$ 50,000 for a total face amount of \$ 100,000

Decrease\* Base Policy by \$ \_\_\_\_\_ for a total face amount of \$ \_\_\_\_\_

Decrease\* \_\_\_\_\_ Rider by \$ \_\_\_\_\_ for a total face amount of \$ \_\_\_\_\_

\* Ultimate Face Amount must meet the minimum face amount requirements for your plan or product.

**C. Benefit and Rider Changes**

*(Please complete Section III of this form and Application for Insurance Part II if adding or increasing a benefit or rider. Please complete an Application for Insurance Part II on each proposed insured being added)*

Accident Only Disability Benefit  Add  Delete  Decrease Benefit Amount \$ \_\_\_\_\_

Accidental Death Benefit  Add  Delete  Decrease Benefit Amount \$ \_\_\_\_\_

Critical Illness Benefit  Add  Delete  Decrease Benefit Amount \$ \_\_\_\_\_

Disability Income Benefit  Add  Delete  Decrease Benefit Amount \$ \_\_\_\_\_

Term Rider  Decreasing  Level \_\_\_\_\_yr.  Add  Delete  Decrease Benefit Amount \$ \_\_\_\_\_

Children's Insurance Benefit Rider  Add  Delete Benefit Amount \$ \_\_\_\_\_

Waiver of Premium or Waiver of Monthly Deduction  Add  Delete

Death Benefit Option Change From \_\_\_\_\_ To \_\_\_\_\_

Other \_\_\_\_\_ Benefit Amount \$ \_\_\_\_\_

Other Insured Rider *(complete information below if adding)*  Add  Delete Benefit Amount \$ \_\_\_\_\_

**Proposed Insured's Name** *(Print First, Middle, Last)* \_\_\_\_\_  Male  Female

Relationship to Primary Insured \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ State of Birth \_\_\_\_\_ Marital Status:  Married  Single  Separated  Divorced  Widowed

Height *(ft/in)* \_\_\_\_\_ Weight *(lbs)* \_\_\_\_\_ SSN/Tax ID \_\_\_\_\_ E-mail \_\_\_\_\_

Residence Address *(No PO Box)* \_\_\_\_\_ Mailing Address *(if different)* \_\_\_\_\_

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

Phone: Day (\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_) \_\_\_\_\_ Best time to call:  8am – Noon  Noon – 5pm  5pm – 9pm

Do you have a driver's license?  Yes License Number \_\_\_\_\_ State of Issue \_\_\_\_\_

No If No, provide details \_\_\_\_\_

Are you employed?  Yes Occupation/Duties \_\_\_\_\_ Annual Income \$ \_\_\_\_\_

No If No, provide details \_\_\_\_\_ Household Income \$ \_\_\_\_\_

Have you ever used any tobacco or nicotine products?  Yes  No

If Yes, when did you last use tobacco or nicotine products *(mm/yyyy)* \_\_\_\_\_ Type \_\_\_\_\_ Quantity \_\_\_\_\_

**D. Tobacco Class Change** *(Please complete Application for Insurance Part II and the Tobacco Questionnaire)*

Change to Non-Tobacco

**E. Rate Reduction** *(Please complete Application for Insurance Part II)*

Reduce or Remove substandard rating

**Section III.**

1. In the past five years, have you:	Yes	No	Provide complete details to any Yes answers
A. Been charged with DUI/DWI, had two or more moving violations, had an accident, or had your driver's license suspended or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
B. Flown as a pilot, student pilot or crew member of any aircraft or have any intentions to do so?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
C. Engaged in parachuting, skydiving, scuba diving below 50 feet, racing of any motor powered land vehicle or watercraft, or any other hazardous activities or extreme sports or have any intention to do so within the next two years?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Have you ever been arrested for, convicted of, or pled guilty or no contest to any felony, misdemeanor, or to possession or distribution of drugs or other illegal substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

**Authorizations, Declarations & Signatures.**

**Authorization to Obtain and Disclose Information** - I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care provider, pharmacy benefit manager, insurance company or reinsurer, government agency, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer or other organization, institution or person to disclose to the insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers of Liberty Life Insurance Company (the "Company"), the following information pertaining to me or any of my minor children proposed for coverage: (1) employment information; (2) other insurance coverage; (3) prescribed drugs; (4) past and present physical, mental, drug and/or alcohol conditions; (5) motor vehicle records; (6) avocations; (7) general reputation; and (8) other personal characteristics.

I understand and agree to the following:

The Company may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits. The Company may disclose all or some of my information to its insurance administrators, its reinsurance companies, its agents, the MIB, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months. A photographic copy of this authorization is as valid as the original and I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation may cause the Company to reject my application.

**Acknowledgement** - By signing below, each person applying for coverage understands, represents, and agrees to the following: I have read this application and the statements and answers made in this application are true and complete to the best of my knowledge and belief and are made to obtain the insurance applied for. I understand that the insurance I applied for will take effect only if the Company accepts this application and issues the requested change or reinstatement and if, on the date of issue: (1) the required premium for the change or reinstatement has been paid; (2) the proposed insured is alive, and (3) all conditions used to determine the proposed insured's insurability remain as stated in the application. No agent or person other than the Company's Home Office officers has the authority to change or modify this application or the policy applied for.

Certain state insurance departments require that we advise you of the following statements:

**For residents of Arkansas:** 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.

**For residents of District of Columbia:** **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.

**For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

All completed materials must be sent to RBC Insurance, PO Box 789, Greenville SC 29602-1389

Signed on \_\_\_\_\_ June 1, 2010  
Date

**X** Signature of Insured \_\_\_\_\_ *John Q. Doe*

**X** Signature of Proposed Other Insured \_\_\_\_\_

**X** Signature of Policy Owner \_\_\_\_\_



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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> READABILITY COMPLIANCE CERTIFICATION.pdf		
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> n/a - application filing only <b>Comments:</b>		
<b>Satisfied - Item:</b> Statement of Variability <b>Comments:</b> <b>Attachment:</b> Statement of Variability.pdf		

## READABILITY COMPLIANCE CERTIFICATION

1. Insurer: Liberty Life Insurance Company  
PO Box 789  
Greenville, South Carolina 29602-0789
2. Certification: I hereby certify that the forms listed below produce Flesch reading ease scores which meet the minimum score required in your state.

In addition, I certify that the forms, except for schedules and tables, are printed in 10 point type, one point leaded. The words and terminology exempted are: (a) all words and terms defined in the forms, (b) all captions and subcaptions, (c) all tables and schedules, and (d) all medical terms. All exempted items are permitted in your state.

### READABILITY SCORE

<u>Name of Form</u>	<u>Form Number</u>	<u>Flesch Score</u>
Application for Policy Change or Reinstatement	CFA3001PCR(07-10)	72.6

June 18, 2010  
Date



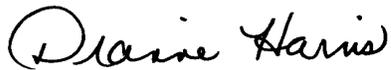
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Mark S. Wessel  
Compliance Officer Policy Forms/Compliance

Statement of Variability  
Form No. **CFA3001PCR(07-10)**

1. Company address.

We certify that any variability within these applications is limited to what is described above. Any change or modification outside of this Statement of Variability will be submitted for prior approval.



\_\_\_\_\_  
Dianne Harris  
Compliance Analyst I

June 18, 2010  
\_\_\_\_\_  
Date