

SERFF Tracking Number: NTAL-126643288 State: Arkansas
 Filing Company: National Teachers Associates Life Insurance Company State Tracking Number: 45800
 Company Tracking Number: 75-305 (5/10)
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 75-305 (5/10) Supplemental Health Application
 Project Name/Number: /75-305 (5/10)

Filing at a Glance

Company: National Teachers Associates Life Insurance Company

Product Name: 75-305 (5/10) Supplemental Health Application SERFF Tr Num: NTAL-126643288 State: Arkansas

TOI: H21 Health - Other SERFF Status: Closed-Approved-Closed State Tr Num: 45800

Sub-TOI: H21.000 Health - Other Co Tr Num: 75-305 (5/10) State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: Wm. Bradley Cox Disposition Date: 06/04/2010

Date Submitted: 05/27/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Authorized
 Project Number: 75-305 (5/10) Date Approved in Domicile:
 Requested Filing Mode: Domicile Status Comments: Filed Exempt
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Group Market Size:
 Overall Rate Impact: Group Market Type:
 Filing Status Changed: 06/04/2010 Explanation for Other Group Market Type:
 State Status Changed: 06/04/2010

Deemer Date: Created By: Wm. Bradley Cox
 Submitted By: Wm. Bradley Cox Corresponding Filing Tracking Number:

Filing Description:

This application is new and does not replace any previously approved form. It is, however, similar to previously approved application form 75-305 (9/07), which was approved by your department.

Upon approval, the application will be used to apply for or amend insurance coverage under our existing approved supplemental health policies. We also intend to use this application with any future supplemental health policies which may be approved for us by your Department.

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This form is being filed Exempt in our domiciliary state of Texas.

Company and Contact

Filing Contact Information

David Mather, Compliance Analyst david.mather@ntalife.com
 4949 Keller Springs Road 972-532-2133 [Phone] 2577 [Ext]
 Addison, TX 75001 972-532-2194 [FAX]

Filing Company Information

National Teachers Associates Life Insurance CoCode: 87963 State of Domicile: Texas
 Company
 4949 Keller Springs Road Group Code: Company Type: LAH
 Addison, TX 75001 Group Name: State ID Number:
 (972) 532-2100 ext. [Phone] FEIN Number: 75-1623431

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Teachers Associates Life Insurance Company	\$50.00	05/27/2010	36853631

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	06/04/2010	06/04/2010

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Disposition

Disposition Date: 06/04/2010

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	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Application for Supplemental Health Insurance	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 75-305 (5/10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/04/2010	75-305 (5/10)	Certificate	Application for Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.700	75-305 (5 10) Generic.pdf 75-305 (5 10) Generic John Doe.pdf

**NATIONAL TEACHERS ASSOCIATES
LIFE INSURANCE COMPANY**

P.O. Box 802207, Dallas, Texas 75380
Phone (888) 671-6771 Fax (972) 532-2180

Check if applicable:

- Name Change
- Policy Reinstatement
- Plan Change:
Policy # _____
- Other _____



**APPLICATION FOR SUPPLEMENTAL
HEALTH INSURANCE**

Please supply the following information for each person applying for coverage. It will be used to determine eligibility for coverage, including age, height, weight, occupation, and medical information below. Maximum age for issuance is 64.

Name of Proposed Primary Insured (Last, First, Middle Initial)					Social Security No. - -				
Sex	Date of Birth		Age (Max. 64)	Height	Weight				
Address					E-mail Address				
City		County or Parish	State	Zip	CODES	St.	Cnty.	City	Bldg.
Home Phone ()		Work Phone ()		Cell Phone ()		Best place and time to call (before 5 pm) <input type="checkbox"/> HM <input type="checkbox"/> WK <input type="checkbox"/> CELL / <input type="checkbox"/> AM <input type="checkbox"/> PM			
School System			School or Business			Occupation			

Complete only if Spouse is proposed to be a Covered Person under this policy or rider.

Name	Height	Weight	Date of Birth	Age (Max. 64)	Social Security No.
					- -

Index of Question Numbers to Answer for the Listed Policies and Riders:

Cancer Policy	Heart & Stroke Policy	All Purpose ICU Rider	Specified Disease Rider
1, 3, 7, 8	2, 3, 5, 7, 8	1 - 8	3, 4, 7, 8

For questions 1-4: Within the past 10 years, has any person proposed for coverage: (i) had symptoms (other than question 3), (ii) received medical advice, (iii) been diagnosed or treated, or (iv) been prescribed medication for:

1. No Yes Cancer (including internal, in situ, melanoma, or skin cancer)? **If yes due to skin cancer (other than melanoma), _____ is/are excluded from benefits for skin cancer. If yes for any other cancer, _____ is/are excluded from the All Purpose ICU Rider and Cancer Policy and related riders.**
2. a. No Yes Any disease, disorder, or abnormality of, or surgery related to, the heart, such as coronary artery disease, heart disease, or heart attack, (excluding: mitral valve prolapse; heart murmur; or irregular heart beat not treated with medication)?
 b. No Yes Any disease, disorder, or abnormality of the circulatory system (including arteries, veins, vessels, and lymph nodes; excluding high blood pressure if controlled)?
 c. No Yes Stroke, transient ischemic attack (TIA or mini-stroke), or any disease, disorder or abnormality of the carotid artery or circulatory system of the brain?
If yes to any part of question 2, _____ is/are excluded from the All Purpose ICU Rider and Heart and Stroke Policy and related riders.
3. No Yes Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus? **If yes, _____ is/are excluded from benefits under all policies and riders.**
4. No Yes Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Legionnaire's Disease, Lupus Erythematosus, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Osteomyelitis, Poliomyelitis, Rabies, Scarlet Fever, Sickle Cell Anemia, Tetanus, Toxic Shock Syndrome, Tuberculosis, Tularemia, or Typhoid Fever? **If yes, _____ is/are excluded from benefits for _____ disease(s) under the Specified Disease Rider and All Purpose ICU Rider.**
5. No Yes Has anyone proposed to be insured: (i) ever been diagnosed with Type I diabetes; or (ii) been prescribed insulin or insulin refills within the past 10 years? **If yes, _____ is/are excluded from the All Purpose ICU Rider and Heart and Stroke Policy and related riders.**
6. No Yes Is any person proposed for coverage pregnant? **If yes, the All Purpose ICU Rider cannot be issued.**



I have reviewed all responses provided in this application for accuracy.

Initial _____



NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

P. O. BOX 802207 • DALLAS, TEXAS 75380 • (888) 671-6771

Thank you for selecting National Teachers Associates Life Insurance Company for your insurance needs! We appreciate the confidence that you have shown in us by completing your application. We will work hard to prove that your confidence in us is justified.

Privacy laws require us to provide you with a copy of our Privacy Notice. If you indicated on your application that we could use your name for marketing purposes, we are also required to obtain your permission on the separate form below. We sincerely appreciate your vote of support for our products, and we ask that you to sign below indicating your consent.

We hope that your experience today has been a positive first step for us to prove our commitment to you. Thank you again for your participation. We are especially excited in having you apply to become a member of our ever-growing family of policyholders.

Sincerely,

Raymond J. Martin, Jr.
President & CEO

PRIVACY NOTICE

We value your privacy and send this notice each year.

PRIVACY PRINCIPLES

- We do not rent, sell or lease your nonpublic personal financial information ("PFI").
- You may authorize us to disclose your PFI.
- Anyone that provides services or products to you for us has agreed to protect your PFI.
- We do not share your PFI with nonaffiliated entities for their marketing purposes.
- We disclose your PFI when required by law.
- These principles apply to past, current and future customers.

[Continued on the Reverse Side]



NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

PRIVACY CONSENT FORM AND AUTHORIZATION

I authorize National Teachers Associates Life Insurance Company ("NTA Life") and its affiliates to use my name, my employer's name, my job title, the insurance plan(s) that I have acquired, and any written correspondence with NTA Life for marketing purposes.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons receiving it, and it would no longer be protected by federal privacy regulations. NTA Life will not condition future coverage on the consent and authorization to disclose this information.

This Consent will remain in effect for the earlier of 24 months or until revoked by me in writing. I may revoke this Consent at any time by mailing a written request to the Director of Compliance at 4949 Keller Springs Rd., Addison, TX 75001. However, any action already taken in reliance on this Consent cannot be reversed, and my revocation will not affect those actions.

NTA Life will maintain this Consent (or a true and correct copy) in its files while it is in force. I have been provided an opportunity to keep a copy of this Consent for my own records. I am also entitled to a copy of this Consent upon written request to NTA Life's Director of Compliance.

Signature

Date

Printed Name



INFORMATION WE COLLECT

We obtain your PFI to provide and support the products and services you request. Your PFI comes from various sources.

- PFI may come from you on your application. PHI also comes from forms, by telephone, and from the Internet. PFI may include your name, address, date of birth, and social security number. PFI may also include work history, income, medical history, beneficiaries, etc.
- PFI may come from your transactions with us. These involve your policy coverage, premium payments, claims, and other insurance policies.
- PFI may come from other sources. These include your employers, medical service providers, information bureaus, etc.

HOW WE USE INFORMATION ABOUT YOU

We use your PFI to underwrite policies, process claims, ensure proper billing, service accounts, and as you request.

WHAT WE MAY DISCLOSE AND TO WHOM

We do not disclose PFI about you to nonaffiliated entities, except as authorized by you. **Washington Residents:** You have the right to limit disclosures of your PFI. See WAC 284-04-510.

OUR SECURITY PROCEDURES

We only provide parties who must know your information to provide insurance products or services with your PFI. We use physical, electronic and procedural safeguards to protect PFI. These safeguards meet federal standards. We review these safeguards regularly.

APPLICABLE AFFILIATES

References to “us” include our affiliates. Our affiliates are insurance agents, service organizations, and third party administrators.

- National Teachers Associates Life Insurance Company.
- National Teacher Associates, Inc. and affiliated state licensed corporations.
- AccuFlex Services, Inc.

NOTICE OF INFORMATION PRACTICES

Some states require us describe our information practices, including information obtained about individuals covered under your policy. The information that we obtain is described above. We may disclose this information to third parties without your consent. However, we only disclose information to a business affiliate, as otherwise permitted by law, or with your consent. You have the right to access and correct your information (other than information that relates to a claim or a judicial proceeding). You may request a written reason for an adverse underwriting decision. For details about our privacy practices in your state, submit a **written request** to our Director of Compliance at 4949 Keller Springs Rd., Addison, TX 75001. Questions may also be directed to Customer Service at (888) 671-6771.

HIPAA NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION

Copies of our HIPAA privacy notice are available at www.ntalife.com or by sending a **written request** to our Director of Compliance at 4949 Keller Springs Rd., Addison, TX 75001. Questions may also be directed to Customer Service at (888) 671-6771.

Please Return the Reverse Side to the Home Office

**NATIONAL TEACHERS ASSOCIATES
LIFE INSURANCE COMPANY**

P.O. Box 802207, Dallas, Texas 75380
Phone (888) 671-6771 Fax (972) 532-2180

Check if applicable:

- Name Change
- Policy Reinstatement
- Plan Change:
Policy # _____
- Other _____



**APPLICATION FOR SUPPLEMENTAL
HEALTH INSURANCE**

Please supply the following information for each person applying for coverage. It will be used to determine eligibility for coverage, including age, height, weight, occupation, and medical information below. Maximum age for issuance is 64.

Name of Proposed Primary Insured (Last, First, Middle Initial) <i>Joe, John A</i>	Social Security No. <i>123 - 45 - 6789</i>
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Sex <i>M</i>	Date of Birth <i>1-1-74</i>	Age (Max. 64) <i>36</i>	Height <i>6'2"</i>	Weight <i>190</i>	
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Address <i>123 Main Street</i>	E-mail Address <i>J. Joe@hotmail.com</i>
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City <i>Dallas</i>	County or Parish <i>Dallas</i>	State <i>TX</i>	Zip <i>75000</i>	CODES	St.	Cnty.	City	Bldg.
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Home Phone <i>(555) 867-5709</i>	Work Phone <i>(555) 867-5709</i>	Cell Phone <i>(555) 867-5709</i>	Best place and time to call (before 5 pm) <input type="checkbox"/> HM <input checked="" type="checkbox"/> WK <input type="checkbox"/> CELL <input type="checkbox"/> AM <i>9</i> <input type="checkbox"/> PM
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School System <i>JISD</i>	School or Business <i>Carter</i>	Occupation <i>Teacher</i>
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Complete only if Spouse is proposed to be a Covered Person under this policy or rider.

Name <i>Jane A Joe</i>	Height <i>5'9"</i>	Weight <i>150</i>	Date of Birth <i>1-1-77</i>	Age (Max. 64) <i>33</i>	Social Security No. <i>234 - 56 - 7891</i>
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Index of Question Numbers to Answer for the Listed Policies and Riders:

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For questions 1-4: Within the past 10 years, has any person proposed for coverage: (i) had symptoms (other than question 3), (ii) received medical advice, (iii) been diagnosed or treated, or (iv) been prescribed medication for:

1. No Yes Cancer (including internal, in situ, melanoma, or skin cancer)? If yes due to skin cancer (other than melanoma), _____ is/are excluded from benefits for skin cancer. If yes for any other cancer, _____ is/are excluded from the All Purpose ICU Rider and Cancer Policy and related riders.
2. a. No Yes Any disease, disorder, or abnormality of, or surgery related to, the heart, such as coronary artery disease, heart disease, or heart attack, (excluding: mitral valve prolapse; heart murmur; or irregular heart beat not treated with medication)?
 b. No Yes Any disease, disorder, or abnormality of the circulatory system (including arteries, veins, vessels, and lymph nodes; excluding high blood pressure if controlled)?
 c. No Yes Stroke, transient ischemic attack (TIA or mini-stroke), or any disease, disorder or abnormality of the carotid artery or circulatory system of the brain?
 If yes to any part of question 2, _____ is/are excluded from the All Purpose ICU Rider and Heart and Stroke Policy and related riders.
3. No Yes Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus? If yes, _____ is/are excluded from benefits under all policies and riders.
4. No Yes Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Legionnaire's Disease, Lupus Erythematosus, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Osteomyelitis, Poliomyelitis, Rabies, Scarlet Fever, Sickle Cell Anemia, Tetanus, Toxic Shock Syndrome, Tuberculosis, Tularemia, or Typhoid Fever? If yes, _____ is/are excluded from benefits for _____ disease(s) under the Specified Disease Rider and All Purpose ICU Rider.
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6. No Yes Is any person proposed for coverage pregnant? If yes, the All Purpose ICU Rider cannot be issued.



I have reviewed all responses provided
in this application for accuracy.

Initial

7. No Yes Is the policy for which you are applying intended to replace or change any of your existing accident and sickness policies? If yes, identify company and type of coverage: _____
8. Yes I understand the coverage for which I am applying does not provide benefits for loss attributable to preexisting medical conditions for 2 years after the Coverage Effective Date, and the policy and riders include a 30-day waiting period for coverage.
9. Yes I request a delayed Coverage Effective Date of _____ Preexisting conditions and the 30-day waiting period will be determined as of the Coverage Effective Date.

CANCER POLICY

Individ. Only One Parent Family
 Basic Green Gold

OPTIONS:

Benefit Booster Rider
 Specified Disease Rider
 All-Purpose ICU: Amount \$ _____
 Other _____
 Other _____

Total Monthly Premium for Policy and Optional Riders: \$ _____

HEART AND STROKE POLICY

Individ. Only One Parent Family
 Basic Green Gold

OPTIONS:

Benefit Booster Rider
 Specified Disease Rider
 All-Purpose ICU: Amount \$ _____
 HBER _____
 Other _____

Total Monthly Premium for Policy and Optional Riders: \$ _____

MODE OF PAYMENT

Initial Premium Check Attached *
with Application: Credit Card
 Other _____

Recurring Monthly Bank Draft
Payments: Credit Card
 Payroll Deduction
 Other _____

Total combined premium applied for:
\$ _____

* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

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.

I (or we) certify that I have read or had read to me the completed application and submit it as my offer for the purchase of insurance. I understand that I have no coverage unless and until the policy is issued by the Company. I represent that the answers are true and correct and realize that any fraudulent statement or material misrepresentation in the application may result in a loss of coverage. I authorize the Company to call me on a recorded phone call to clarify or verify certain information in this application and agree that a transcript of such recording can be made a part of my application for insurance. No oral statement between the agent and me will be binding on the Company. No person to be covered under this policy is currently receiving benefits under Medicare or Medicaid. A copy of this application will be valid as if it were an original. I agree to be bound by the Arbitration Program for the resolution of disputes under the Federal Arbitration Act if included in any policy for which I am applying. I also certify that I have received a copy of the Company's Privacy Notice and HIPAA Notice of Privacy Practices.

DATED AT Dallas TX, THIS 25 DAY OF May, 2010
City and State Day Month Year

X John A. Doe X _____
Signature of Proposed Primary Insured Signature of Applicant (if not the Proposed Primary Insured)

BANK DRAFT AUTHORIZATION

PLEASE ATTACH A SPECIMEN CHECK MARKED "VOID"

I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account specified on the attached specimen check, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than \$200.

X John A. Doe 5/25/10 Requested first draft date (1-28 only)
Signature exactly as it appears on bank records Date Signed

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

X John C. Doe John C. Doe 111-1 111
Licensed Agent Signature Printed Agent Name License ID No. Agent No.

4949 Keller Springs Road, Addison, TX 75001 1-800-TALK-NTA
Address Phone

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR Read Cert.pdf AR Rule & Reg 19 Cert.pdf	Approved-Closed	06/04/2010
Satisfied - Item: Application Comments: Attachments: 75-305 (5 10) Generic.pdf 75-305 (5 10) Generic John Doe.pdf	Approved-Closed	06/04/2010
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A Comments:	Approved-Closed	06/04/2010
Bypassed - Item: Outline of Coverage Bypass Reason: N/A Comments:	Approved-Closed	06/04/2010
Satisfied - Item: Cover Letter	Approved-Closed	06/04/2010

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Comments:

Attachment:

AR Supp App Letter.pdf



NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

4949 Keller Springs Road • Addison, Texas 75001-5910
(972) 532-2100 • Fax (972) 532-2194
www.ntalife.com

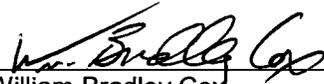
ARKANSAS

I hereby certify that to the best of my knowledge and belief the following forms, according to the
Flesh test, have these readability scores:

Defined terms and headings have been excluded for purposes of the calculation of the
Readability score.

FORM	FORM NO.	SCORE
Application for Supplemental Health Insurance	75-305 (5/10)	52.7

Signed



William Bradley Cox
General Counsel and
Vice President

Date

5-25-10



**NATIONAL TEACHERS ASSOCIATES
LIFE INSURANCE COMPANY**

4949 Keller Springs Road • Addison, Texas 75001-5910
(972) 532-2100 • Fax (972) 532-2194
www.ntalife.com

ARKANSAS

To the best of my knowledge, this submission meets the requirements of the Rule and Regulation 19 and the applicable requirements of the Arkansas Department of Insurance.

Signed *William Bradley Cox*
William Bradley Cox
General Counsel and
Vice President

Date 5-25-10

**NATIONAL TEACHERS ASSOCIATES
LIFE INSURANCE COMPANY**

P.O. Box 802207, Dallas, Texas 75380
Phone (888) 671-6771 Fax (972) 532-2180

Check if applicable:

- Name Change
- Policy Reinstatement
- Plan Change:
Policy # _____
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**APPLICATION FOR SUPPLEMENTAL
HEALTH INSURANCE**

Please supply the following information for each person applying for coverage. It will be used to determine eligibility for coverage, including age, height, weight, occupation, and medical information below. Maximum age for issuance is 64.

Name of Proposed Primary Insured (Last, First, Middle Initial)					Social Security No. - -				
Sex	Date of Birth		Age (Max. 64)	Height	Weight				
Address					E-mail Address				
City		County or Parish	State	Zip	CODES	St.	Cnty.	City	Bldg.
Home Phone ()		Work Phone ()		Cell Phone ()		Best place and time to call (before 5 pm) <input type="checkbox"/> HM <input type="checkbox"/> WK <input type="checkbox"/> CELL / <input type="checkbox"/> AM <input type="checkbox"/> PM			
School System			School or Business			Occupation			

Complete only if Spouse is proposed to be a Covered Person under this policy or rider.

Name	Height	Weight	Date of Birth	Age (Max. 64)	Social Security No.
					- -

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 c. No Yes Stroke, transient ischemic attack (TIA or mini-stroke), or any disease, disorder or abnormality of the carotid artery or circulatory system of the brain?
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3. No Yes Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus? **If yes, _____ is/are excluded from benefits under all policies and riders.**
4. No Yes Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Legionnaire's Disease, Lupus Erythematosus, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Osteomyelitis, Poliomyelitis, Rabies, Scarlet Fever, Sickle Cell Anemia, Tetanus, Toxic Shock Syndrome, Tuberculosis, Tularemia, or Typhoid Fever? **If yes, _____ is/are excluded from benefits for _____ disease(s) under the Specified Disease Rider and All Purpose ICU Rider.**
5. No Yes Has anyone proposed to be insured: (i) ever been diagnosed with Type I diabetes; or (ii) been prescribed insulin or insulin refills within the past 10 years? **If yes, _____ is/are excluded from the All Purpose ICU Rider and Heart and Stroke Policy and related riders.**
6. No Yes Is any person proposed for coverage pregnant? **If yes, the All Purpose ICU Rider cannot be issued.**



I have reviewed all responses provided
in this application for accuracy.

Initial



NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

P. O. BOX 802207 • DALLAS, TEXAS 75380 • (888) 671-6771

Thank you for selecting National Teachers Associates Life Insurance Company for your insurance needs! We appreciate the confidence that you have shown in us by completing your application. We will work hard to prove that your confidence in us is justified.

Privacy laws require us to provide you with a copy of our Privacy Notice. If you indicated on your application that we could use your name for marketing purposes, we are also required to obtain your permission on the separate form below. We sincerely appreciate your vote of support for our products, and we ask that you to sign below indicating your consent.

We hope that your experience today has been a positive first step for us to prove our commitment to you. Thank you again for your participation. We are especially excited in having you apply to become a member of our ever-growing family of policyholders.

Sincerely,

Raymond J. Martin, Jr.
President & CEO

PRIVACY NOTICE

We value your privacy and send this notice each year.

PRIVACY PRINCIPLES

- We do not rent, sell or lease your nonpublic personal financial information ("PFI").
- You may authorize us to disclose your PFI.
- Anyone that provides services or products to you for us has agreed to protect your PFI.
- We do not share your PFI with nonaffiliated entities for their marketing purposes.
- We disclose your PFI when required by law.
- These principles apply to past, current and future customers.

[Continued on the Reverse Side]



NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

PRIVACY CONSENT FORM AND AUTHORIZATION

I authorize National Teachers Associates Life Insurance Company ("NTA Life") and its affiliates to use my name, my employer's name, my job title, the insurance plan(s) that I have acquired, and any written correspondence with NTA Life for marketing purposes.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons receiving it, and it would no longer be protected by federal privacy regulations. NTA Life will not condition future coverage on the consent and authorization to disclose this information.

This Consent will remain in effect for the earlier of 24 months or until revoked by me in writing. I may revoke this Consent at any time by mailing a written request to the Director of Compliance at 4949 Keller Springs Rd., Addison, TX 75001. However, any action already taken in reliance on this Consent cannot be reversed, and my revocation will not affect those actions.

NTA Life will maintain this Consent (or a true and correct copy) in its files while it is in force. I have been provided an opportunity to keep a copy of this Consent for my own records. I am also entitled to a copy of this Consent upon written request to NTA Life's Director of Compliance.

Signature

Date

Printed Name



INFORMATION WE COLLECT

We obtain your PFI to provide and support the products and services you request. Your PFI comes from various sources.

- PFI may come from you on your application. PHI also comes from forms, by telephone, and from the Internet. PFI may include your name, address, date of birth, and social security number. PFI may also include work history, income, medical history, beneficiaries, etc.
- PFI may come from your transactions with us. These involve your policy coverage, premium payments, claims, and other insurance policies.
- PFI may come from other sources. These include your employers, medical service providers, information bureaus, etc.

HOW WE USE INFORMATION ABOUT YOU

We use your PFI to underwrite policies, process claims, ensure proper billing, service accounts, and as you request.

WHAT WE MAY DISCLOSE AND TO WHOM

We do not disclose PFI about you to nonaffiliated entities, except as authorized by you. **Washington Residents:** You have the right to limit disclosures of your PFI. See WAC 284-04-510.

OUR SECURITY PROCEDURES

We only provide parties who must know your information to provide insurance products or services with your PFI. We use physical, electronic and procedural safeguards to protect PFI. These safeguards meet federal standards. We review these safeguards regularly.

APPLICABLE AFFILIATES

References to “us” include our affiliates. Our affiliates are insurance agents, service organizations, and third party administrators.

- National Teachers Associates Life Insurance Company.
- National Teacher Associates, Inc. and affiliated state licensed corporations.
- AccuFlex Services, Inc.

NOTICE OF INFORMATION PRACTICES

Some states require us describe our information practices, including information obtained about individuals covered under your policy. The information that we obtain is described above. We may disclose this information to third parties without your consent. However, we only disclose information to a business affiliate, as otherwise permitted by law, or with your consent. You have the right to access and correct your information (other than information that relates to a claim or a judicial proceeding). You may request a written reason for an adverse underwriting decision. For details about our privacy practices in your state, submit a **written request** to our Director of Compliance at 4949 Keller Springs Rd., Addison, TX 75001. Questions may also be directed to Customer Service at (888) 671-6771.

HIPAA NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION

Copies of our HIPAA privacy notice are available at www.ntalife.com or by sending a **written request** to our Director of Compliance at 4949 Keller Springs Rd., Addison, TX 75001. Questions may also be directed to Customer Service at (888) 671-6771.

Please Return the Reverse Side to the Home Office

**NATIONAL TEACHERS ASSOCIATES
LIFE INSURANCE COMPANY**

P.O. Box 802207, Dallas, Texas 75380
Phone (888) 671-6771 Fax (972) 532-2180

Check if applicable:

- Name Change
- Policy Reinstatement
- Plan Change:
Policy # _____
- Other _____



**APPLICATION FOR SUPPLEMENTAL
HEALTH INSURANCE**

Please supply the following information for each person applying for coverage. It will be used to determine eligibility for coverage, including age, height, weight, occupation, and medical information below. Maximum age for issuance is 64.

Name of Proposed Primary Insured (Last, First, Middle Initial) <i>Joe, John A</i>	Social Security No. <i>123 - 45 - 6789</i>
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Sex <i>M</i>	Date of Birth <i>1-1-74</i>	Age (Max. 64) <i>36</i>	Height <i>6'2"</i>	Weight <i>190</i>	
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Address <i>123 Main Street</i>	E-mail Address <i>J. Joe@hotmail.com</i>
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City <i>Dallas</i>	County or Parish <i>Dallas</i>	State <i>TX</i>	Zip <i>75000</i>	CODES	St.	Cnty.	City	Bldg.
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Home Phone <i>(555) 867-5709</i>	Work Phone <i>(555) 867-5709</i>	Cell Phone <i>(555) 867-5709</i>	Best place and time to call (before 5 pm) <input type="checkbox"/> HM <input checked="" type="checkbox"/> WK <input type="checkbox"/> CELL <input type="checkbox"/> AM <i>9</i> <input type="checkbox"/> PM
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School System <i>JISD</i>	School or Business <i>Carter</i>	Occupation <i>Teacher</i>
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Complete only if Spouse is proposed to be a Covered Person under this policy or rider.

Name <i>Jane A Joe</i>	Height <i>5'9"</i>	Weight <i>150</i>	Date of Birth <i>1-1-77</i>	Age (Max. 64) <i>33</i>	Social Security No. <i>234 - 56 - 7891</i>
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Index of Question Numbers to Answer for the Listed Policies and Riders:

Cancer Policy	Heart & Stroke Policy	All Purpose ICU Rider	Specified Disease Rider
1, 3, 7, 8	2, 3, 5, 7, 8	1 - 8	3, 4, 7, 8

For questions 1-4: Within the past 10 years, has any person proposed for coverage: (i) had symptoms (other than question 3), (ii) received medical advice, (iii) been diagnosed or treated, or (iv) been prescribed medication for:

1. No Yes Cancer (including internal, in situ, melanoma, or skin cancer)? If yes due to skin cancer (other than melanoma), _____ is/are excluded from benefits for skin cancer. If yes for any other cancer, _____ is/are excluded from the All Purpose ICU Rider and Cancer Policy and related riders.
2. a. No Yes Any disease, disorder, or abnormality of, or surgery related to, the heart, such as coronary artery disease, heart disease, or heart attack, (excluding: mitral valve prolapse; heart murmur; or irregular heart beat not treated with medication)?
 b. No Yes Any disease, disorder, or abnormality of the circulatory system (including arteries, veins, vessels, and lymph nodes; excluding high blood pressure if controlled)?
 c. No Yes Stroke, transient ischemic attack (TIA or mini-stroke), or any disease, disorder or abnormality of the carotid artery or circulatory system of the brain?
 If yes to any part of question 2, _____ is/are excluded from the All Purpose ICU Rider and Heart and Stroke Policy and related riders.
3. No Yes Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus? If yes, _____ is/are excluded from benefits under all policies and riders.
4. No Yes Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Legionnaire's Disease, Lupus Erythematosus, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Osteomyelitis, Poliomyelitis, Rabies, Scarlet Fever, Sickle Cell Anemia, Tetanus, Toxic Shock Syndrome, Tuberculosis, Tularemia, or Typhoid Fever? If yes, _____ is/are excluded from benefits for _____ disease(s) under the Specified Disease Rider and All Purpose ICU Rider.
5. No Yes Has anyone proposed to be insured: (i) ever been diagnosed with Type I diabetes; or (ii) been prescribed insulin or insulin refills within the past 10 years? If yes, _____ is/are excluded from the All Purpose ICU Rider and Heart and Stroke Policy and related riders.
6. No Yes Is any person proposed for coverage pregnant? If yes, the All Purpose ICU Rider cannot be issued.



I have reviewed all responses provided
in this application for accuracy.

Initial

7. No Yes Is the policy for which you are applying intended to replace or change any of your existing accident and sickness policies? If yes, identify company and type of coverage: _____
8. Yes I understand the coverage for which I am applying does not provide benefits for loss attributable to preexisting medical conditions for 2 years after the Coverage Effective Date, and the policy and riders include a 30-day waiting period for coverage.
9. Yes I request a delayed Coverage Effective Date of _____ Preexisting conditions and the 30-day waiting period will be determined as of the Coverage Effective Date.

CANCER POLICY
 Individ. Only One Parent Family
 Basic Green Gold

OPTIONS:

Benefit Booster Rider
 Specified Disease Rider
 All-Purpose ICU: Amount \$ _____
 Other _____
 Other _____

Total Monthly Premium for Policy and Optional Riders: \$ _____

HEART AND STROKE POLICY
 Individ. Only One Parent Family
 Basic Green Gold

OPTIONS:

Benefit Booster Rider
 Specified Disease Rider
 All-Purpose ICU: Amount \$ _____
 HBER _____
 Other _____

Total Monthly Premium for Policy and Optional Riders: \$ _____

MODE OF PAYMENT

Initial Premium Check Attached *
 with Application: Credit Card
 Other _____

Recurring Monthly Bank Draft
 Payments: Credit Card
 Payroll Deduction
 Other _____

Total combined premium applied for:
 \$ _____

* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

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.

I (or we) certify that I have read or had read to me the completed application and submit it as my offer for the purchase of insurance. I understand that I have no coverage unless and until the policy is issued by the Company. I represent that the answers are true and correct and realize that any fraudulent statement or material misrepresentation in the application may result in a loss of coverage. I authorize the Company to call me on a recorded phone call to clarify or verify certain information in this application and agree that a transcript of such recording can be made a part of my application for insurance. No oral statement between the agent and me will be binding on the Company. No person to be covered under this policy is currently receiving benefits under Medicare or Medicaid. A copy of this application will be valid as if it were an original. I agree to be bound by the Arbitration Program for the resolution of disputes under the Federal Arbitration Act if included in any policy for which I am applying. I also certify that I have received a copy of the Company's Privacy Notice and HIPAA Notice of Privacy Practices.

DATED AT Dallas TX, THIS 25 DAY OF May, 2010
 City and State Day Month Year

X John A. Doe X _____
 Signature of Proposed Primary Insured Signature of Applicant (if not the Proposed Primary Insured)

BANK DRAFT AUTHORIZATION

PLEASE ATTACH A SPECIMEN CHECK MARKED "VOID"

I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account specified on the attached specimen check, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than \$200.

X John A. Doe 5/25/10 Requested first draft date (1-28 only)
 Signature exactly as it appears on bank records Date Signed

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

X John C. Doe John C. Doe 111-1 111
 Licensed Agent Signature Printed Agent Name License ID No. Agent No.
4949 Keller Springs Road, Addison, TX 75001 1-800-TALK-NTA
 Address Phone



NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

4949 Keller Springs Road • Addison, Texas 75001-5910
(972) 532-2100 • Fax (972) 532-2194
www.ntalife.com

May 25, 2010

Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: National Teachers Associates Life Insurance Company
NAIC# 87963
Federal ID # 75-1623431

Form: 75-305 (5/10) Application for Supplemental Health Insurance

Dear Department of Insurance:

The above-referenced application form is enclosed for your review and approval.

This application is new and does not replace any previously approved form. It is, however, similar to previously approved application form 75-305 (9/07), which was approved by your department on September 28, 2007.

Upon approval, the application will be used to apply for or amend insurance coverage under our existing approved supplemental health policies. We also intend to use this application with any future supplemental health policies which may be approved for us by your Department.

This form is being filed Exempt in our domiciliary state of Texas.

We have included the application and required transmittal forms. If you have any questions, or if you require additional information, please call me at (800) 825-5682 extension 2156. You may also e-mail me directly at: david.mather@ntalife.com.

Sincerely,

David R. Mather
Compliance Analyst

Enclosures