

SERFF Tracking Number: RNOA-126647307 State: Arkansas
Filing Company: Royal Neighbors of America State Tracking Number: 45810
Company Tracking Number: 101720 RNOA-126647307
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Application for Simplified Issue Individual Whole Life Insurance
Project Name/Number: Application for Simplified Issue Individual Whole Life Insurance/101720

Filing at a Glance

Company: Royal Neighbors of America

Product Name: Application for Simplified Issue SERFF Tr Num: RNOA-126647307 State: Arkansas

Individual Whole Life Insurance

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 45810

Sub-TOI: L08.000 Life - Other

Co Tr Num: 101720 RNOA-
126647307 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird
Disposition Date: 06/01/2010
Authors: John Friederich, Philip
Blankenfeld, Deb Zemo, Kelli
Zimmer

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

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Application for Simplified Issue Individual Whole Life
Insurance

Status of Filing in Domicile: Not Filed

Project Number: 101720

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Illinois is projected
to be filed on June 15, 2010.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/01/2010

Explanation for Other Group Market Type:

State Status Changed: 06/01/2010

Deemer Date:

Created By: Deb Zemo

Submitted By: Deb Zemo

Corresponding Filing Tracking Number: 101720

Filing Description:

This application is new and has never been issued by Royal Neighbors of America (Royal Neighbors), nor has it been available for attachment to any life insurance certificate issued by Royal Neighbors at, or subsequent to issue.

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To the best of my knowledge and belief, no part of this submission contains any unusual or possibly controversial items contrary to normal industry standards, and no assumptions or provisions contained in the forms unfairly discriminate in the availability of rates or benefits to individuals of the same class, equal expectation of life, and degree of risk or hazard.

It is intended that this application will be used with the forms contained in the Forms List included in the Supporting Documentation tab.

Company and Contact

Filing Contact Information

Debra Zemo, Compliance Assistant/Legal Secretary
 zemodm@royalneighbors.org
 230 16th Street
 Rock Island, IL 61201
 800-627-4762 [Phone] 8233 [Ext]
 309-788-3887 [FAX]

Filing Company Information

Royal Neighbors of America
 230 16th Street
 Rock Island, IL 61201
 (309) 732-8232 ext. 8232[Phone]

 CoCode: 57657 State of Domicile: Illinois
 Group Code: Company Type: Life, Health, Annuity
 Group Name: Royal Neighbors State ID Number:
 FEIN Number: 36-1711198

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Royal Neighbors of America	\$50.00	05/27/2010	36864809

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/01/2010	06/01/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Forms List	Deb Zemo	05/27/2010	05/27/2010

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Disposition

Disposition Date: 06/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Application for Simplified Issue Individual Whole Life Insurance
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Forms List		Yes
Form	Application for Simplified Issue Individual Whole Life Insurance		Yes

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Amendment Letter

Submitted Date: 05/27/2010

Comments:

Forms List

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Forms List

Comment: Form 200612A-AR approved 11/6/2006

Form 200613A-AR approved 11/27/2006

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Form Schedule

Lead Form Number: 101720

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	101720	Application/	Application for	Initial		52.800	101720
	Rev. 5-	Enrollment	Simplified Issue				SIWL.pdf
	2010	Form	Individual Whole Life Insurance				

Royal Neighbors of America

Application for Simplified Issue Individual Whole Life Insurance



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www.royalneighbors.org

Rock Island, Home Office
230 16th St., Rock Island, IL 61201
(800) 627-4762



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Application for Simplified Issue Individual Whole Life Insurance

Mail certificate to agent

PART 1

SECTION 1 – Proposed Insured

Name _____ Street _____
 City _____ State _____ ZIP _____
 SSN/Tax ID _____ Marital status S M W D Sex M F
 Phone number () _____ DOB _____ State/Country of birth _____
 U.S. driver's license Green Card Passport ID number _____ ID issuer _____
 Other _____ ID issue date _____ ID expiration date _____
 E-mail address _____
 Are you a U.S. citizen? Yes No If No, do you have a green card? Yes No Permanent Resident ID # _____

SECTION 2 – Other Insurance

1. EXISTING or APPLIED FOR INSURANCE
 Does the Proposed Insured have any existing life insurance (L) or annuity (A) contracts with this or any other company? Yes No
IF YES, complete and submit state replacement forms, if required, with this application. Provide details:
 Company _____ Life Insurance Annuity Amount _____

2. REPLACEMENT
 In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (*except conversions*) involving an annuity or other life insurance? Yes No
If Yes, complete and submit a replacement questionnaire **AND** any other state required replacement forms with this application.

SECTION 3 – Proposed Owner or Payor other than Owner (If Applicable)

OWNER other than PROPOSED INSURED or PAYOR OTHER THAN OWNER (If applicable)

Name _____ SSN/Tax ID _____
 Street _____ Phone number () _____ DOB _____
 City _____ State _____ ZIP _____ Relationship to Proposed Insured _____
 U.S. driver's license Green Card Passport E-mail address _____
 Other _____ Are you a U.S. citizen? Yes No
 ID number _____ ID issuer _____ If No, do you have a green card? Yes No
 ID issue date _____ ID expiration date _____ Permanent Resident ID # _____
 Check if you wish ownership to revert to Insured upon Owner's death.* * There may be tax consequences, please consult your tax advisor.

SECTION 4 – Beneficiary(ies)

Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.

PRIMARY (Percent of proceeds _____%) **PRIMARY** (Percent of proceeds _____%) **CONTINGENT**

Name _____ Name _____
 Street _____ Street _____
 City _____ State _____ ZIP _____ City _____ State _____ ZIP _____
 DOB _____ SSN/Tax ID _____ DOB _____ SSN/Tax ID _____
 Relationship to Proposed Insured _____ Relationship to Proposed Insured _____

SECTION 5 – Information Regarding Insurance Applied for

1. LIFE INSURANCE PLAN Simplified Issue Whole Life Graded Death Benefit

2. RIDER Accelerated Living Benefit Rider (no additional premium)
 Other _____

3. FACE AMOUNT \$ _____

4. AUTOMATIC PREMIUM LOAN will be provided.
 No Check if APL is **NOT** desired.



SECTION 6 – Payment Information

If **Electronic Payment** is chosen, complete Pre-Authorized Collection (PAC) form on page 4.

1. PAYMENT MODE *(Check one)*

Direct bill: Annual Semi-Annual Quarterly

Electronic payment: Annual Semi-Annual Quarterly Monthly Payment with app \$ _____

Draft first payment Payment quoted \$ _____

2. BILLING ADDRESS INFORMATION

Proposed Insured's address Primary Owner's address

PART 2

SECTION 1 – Physician Information

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured. Check here if no doctor, practitioner, or health care facility is known.

Physician name/Clinic _____ City _____ State _____ ZIP _____

Date last consulted _____ Provide reasons for treatments and the results. _____

List all currently prescribed medications, dosage, frequency, and diagnosis. _____

SECTION 2 – Medical Questions

1. Has the Proposed Insured used tobacco in any form in the last 12 months? Yes No

If any answer to questions 2 through 7 is Yes, the Proposed Insured is not eligible for ANY coverage.

2. Is the Proposed Insured currently:

a. Hospitalized, in a nursing facility or receiving Hospice Care? Yes No

b. Confined to a wheelchair, bed, or using oxygen equipment to assist in breathing? Yes No

3. Has a member of the medical profession ever diagnosed or treated the Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any immune deficiency disease; or has the Proposed Insured tested positive for the Human Immunodeficiency Virus (HIV)? Yes No

4. Has the Proposed Insured ever been diagnosed as having or been treated for:

a. Congestive heart failure, or had or been recommended to have an organ transplant? Yes No

b. Insulin shock, diabetic coma, amputation caused by disease, or taken insulin shots prior to age 50? Yes No

5. During the past 18 months has the Proposed Insured been diagnosed as having:

a. Stroke, aneurysm, cardiomyopathy, or circulatory surgery? Yes No

b. Angina (chest pain), heart attack or failure, or heart surgery? Yes No

6. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:

a. Internal Cancer, Melanoma, or Leukemia? Yes No

b. Dementia, Alzheimer's Disease, mental incapacity? Yes No

c. Cirrhosis, liver disease, kidney failure (including dialysis), chronic kidney disease, or systemic lupus? Yes No

7. During the past 18 months, has the Proposed Insured been diagnosed as having:

a. A condition expected to result in death within 12 months? Yes No

b. Been advised by a medical professional to have any diagnostic testing which has not been completed or for which the results have not been received? Yes No

c. Been recommended to have treatment or counseling for alcohol or drug abuse? Yes No

8. Prior to the age of 50 or during the past 36 months, has the Proposed Insured been diagnosed as having, or been hospitalized for:

a. Stroke, angina (chest pain), heart attack, or cardiomyopathy? Yes No

b. Heart or circulatory surgery (including pacemaker, heart valve replacement, by-pass, angioplasty, stent implant, or any procedure to improve circulation to the heart or brain)? Yes No

9. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:

a. Emphysema or chronic obstructive pulmonary disease (COPD)? Yes No

b. Neuromuscular disease (including Multiple Sclerosis, Lou Gehrig's Disease, Epilepsy, or Parkinson's Disease)? Yes No

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Proposed Owner, certify that:

The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:

- a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **OR**
- b) the IRS has notified me that I am not subject to backup withholding. *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*

I am a U.S. citizen or a U.S. resident alien for tax purposes. **Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.



Agreement/Acknowledgement

Agreement/Disclosure: I have read this application for life insurance including any amendments and supplements and, to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued and will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (Royal Neighbors), become part of the new certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or certificate.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown under "Corrections and Amendments." Acceptance of a certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
- If not a current member, I, the Proposed Insured, hereby apply to become a member of Royal Neighbors as indicated by my signature on page 3. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors was founded more than 100 years ago.

Authorization

I, the Proposed Insured, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, MIB, Inc. (MIB), consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors of America (Royal Neighbors), its agents, employees, or representatives. This includes information on the treatment of alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors. Any protected information obtained will not be released by Royal Neighbors to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, insurance certificate(s), or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for 24 months from the date signed if used in connection with an application for life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

Check here if a copy of this authorization is desired.

Additional Information:

Corrections and Amendments (For Home Office Use Only)

Except as may be provided under the Conditional Receipt on page 5 of this application, Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the certificate has been issued and delivered to the certificateowner; c) the first premium has been paid to and accepted by Royal Neighbors; and d) at the time of delivery and payment, the facts concerning the insurability of the Insured are as stated in this application.

SIGNATURES:



Signed at city, state _____ Date _____

Proposed Insured _____



Signed at city, state _____ Date _____

Proposed Owner _____

(If other than Proposed Insured) If the Owner is a firm or corporation, include Officer's title with signature.



Agent's Report

REPLACEMENT:

Do you have any knowledge or reason to believe the Proposed Insured has any existing or applied for life insurance or annuity contracts with this or any other company? Yes No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? Yes No

Do you have any knowledge or reason to believe that the Proposed Insured has in-force life insurance or annuity contracts that may be replaced as a result of this transaction? Yes No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? Yes No

Did you use only written sales material approved for use by Royal Neighbors? Yes No

Did you personally review the I.D. of the Owner? Yes No If Yes, form of I.D. _____

Did you personally interview the Proposed Insured? Yes No Was the proposed insured with you at the time of the interview? Yes No

Agent no. _____ Agent license no. _____ Agent chapter no. _____



Signature of Writing Agent _____ Date _____

Printed name of Writing Agent _____

If applicable, complete and sign the following statement(s):

Agent Signature _____ Date _____

Agent Name _____ ID Number _____ Percent _____
Please print

Agent Signature _____ Date _____

Agent Name _____ ID Number _____ Percent _____
Please print



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Authorization for Pre-Authorized Collection Plan

I authorize Royal Neighbors of America (*Royal Neighbors*) and the financial institution named below to initiate automatic withdrawals from my checking/savings account. This authority will remain in effect until I notify Royal Neighbors or the bank to cancel it in such time as to afford a reasonable opportunity to act on the request. I can stop payment of any withdrawal by notifying Royal Neighbors three days before my scheduled withdrawal day. Royal Neighbors reserves the option to change the method of payment to another qualifying mode after the occurrence of a transaction not honored.

Name of financial institution _____ City _____ State _____

Name (*please print*) _____ Phone number () _____

Street address/PO Box _____

City _____ State _____ ZIP _____

I would like the payment withdrawn on the _____ day of the month. (*If no day is selected the default day is the 5th of the month.*)

Routing no. _____

Checking account no. _____ OR Savings account no. _____



Signature as it appears on bank records _____ Date _____

PLEASE RETURN THIS AUTHORIZATION WITH A VOIDED CHECK



This receipt must be completed and given to every applicant for insurance.



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Conditional Receipt

Unless each and every condition specified in paragraph 1 below is fulfilled exactly, no insurance will become effective prior to delivery of the certificate of insurance. No agent of Royal Neighbors of America (*Royal Neighbors*) is authorized to alter or waive any of the conditions.

Received from _____ on (Date) _____ the sum of \$ _____ / no money received with application in connection with an application to Royal Neighbors for the following insurance certificate ("No money received" includes all applications where the first premium is to be paid by preauthorized collection from payor's account. If this box is checked no insurance will be in effect until all conditions provided in the certificate of insurance and application have been fully complied with.):

Proposed Insured: _____ Life Insurance Amount: \$ _____ Plan: _____

1. All of the following conditions must be met before insurance may become effective prior to delivery of the certificate:
 - a) The payment indicated above must be at least equal to one month's premium at the premium class applied for. Assuming all other conditions under this paragraph have been met, if Royal Neighbors, in accordance with its rules, would have issued the certificate under a different premium class than applied for, and the premium paid was less than the premium that would have been required for the issuance of a certificate at this new premium class, then the death benefit payable under the receipt shall be such as the premium paid would have purchased at the new premium class.
 - b) All medical requirements required by Royal Neighbors must be completed and received at the Home Office of Royal Neighbors.
 - c) As of the effective date, as defined below, the Proposed Insured must be a standard risk under rules and practices of Royal Neighbors for the plan and the amount of life insurance applied for, without change and at the rate of premium paid.
 - d) As of the effective date, the state of health and all factors affecting the insurance of the Proposed Insured must be as stated in the application.
2. When each and every one of the conditions of paragraph 1 have been met, the insurance coverage, as provided by the terms and conditions of the certificate of life insurance applied for will begin as of the Effective Date. "Effective Date" as used herein, means the later of:
 - a) the date of completion of the application; or
 - b) the date of completion of all medical requirements required by Royal Neighbors.
3. If the conditions have been met and coverage begins, coverage under this receipt will terminate 60 days from the date of this receipt unless prior to that date the insurance certificate is issued and accepted.

IMPORTANT INFORMATION: If no check or money order is received with this application, then this conditional insurance does not provide coverage and no insurance will be in effect until all conditions provided in the certificate of insurance and application have been fully complied with.



Signature of Agent Receiving the Payment _____



Signature of Proposed Insured _____

I understand and agree to the terms, conditions, and limits of this receipt and the agreements in the application, all of which have been fully explained to me by the agent.



Signature of Proposed Owner _____

Royal Neighbors of America

www.royalneighbors.org

Rock Island, Home Office

230 16th St., Rock Island, IL 61201

(800) 627-4762



Important Information for Applicant

Arkansas and California: 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.

District of Columbia: 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.

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

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

MIB, Inc. (MIB), Notice

Information regarding your insurability will be treated as confidential. Royal Neighbors or its reinsurers may make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 if a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901, TTY (866) 346-3642. 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 Report Act. The address of MIB's information office is: 400 Braintree, Boston, MA 02184-8734.

Royal Neighbors or its reinsurers may also release information in its file to other insurance companies to whom you 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.

Fair Credit Report Act Notice

This is to inform you that as part of our underwriting procedures in connection with this application, an investigative consumer report may be obtained on the Proposed Insured and the Proposed Petitioner. This report will provide applicable information concerning character, general reputation, personal characteristics, and mode of living.* This information will be obtained through personal interviews with neighbors, friends, and associates. You may request to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. No information collected concerning the sexual orientation of the Proposed Insured or Proposed Petitioner will be used to determine her or his eligibility for life insurance.

**Information obtained will not be used to determine sexual orientation.*

Royal Neighbors of America

www.royalneighbors.org

Rock Island, Home Office

230 16th St., Rock Island, IL 61201

(800) 627-4762



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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: Certification.pdf Flesch.pdf		
Bypassed - Item: Application Bypass Reason: N/A - no policy filed; application to be approved in forms tab Comments:		
Satisfied - Item: Forms List Comments: Form 200612A-AR approved 11/6/2006 Form 200613A-AR approved 11/27/2006		

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: ROYAL NEIGHBORS OF AMERICA

Form Number(s): 101720 Rev. 5-2010

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Bruce R. Peterson

Signature of Company Officer

BRUCE R PETERSON

Name

SECRETARY AND GENERAL COUNSEL

Title

5/27/2010

Date



230 16th Street | Rock Island, IL 61201

Phone: (309) 788-4561 | Toll-free: (800) 627-4762

E-mail: contact@royalneighbors.org | Web site: www.royalneighbors.org

CERTIFICATION OF FLESCH READING EASE SCORE

Royal Neighbors of America does hereby certify that the following certificate forms and application, specimen copies of which are submitted herewith, are in its judgment readable based on the factors specified in Arkansas Flesch Methodology Regulations.

<u>FORM</u>	<u>TITLE</u>	<u>FLESCH SCALE READABILITY ANALYSIS AND TEST SCORE</u>
ICC101720 Rev. 3-2010	Application for Simplified Issue Individual Whole Life Insurance	52.8

- A Flesch reading ease test scores of the above forms is as indicated above.
- The forms are printed, except for specification pages, schedules and tables, in not less than ten point, one point leaded.
- The forms listed above were analyzed in their entirety both to the method and formula as specified in Arkansas Flesch Methodology Regulations.

Dated this 27th day of May 2010


Bruce R. Peterson – Secretary and General Counsel