

SERFF Tracking Number: VLIC-126621801 State: Arkansas
 Filing Company: Vantis Life Insurance Company State Tracking Number: 45856
 Company Tracking Number:
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: Questionnaires and Reinstatement Application
 Project Name/Number: /

Filing at a Glance

Company: Vantis Life Insurance Company

Product Name: Questionnaires and Reinstatement Application SERFF Tr Num: VLIC-126621801 State: Arkansas

TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- Closed State Tr Num: 45856

Sub-TOI: L04I.213 Specified Age or Duration - Co Tr Num: State Status: Approved-Closed
 Fixed/Indeterminate Premium - Single Life

Filing Type: Form Reviewer(s): Linda Bird

Authors: Lisa Conti, Gail Aziz Disposition Date: 06/03/2010

Date Submitted: 06/02/2010 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: Domicile Status Comments:

Explanation for Combination/Other: Market Type: Individual

Submission Type: New Submission Group Market Size:

Overall Rate Impact: Group Market Type:

Filing Status Changed: 06/03/2010 Explanation for Other Group Market Type:

State Status Changed: 06/03/2010

Deemer Date: Created By: Gail Aziz

Submitted By: Gail Aziz Corresponding Filing Tracking Number:

Filing Description:

Forms CMP MSQ-1, CMP ALDRQ-1, CMP DMQ-1, and CMP-HST-1 are supplements to Applications which were previously approved by your Department. CMP MSQ-1, CMP ALDRQ-1, CMP DMQ-1 are used in the underwriting process to evaluate the underwriting risk. These Supplements will be completed by the Proposed Insured when a "Yes" answer to the corresponding question is given during the application process. CMP-HST-1 will be used to update applications pending in underwriting for over 90 days.

SERFF Tracking Number: VLIC-126621801 State: Arkansas
 Filing Company: Vantis Life Insurance Company State Tracking Number: 45856
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life

Product Name: Questionnaires and Reinstatement Application
 Project Name/Number: /

Form CMP-REIN-1 is required to be completed by an insured who wishes to reinstate coverage that has lapsed. Form CMP-RATERED-1 is to be used by an insured who wishes for us to consider a rate reduction on a sub-standard issued policy. Both of these forms will be available for use with all policies approved by your department. These forms will be also be used in conjunction with the applications referenced above.

All of the above referenced forms will be used with forms marketed to family households through licensed agents and financial institutions.

Company and Contact

Filing Contact Information

Gail Aziz, Compliance Associate gaziz@vantislife.com
 200 Day Hill Rd 860-298-5450 [Phone]
 Windsor, CT 06095 860-298-5479 [FAX]

Filing Company Information

Vantis Life Insurance Company CoCode: 68632 State of Domicile: Connecticut
 200 Day Hill Road Group Code: Company Type:
 Windsor, CT 06095 Group Name: State ID Number:
 (860) 298-6008 ext. [Phone] FEIN Number: 06-0523876

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? Yes
 Fee Explanation: 6 forms @\$50.00 per form = \$300.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Vantis Life Insurance Company	\$300.00	06/02/2010	36951288

SERFF Tracking Number: VLIC-126621801 State: Arkansas
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TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
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Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	06/03/2010	06/03/2010

SERFF Tracking Number: VLIC-126621801 *State:* Arkansas
Filing Company: Vantis Life Insurance Company *State Tracking Number:* 45856
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TOI: L04I Individual Life - Term *Sub-TOI:* L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
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Project Name/Number: /

Disposition

Disposition Date: 06/03/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: VLIC-126621801 State: Arkansas
 Filing Company: Vantis Life Insurance Company State Tracking Number: 45856
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life

Product Name: Questionnaires and Reinstatement Application
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Updated Fraud Notice		Yes
Supporting Document	Certificate of Compliance		Yes
Form	Questionnaire		Yes
Form	Application		Yes
Form	Application		Yes

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 Product Name: Questionnaires and Reinstatement Application
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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	CMP ALDRQ-1	Application/Questionnaire Enrollment Form	Initial		0.000	AlcoholDrugUsageQuestionnaireCMP ALDRQ-1.pdf
	CMP DMQ-1	Application/Questionnaire Enrollment Form	Initial		0.000	DiabetesMellitusQuestionnaireCMP DMQ-1.pdf
	CMP MSQ-1	Application/Questionnaire Enrollment Form	Initial		0.000	MilitaryStatusQuestionnaire CMP MSQ-1.pdf
	CMP-HST-1	Application/Questionnaire Enrollment Form	Initial		0.000	HealthStatementCMP-HST-1.pdf
	CMP-RATERED-1	Application/ Application Enrollment Form	Initial		0.000	RequestForRateReduction CMP-RATERED-1.pdf
	CMP-REIN-1	Application/ Application Enrollment Form	Initial		0.000	ReinstatementRequestCMP-REIN-1.pdf

Name of Proposed Insured: _____

Date of Birth: _____ Policy Number: _____

1.) Do you presently use alcohol beverages and/or drugs of any kind? Yes No

If **YES**, please advise:

Alcohol:

Frequency: (Daily/Weekly) _____

Type: (Beer/Wine/Liquor) _____

Number of drinks: (or ounces) _____

Drugs:

Frequency: (Daily/Weekly) _____

Type: (cocaine, amphetamines, barbiturates, heroin, crack, marijuana, LSD, PCP, other): _____

Give the date of the last time you used alcohol and/or drugs: _____

2.) Have you ever consulted, been advised by, or been actively treated by any physician or facility regarding the excessive consumption of alcohol/drugs or been treated for any associated liver problems? Yes No

If **YES**, please indicate the dates of consultation and the names and addresses of attending physicians and/or facilities: _____

3.) Have you ever been a member of Alcoholic Anonymous, a counseling program, or other similar organizations for alcohol or drugs? Yes No

If **YES**, please answer the following questions:

When? _____

How long were you an active participant? _____

Have you had any relapse? _____

Are you presently an active participant? _____

4.) Have you ever been convicted of driving while intoxicated or while under the influence of drugs? Yes No

If **YES**, please indicate dates and locations: _____

I agree that all answers on this form are full and correct, to the best of my knowledge and belief. They are made in continuation of and as part of my application for life insurance.

X _____
Signature of Proposed Insured Date

Name of Proposed Insured: _____

Date of Birth: _____ Policy Number: _____

Please give details of all "YES" answers including dates, durations, results, Doctor's names and addresses.

1.) Do any of your parents, brothers, sisters, or children have diabetes? Yes No _____

2.) When was your diabetes first diagnosed? _____

Doctor's name & address? _____

What symptoms did you have? _____

3.) Name and address of present Doctor: _____

4.) How often do you visit your Doctor? _____

Date of last visit? _____

5.) What treatment do you use? _____

Name medication and daily dosage: _____

Diet only: _____

Insulin: _____

Oral medication: _____

Insulin and oral: _____

6. Have you ever had any of the following (Please answer YES or NO, if answer is YES, give details, i.e. dates, how often):

Diabetic coma: Yes No _____

High blood pressure: Yes No _____

Insulin shock: Yes No _____

Kidney trouble: Yes No _____

Protein in urine: Yes No _____

Eye trouble: Yes No _____

Numbness or tingling in legs or feet: Yes No _____

Heart or circulation trouble: Yes No _____

Poor circulation, infection: Yes No _____

7. Any electrocardiograms and/or other cardiac tests (i.e. stress test)? Yes No

Name of Doctor: _____

Results reported to you: _____

8. Please provide the dates and results of your last blood glucose and HB Alc (glycosylated hemoglobin) tests, if known.

I agree that all answers on this form are full and correct, to the best of my knowledge and belief. They are made in continuation of and as part of my application for life insurance.

X

Signature of Proposed Insured

Date

Name of Proposed Insured: _____

Date of Birth: _____ Policy Number: _____

1.) Are you now a member of any military service, active or inactive? Yes No

If **NO**, date and sign below. If **YES**, proceed to questions 2-10 and date and sign below.

2.) Branch of Service:

Army Navy Marines Airforce Coast Guard

3.) Present Duty Status:

Active Active Reserve Inactive Reserve National Guard ROTC

4.) Present Rank: _____

5.) Present Unit: _____

6.) Military Occupational Specialty: _____

7.) Address of Present Unit: _____

8.) Present Assignment: _____

9.) Are you receiving any supplemental or hazardous duty pay based on your duties? Yes No

If **YES**, please give details. _____

10.) To your knowledge and belief, have you been told or are you aware that:

A. Your unit will be transferred overseas? Yes No

If **YES**, where? _____

B. You will be transferred to a new unit? Yes No

C. You or your unit will be alerted for duty (if presently in Reserve or National Guard)? Yes No

I agree that all answers on this form are full and correct, to the best of my knowledge and belief. They are made in continuation of and as part of my application for life insurance.

X

Signature of Proposed Insured

Date

Medical Information Bureau: Information you provide will be treated as confidential except that Vantis Life Insurance Company may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Vantis Life Insurance Company or its reinsurers 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. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184; telephone: 866-692-6901

Fair Credit Reporting Act: As part of our normal procedure, an investigation consumer report may be made whereby information is obtained through personal interviews with third parties such as family members, business associates, friends, financial sources, neighbors or others with whom you are acquainted. Such an inquiry typically may include information as to character, general reputation, personal characteristics and mode of living of the person to be insured. You have the right under the law to receive on your written request, disclosures of the nature and scope of any investigative consumer report.

Supplementary Notice of Information Practices: Vantis Life may need to obtain data about you prior to issuance of insurance. Some data will be obtained from you and some from other sources. That data and any data that is collected at a later date, may in some cases be disclosed to third parties without your specific consent. You have the right of access and correction to data received about you, but data about a civil or criminal proceeding is excepted. If you would like a more detailed explanation of our information practices, please contact: Underwriting Department, Vantis Life Insurance Company, 200 Day Hill Road, Windsor, CT 06095.



Vantis Life Insurance Company
 200 Day Hill Road, Windsor, CT 06095
 1-866-826-8471 • www.VantisLife.com

HEALTH STATEMENT

Name of Proposed Insured: _____

Date of Birth: _____ Policy Number: _____

Please answer all questions. This form is required in order to update your original application or for completion of a transaction now pending with Vantis Life Insurance Company.

Since the date of the last application or paramedical examination for insurance with Vantis Life, has the proposed insured:

- 1. Had any illness or injury?..... Yes No
- 2. Consulted or been examined by a physician?..... Yes No
- 3. Had life, accident or health insurance postponed, rated, declined, canceled, or renewal or reinstatement refused?..... Yes No

If the answer to any of the above questions is "YES" give details

Name & Address of Physicians (If None, state None)	Reason Consulted	Date Seen	Medication or Treatment Given (If None, state NONE)

- 4. Proposed Insured's Occupation _____ Present Weight _____
 - 5. Have you been continuously and actively at work on a full time basis (minimum 30 hours per week) at the occupation specified above for the last 90 days?..... Yes No
- If "No", give details _____

I represent to the best of my knowledge and belief that the answers and statements in this application consisting of all Parts, and any amendments, are true, complete and correctly recorded. I acknowledge that the Company will rely on these answers and statements in determining whether, and on what terms, to issue a policy. I understand if any answers and/or statements are false, incomplete or incorrectly recorded, any policy issued may be void.

X _____
 Signature of Proposed Insured Date

Home Office Use Only

APP DEC W/D PP | UND | Date

• GENERAL INFORMATION

Name of Proposed Insured: _____

Address: _____

Date of Birth: _____ Height: _____ Weight: _____ Social Security #: _____ - _____ - _____

Occupation: _____ Policy Number: _____

Do you currently use any tobacco products? Yes No

Have you smoked any cigarettes or used any tobacco products in the past and quit? Yes No

If "Yes", When did you quit? _____
 Month / Day / Year

Did you quit at the recommendation of a physician because of a medical condition? Yes No

If "Yes", give the medical condition, etc. _____

For policies rated due to occupation, a letter of explanation from the insured must accompany this form.
 For policies rated due to aviation or avocation, the appropriate questionnaire must accompany this form.

• MEDICAL INFORMATION

Answer the following questions "Yes or No":
 Since making application for the above-numbered policy, to the best of your knowledge and belief, have you had, been told that you had, been treated by a licensed physician for or had surgery for:
 (Please circle any condition answered "Yes" and give details in the space to the right. Include name, address and phone number for physicians, hospitals, etc.)

a. Heart, blood vessels, chest pain, palpitation, heart murmur, heart attack, shortness of breath, high blood pressure? Yes No _____

b. Lungs, tuberculosis, asthma, bronchitis or emphysema? Yes No _____

c. Albumin, blood or sugar in urine, diabetes, kidney or reproductive organs? Yes No _____

d. Mental, emotional or nervous system disorder, epilepsy, stroke or any disorder of the brain? Yes No _____

e. Anemia or blood disorder? Yes No _____

f. Cancer or other tumor? Yes No _____

g. Thyroid, gout, arthritis, muscles, bones or joints? Yes No _____

h. Ulcers, rectal bleeding or digestive system (stomach, intestines, liver, gall bladder or pancreas)? Yes No _____

i. Any physical deformity or surgical operation? Yes No _____

j. Alcoholism, alcohol abuse or addiction? Yes No _____

k. Ever used heroin, narcotics, cocaine or any drugs except as prescribed by a physician? Yes No _____

l. Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions? Yes No _____

m. Are you now under observation or taking treatment? Yes No _____

Name & Address of Physician	Date Last Seen	Reason and Treatment Given

• **AUTHORIZATION TO RELEASE INFORMATION**

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to Vantis Life or its reinsurers, or any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person. I understand that the information released to Vantis Life or its reinsurers will be used to determine my eligibility for the insurance requested. Vantis Life may re-disclose such information for that purpose to any reinsurer, and to any person or entity performing a business or legal function for the benefit of Vantis Life. This information may also be re-disclosed as otherwise specifically permitted or required by law. This authorization extends to and includes any information relating to alcohol or drug abuse, tobacco use history or mental health care. This authorization or photocopies of it will be valid for two years following the date signed, unless otherwise required by law. The information released to Vantis Life will not be given, sold or transferred to any other person not mentioned above.

I acknowledge that I have read the IMPORTANT NOTICE and I understand that I am entitled to a photocopy of this authorization upon request. I hereby acknowledge receipt of the notice to applicant.

X

Signature of Insured

Date

Medical Information Bureau: Information you provide will be treated as confidential except that Vantis Life Insurance Company may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Vantis Life Insurance Company or its reinsurers 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. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184; telephone: 866-692-6901

Fair Credit Reporting Act: As part of our normal procedure, an investigation consumer report may be made whereby information is obtained through personal interviews with third parties such as family members, business associates, friends, financial sources, neighbors or others with whom you are acquainted. Such an inquiry typically may include information as to character, general reputation, personal characteristics and mode of living of the person to be insured. You have the right under the law to receive on your written request, disclosures of the nature and scope of any investigative consumer report.

Supplementary Notice of Information Practices: Vantis Life may need to obtain data about you prior to issuance of insurance. Some data will be obtained from you and some from other sources. That data and any data that is collected at a later date, may in some cases be disclosed to third parties without your specific consent. You have the right of access and correction to data received about you, but data about a civil or criminal proceeding is excepted. If you would like a more detailed explanation of our information practices, please contact: Underwriting Department, Vantis Life Insurance Company, 200 Day Hill Road, Windsor, CT 06095.

• **GENERAL INFORMATION**

Name of Proposed Insured: _____
 Address: _____
 Date of Birth: _____ Height: _____ Weight: _____ Social Security #: _____ - _____ - _____
 Occupation: _____ Policy Number: _____

• **MEDICAL INFORMATION (Please provide physician information)**

1. Name & Address of Physician(s) (If None, state None)	Reason Consulted	Date Seen	Medication or Treatment Given (If None, state NONE)

2. Have you been continuously and actively at work on a full time basis (minimum 30 hours per week) at the occupation specified above for the last 90 days? Yes No
 If "No", give details _____

3. Have you ever been told you had, or had reason to believe that you had, consulted with, or been treated by a doctor for any of the following: Cancer; High Blood Pressure; Ulcer; Tumor; Diabetes; Glandular Disorder; Any Brain or Nervous System Disorder; Heart Attack; Chest Pain or Heart Disorder; Any Disorder of the Kidneys, Lungs, Blood, Liver; Any Drug or Alcohol Habit; Acquired Immunodeficiency Syndrome (AIDS); or a Disease of the Immune System? Yes No
 If "Yes", give details _____

4. Have you ever used barbituates, heroin, narcotics, amphetamines, cocaine, or any drugs except prescribed by a physician? Yes No If "Yes", give details _____

5. Ever used cigarettes, cigars, or any other form of nicotine-based products? Yes No
 If "Yes", do you currently smoke or use other form of nicotine-based products? Yes No
 What product do you use and how frequently: _____
 If not currently smoking or using a nicotine-based product, provide date last used: _____

6. Within the last 3 years, have you engaged in or do you contemplate engaging in: skydiving, scindiving, or scubadiving; motorcycle or auto racing; or hang gliding? Yes No
 If "Yes", complete the avocation questionnaire.

7. Within the last 3 years, have you flown or do you contemplate flying other than as a fare-paying passenger on a commercial airline? Yes No If "Yes", complete the aviation questionnaire.

8. Since the issuance of the above numbered policy, has the insured made an application for life insurance which was declined, postponed or accepted at extra premium? Yes No
 If "Yes", Company Name: _____
 Reason for adverse action: _____

I represent to the best of my knowledge and belief that the answers and statements in this application consisting of all Parts, and any amendments, are true, complete and correctly recorded. I acknowledge that the Company will rely on these answers and statements in determining whether, and on what terms, to issue a policy. I understand that if any answers and/or statements are false, incomplete or incorrectly recorded, any policy issued may be void.

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I acknowledge that I have read the IMPORTANT NOTICE and I understand that I am entitled to a photocopy of this authorization upon request. I hereby acknowledge receipt of the notice to applicant.

X	X	
Signature of Proposed Insured	Signature of Owner (if different from Proposed Insured)	Date

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: CERTIFICATION OF READABILITY June 1.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: N/A to this filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment: ArkansasFilingLetter.pdf		

	Item Status:	Status Date:
Satisfied - Item: Updated Fraud Notice		
Comments: Updated copy of previously approved multi-state fraud notice used with all applications.		
Attachment: Fraud Language April 2010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certificate of Compliance		

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Comments:

Attachment:

CERTIFICATION OF COMPLIANCE.pdf



CERTIFICATION OF READABILITY

COMPANY NAME: VantisLife Insurance Company

FORM NUMBER AND DESCRIPTION: **CMP ALDRQ-1: Questionnaire-Alcohol/Drug Usage**
CMP DMQ-1: Questionnaire-Diabetes Mellitus
CMP MSQ-1: Questionnaire-Military Status
CMP-HST-1: Questionnaire-Health Statement
CMP-RATERED-1: Application-Request for Rate Reduction
CMP-REIN-1: Application – Reinstatement Request

I hereby certify that these forms meet the Flesch minimum reading ease test scores.

The flesch reading ease score for form CMP ALDRQ-1 is 61.3

The flesch reading ease score for form CMP DMQ-1 is 73

The flesch reading ease score for form CMP MSQ-1 is 56

When combined with the forms for which they are intended to be used, the flesch reading ease scores for form CMP-RATERED-1 are 45.1 and 45, respectively.

When combined with the forms for which they are intended to be used, the flesch reading ease scores for form CMP-REIN-1 are both 45.5.

When combined with the forms for which they are intended to be used, the flesch reading ease scores for form CMP-HST-1 are 46.4 and 47.3, respectively.

A handwritten signature in cursive script that reads "Diane A. Mastrone".

Diane A. Mastrone, ALHC
AVP, Claims and Compliance

June 1, 2010

Date



June 1, 2010

Arkansas Insurance Department
Life & Health Division
1200 West Third Street
Little Rock, AR 72201

Re: NAIC # 68632
Form Filing
CMP MSQ-1 – Military Status Questionnaire
CMP ALDRQ-1 – Alcohol/Drug Usage Questionnaire
CMP DMQ-1 – Diabetes Mellitus Questionnaire
CMP-RATERED-1-Request for Rate Reduction
CMP-HST-1-Health Statement
CMP-REIN-1-Reinstatement Request

Dear Sirs:

The above referenced forms are being submitted for your approval.

Forms **CMP MSQ-1**, **CMP ALDRQ-1**, **CMP DMQ-1** and **CMP-HST** are supplements to Applications APP 2801-1 and APP 2884A, which were approved by your Department 08/16/2007 and 08/08/2006 respectively. CMP MSQ-1, CMP ALDRQ-1, CMP DMQ-1 are used in the underwriting process to evaluate the underwriting risk. These Supplements will be completed by the Proposed Insured when a “Yes” answer to the corresponding question is given during the application process. CMP-HST-1 will be used to update applications pending in underwriting for over 90 days.

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All of the above referenced forms will be used with forms marketed to family households through licensed agents and financial institutions.

If you have any questions, please feel free to call me at 860-298-5450 or email me at gaziz@vantislife.com.

Sincerely,

A handwritten signature in cursive script that reads "Gail Aziz".

Gail Aziz,
Compliance Associate



For residents of AR, IA, IL, OH: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact materials thereto commits a fraudulent insurance act, which is a crime.

For residents of AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law

For residents of AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For residents of CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of DE, ID: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.”

For residents of IN: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For residents of FL, KY, TN, TX: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, or incomplete or misleading information is guilty of a felony of the third degree.

For residents of DC, LA, RI: 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 MD: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

For residents of MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of ND, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

For residents of ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

For residents of NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.”

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

For residents of NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for payment of a loss or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and prison.

For residents of NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.



CERTIFICATION OF COMPLIANCE

COMPANY NAME: VantisLife Insurance Company

FORM NUMBER AND DESCRIPTION: CMP MSQ-1 - Military Status Questionnaire
CMP ALDRQ-1 - Alcohol/Drug Usage Questionnaire
CMP DMQ-1 - Diabetes Mellitus Questionnaire
CMP-RATERED-1-Request for Rate Reduction
CMP-HST-1-Health Statement
CMP-REIN-1-Reinstatement Request

I hereby certify, that the forms submitted herewith, comply with all laws, rules, bulletins and published guidelines applicable to the particular type of form.

A handwritten signature in cursive script that reads "Diane A. Mastrone".

Diane A. Mastrone, ALHC
AVP, Claims and Compliance

June 1, 2010
Date