

SERFF Tracking Number: EMCN-126731167 State: Arkansas  
 Filing Company: EMC National Life Company State Tracking Number: 46268  
 Company Tracking Number: EAP009 (6-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Application for Individual Life Insurance for Youth  
 Project Name/Number: /

## Filing at a Glance

Company: EMC National Life Company

Product Name: Application for Individual Life Insurance for Youth SERFF Tr Num: EMCN-126731167 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 46268

Sub-TOI: L08.000 Life - Other

Co Tr Num: EAP009 (6-10)

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Michele Johnson

Disposition Date: 07/22/2010

Date Submitted: 07/21/2010

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:

Date Approved in Domicile: 07/19/2010

Requested Filing Mode: Review & Approval

Domicile Status Comments: Iowa is a part of the Interstate Compact, and we received approval from the Compact on 7/19/2010.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/22/2010

Explanation for Other Group Market Type:

State Status Changed: 07/22/2010

Deemer Date:

Created By: Michele Johnson

Submitted By: Michele Johnson

Corresponding Filing Tracking Number:

Filing Description:

Form EAP009 (6-10), Application for Individual Life Insurance for Youth Products is a new form and will not replace an existing form. Our licensed representatives will utilize this application for clients who will be applying for our Youth Products. Following is a list of these products and their approval dates:

LP810 Single Premium Term to Age 25 approved 02/15/1989

LP816 Term to Age 25 with Premiums Payable for Two Years approved 08/17/1993

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LP300 Young American Increasing Whole Life Policy approved 10/28/2005

This submission contains no unusual or possibly controversial items from normal company or industry standards.

This application was written to be readable and easily understood by insureds. The form achieved a flesch score of 53.

Bracketed matter shown in the application is subject to change. The accompanying Statement of Variability provides an explanation of the variable items applicable to this form.

Our licensed representatives will use this application when meeting with clients and applying for term or whole life insurance. It will be used in both paper and electronic format.

Our electronic application process complies with the Uniform Electronic Transaction Act. The applicant can review and/or correct any information entered into the application screens before signing the application. Appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it. Once completed, the information is transmitted to the home office via a secured web protocol. At the end of the process the completed application will be printed and be formatted the same as the application submitted in this filing. Both internal and external safeguards for electronic information have been implemented by our Technical Services Department.

There are two additional forms that we have included for information purposes only. Both will be used regardless of whether the application is completed via paper or electronically. One is the Parental Authorization form. Whenever the applicant is not a parent, if the parent is not present to sign, we will require this form to be filled out and returned to our office. The other form is the Check Plan Authorization form. Whenever an applicant chooses Monthly Check Plan we will need this information in order to set up the automatic drafts from their account.

Should you have any questions, please contact me at 515-237-2146, or via electronic mail at [mjohnson@emcni.com](mailto:mjohnson@emcni.com). Thank you.

## Company and Contact

### Filing Contact Information

Michele Johnson, Actuarial Analyst  
4095 NW Urbandale Dr.  
Urbandale, IA 50322

[mjohnson@emcni.com](mailto:mjohnson@emcni.com)  
515-237-2146 [Phone]  
515-237-2281 [FAX]

### Filing Company Information

EMC National Life Company  
4095 NW Urbandale Drive

CoCode: 62928  
Group Code:

State of Domicile: Iowa  
Company Type: L and Health

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Project Name/Number: /  
Urbandale, IA 50322-7914 Group Name: State ID Number:  
(515) 645-4000 ext. 4094[Phone] FEIN Number: 42-0868851  
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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
EMC National Life Company	\$50.00	07/21/2010	38179125

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/22/2010	07/22/2010

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## Disposition

Disposition Date: 07/22/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Parental Authorization Form		Yes
Supporting Document	Check Plan Authorization		Yes
Form	Application for Individual Life Insurance for Youth Products		Yes

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## Form Schedule

### Lead Form Number: EAP009 (6-10)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	EAP009 (6-10)	Application/ Enrollment Form	Application for Individual Life Insurance for Youth Products	Initial		53.000	EAP009_610-no-check-plan.pdf





**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I, the undersigned, understand EMC National Life Company (EMCNL), its reinsurers, insurance support organizations and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to EMC National Life Company, P.O. Box 9144, Des Moines, Iowa 50306-9144 or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.
- Protected Health Information: Any and all records and health information within such Medical Person’s possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, to furnish such information to EMCNL, its reinsurers and their authorized representative upon presenting this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for EMCNL to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

This authorization will remain in effect from the date signed below for a period of two years, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to EMCNL at the address above. The right to revoke this authorization is limited to the extent that EMCNL has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law. EMCNL or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, EMCNL may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize EMC National Life Company to obtain an investigative consumer report on me, if required.

Signature of Parent or Guardian	Printed Name	Date
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Children age 18 and over Signature	Printed Name	Date
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**ALWAYS DETACH AND GIVE TO APPLICANT**

**FAIR CREDIT REPORTING ACT**

In Compliance with 15 USC 1681 et. seq., this notice is to inform you that:

In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request to EMC National Life Company, P.O. Box 9144, Des Moines, IA 50306-9144 within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

**NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. EMC National Life Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information 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 Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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

**COMPLETE, DETACH AND GIVE TO APPLICANT ONLY WHEN FULL FIRST PREMIUM IS PAID WITH APPLICATION**

**CONDITIONAL COVERAGE RECEIPT**

RECEIVED FROM \_\_\_\_\_, this \_\_\_\_ day of \_\_\_\_\_ the sum of \$ \_\_\_\_\_, subject to the terms and conditions of the policy, as full (check one)  single premium  annual  semiannual  quarterly  monthly check plan premium, along with the application bearing the date of this Receipt, for coverage on \_\_\_\_\_, the Proposed Insured(s).

**TERMS AND CONDITIONS**

"Effective Date" as used herein means the later of a) the date the application is signed; b) the date of completion of all medical examinations, if required; or c) the requested Effective Date shown on the application.

Coverage may become effective prior to the policy delivery if and when all of the following conditions are met:

1. The amount of the payment is equal to the first full premium selected and the payment is taken with the application;
2. The Proposed Insured(s) must be, on the Effective Date as defined above, a risk acceptable to EMC National Life Company under its rules, standards and practices for the exact contract of insurance and premium applied for, without any modifications; and
3. The contract is issued exactly as applied for within 60 days from the date of the application. If the application is declined or disapproved or if the contract is not issued within 60 days from the date of application, then this condition has not been fulfilled, no coverage is or has been provided under the terms of this Conditional Receipt, and any premium paid will be returned.

If any of the above conditions is not met, there shall be no liability on the part of EMC National Life Company except to return the premiums collected with the application.

This Receipt shall be rendered void if it is modified or altered, or if a check or draft given in payment is not honored. No agent or broker of EMC National Life Company, P.O. Box 9202, Des Moines, IA 50306-9202 is authorized to waive or alter any of the above conditions.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Agent's Signature**

\_\_\_\_\_  
**Date**

**ALL PREMIUM CHECKS OR DRAFTS MUST BE MADE PAYABLE TO EMC NATIONAL LIFE COMPANY.  
DO NOT MAKE CHECKS PAYABLE TO THE AGENT. DO NOT LEAVE THE PAYEE BLANK.**

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## Supporting Document Schedules

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Flesch Certification  
**Comments:**  
 Flesch score certification and certificate of compliance attached.  
**Attachments:**  
 AR Read Cert.pdf  
 AR Cert Comp.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Statement of Variability  
**Comments:**  
 Statement of Variability attached.  
**Attachment:**  
 Youth App EAP009 - Stmt of Variability.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Parental Authorization Form  
**Comments:**  
 Parental authorization form attached for informational purposes.  
**Attachment:**  
 Parental Authorization Form LP594 (5-10).pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Check Plan Authorization  
**Comments:**  
 Check Plan Authorization form attached for informational purposes.  
**Attachment:**  
 CheckPlanfromICC10EAP009\_610.pdf

**READABILITY  
CERTIFICATION**

I certify to the best of my knowledge that the forms being filed are readable based on the factors specified in Sections 66-3251 to 66-3258 of the Arkansas Statutes. The Flesch Scores are as follows:

Form Number  
EAP009 (6-10)

Flesch Score  
53.0



\_\_\_\_\_  
Mark C. Rowley, FSA, MAAA  
Vice President, Managing Actuary

July 21, 2010  
Date

**STATE OF ARKANSAS**  
**CERTIFICATE OF COMPLIANCE**

I hereby certify that this submission complies with the Arkansas Rule and Regulation 19 which relates to eliminating the act of denying benefits or coverage on the basis of sex or marital status in the terms and conditions of insurance contracts or underwriting criteria, as applicable.

I hereby certify that this submission complies with the Arkansas Rule and Regulation 49 which relates to providing Life and Health Guaranty Association notices, as applicable.

I hereby certify that this submission complies with the Arkansas Statutes – Insurance Laws 23-79-138 which relates to required policy information on every policy of life insurance, accident and health insurance issued, as applicable.



Mark C. Rowley, FSA, MAAA  
Vice President, Managing Actuary

July 21, 2010  
Date

**EMC National Life Company**  
**Statement of Variability**

**Application for Individual Life Insurance for Youth Products EAP009 (6-10)**

**1. Company Address –  
Top of Page 1**

In the event of a change in the company address, the new information will be shown.

**2. Amount of Insurance –  
Page 1 – Question 4**

Currently this application will be used with two existing products and their currently available face amounts, Youth Plus Term (\$5,000, \$7,500, \$10,000 and \$20,000) and Young American Increasing Whole Life (\$2,000 - \$35,000). If we change the face amounts on these products in the future or if we discontinue selling one of the products, we would like to be able to continue using this application. Also, if we develop any new youth products, we would like to be able to add the new product face amounts to this application.

**3. Premium Options –  
Page 1 – Question 5**

Currently this application will be used with two existing products and their currently available premium paying periods, Youth Plus Term (Single Premium and 2 Year Payment Plan) and Young American Increasing Whole Life (Single Premium, 5 Pay, 10 Pay, 20 Pay and Continuous). If we change the premium paying periods available on these products in the future or if we discontinue selling one of the products, we would like to be able to continue using this application. Also, if we develop any new youth products, we would like to be able to add the new product pay periods to this application.

**4. Mode -  
Page 1 – Question 6**

We currently offer payment modes of single premium, annual, semiannual, quarterly and monthly check plan. We would like the option to change the modes that are offered in the future.



P.O. Box 9144 ▪ Des Moines, IA 50306-9144 ▪ 1.800.232.5818 ▪ www.EMCNationalLife.com

**AUTHORIZATION OF PARENT TO APPLICATION FOR INSURANCE**

I, as a parent of \_\_\_\_\_ (the "Proposed Insured"), consent  
(Name of Child)

to and approve the application for insurance upon the terms and conditions contained in the application to EMC National Life Company.

Dated \_\_\_\_\_, 20\_\_\_\_, applied for by \_\_\_\_\_,  
(Name of Applicant)

the \_\_\_\_\_ of the proposed insured, and  
(Relationship to Proposed Insured)

certify that I have read the application and that the statements and answers in it are complete and true to the best of my knowledge and belief.

Dated at \_\_\_\_\_, the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
(Signature of Agent)

\_\_\_\_\_  
(Policy Number)



