

SERFF Tracking Number: WAKE-126804907 State: Arkansas  
Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 46744  
Company Tracking Number: KEGUCTHQAR  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Health Questionnaire  
Project Name/Number: The Order of United Commercial Travelers of America/KEGUCTHQAR

## Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Health Questionnaire

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: WAKE-126804907 State: Arkansas

SERFF Status: Closed-Approved- Closed State Tr Num: 46744

Co Tr Num: KEGUCTHQAR

Authors: Toni Hess, Katlyn Gorman, Austin Taylor, Michelle Miller, Ben Cohen

Date Submitted: 09/09/2010

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 09/13/2010

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: The Order of United Commercial Travelers of America

Project Number: KEGUCTHQAR

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/13/2010

Deemer Date:

Submitted By: Katlyn Gorman

Filing Description:

Please see cover letter under supporting documentation tab for description of filing.

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 08/11/2010

Domicile Status Comments: This filing was approved in the home domicile state of Ohio on August 11, 2010.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/13/2010

Created By: Katlyn Gorman

Corresponding Filing Tracking Number:

## Company and Contact

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**Filing Contact Information**

Katlyn Gorman, Administrative Assistant katlyn.gorman@wakelyactuarial.com  
 34125 US Highway 19 North 888-590-5504 [Phone] 2100 [Ext]  
 Suite 310 727-373-4559 [FAX]  
 Palm Harbor, FL 34684

**Filing Company Information**

(This filing was made by a third party - WAS01)

The Order of United Commercial Travelers of America CoCode: 56383 State of Domicile: Ohio  
 1801 Watermark Drive, Suite 100 Group Code: -99 Company Type:  
 P.O. Box 159019 Group Name: State ID Number:  
 COLUMBUS, OH 43215-8619 FEIN Number: 31-4273120  
 (800) 848-0123 ext. [Phone]

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$350.00  
 Retaliatory? Yes  
 Fee Explanation: \$50.00 per form X 7  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	\$350.00	09/09/2010	39369162

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/13/2010	09/13/2010

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## Disposition

Disposition Date: 09/13/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: WAKE-126804907 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Yes	Yes
Supporting Document	Application	Yes	Yes
Supporting Document	Cover Letter	Yes	Yes
Supporting Document	Authorization Letter	Yes	Yes
Form	Coronary Questionnaire	Yes	Yes
Form	Diabetes Questionnaire	Yes	Yes
Form	Drug Questionnaire	Yes	Yes
Form	Hypertension Questionnaire	Yes	Yes
Form	Physical History Questionnaire	Yes	Yes
Form	Life-Certificate of Health	Yes	Yes
Form	Life-Replacement Form	Yes	Yes

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## Form Schedule

### Lead Form Number: CADQ 0610

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	CADQ 0610	Other	Coronary Questionnaire	Initial			CADQ 0610.pdf
	DMQ 0610	Other	Diabetes Questionnaire	Initial			DMQ 0610.pdf
	DQ 0610	Other	Drug Questionnaire	Initial			DQ 0610.pdf
	HYPQ 0610	Other	Hypertension Questionnaire	Initial			HYPQ 0610.pdf
	PHQ 0610	Other	Physical History Questionnaire	Initial			PHQ 0610.pdf
	LIFE COH 0710	Other	Life-Certificate of Health	Initial			LIFE COH 0710.pdf
	LRF2008	Other	Life-Replacement Form	Initial			LRF2008.pdf



# Coronary Artery Disease Questionnaire

**Home Office:**

1801 Watermark Drive, Suite 100  
P.O. Box 159019  
Columbus, OH 43215

Phone: (614) 487-9680  
Toll-free: (800) 848-0123  
Fax: (614) 487-9675

**Name of Proposed Insured:** \_\_\_\_\_

1. Please describe the initial episode, including:

- a) Nature of episode: \_\_\_\_\_
- b) Date: \_\_\_\_\_
- c) Duration of acute symptoms: \_\_\_\_\_
- d) Date of return to normal activities: \_\_\_\_\_

2. Has myocardial infarction occurred?  Yes  No If so, please indicate the site, if known, i.e. anterior, inferior, anterolateral, posterolateral, subendocardial, etc.

\_\_\_\_\_

3. If the history is one of angina pectoris, have symptoms always been non-disabling or short duration and easily controlled?  Yes  No

4. Please give dates and results of any investigations performed. i.e. resting/exercise ECGs, cardiac enzyme levels, isotope imaging, angiography, etc. Please mention specifically the location and severity of coronary stenosis and the state of left ventricular function, if known.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Has cardiac surgery been performed?  Yes  No If so, please provide date and type of surgery:

- a. Coronary artery bypass grafting (please state number and sites of grafts) \_\_\_\_\_
- b. Left ventricular aneurysmectomy \_\_\_\_\_
- c. Transluminal coronary angioplasty \_\_\_\_\_

6. Please describe the subsequent course, including the dates, nature and duration of further symptoms and, in particular, any disabling episodes.

\_\_\_\_\_  
\_\_\_\_\_

7. How would you describe the applicant's current symptoms? \_\_\_\_\_

- a) No symptoms whatsoever
- b) Infrequent minor symptoms on extraordinary activity
- c) Occasional symptoms with every day activity
- d) More frequent symptoms with every day activity
- e) Severe limitation of functional capacity

8. What is the current therapy? \_\_\_\_\_

9. Is there any other disorder of the cardiovascular system?  Yes  No

If so, please give details: \_\_\_\_\_

I hereby represent, to the best of my knowledge and belief, that all of the above statements are complete and true, and I agree that they shall form a part of the application and are made to request that The Order of United Commercial Travelers of America issue the policy applied for.

**Signature of Proposed Insured:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Diabetes Mellitus Questionnaire



THE ORDER OF  
UNITED  
COMMERCIAL  
TRAVELERS  
OF AMERICA

**Home Office:**

1801 Watermark Drive, Suite 100  
P.O. Box 159019  
Columbus, OH 43215

Phone: (614) 487-9680  
Toll-free: (800) 848-0123  
Fax: (614) 487-9675

**Name of Proposed Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

1. Name/Address of physician(s) consulted for diabetes? (If Kaiser, obtain patient #)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date & reason last consulted? \_\_\_\_\_

What treatment was given or medications prescribed or changed? \_\_\_\_\_

How often do you consult your physician? \_\_\_\_\_

2. Date diabetes was diagnosed? \_\_\_\_\_

3. Identify any parents, brothers, sisters or children that have diabetes and the age at which they were diagnosed.

4. How is your diabetes controlled? (circle one)      Diet      Oral      Medications      Insulin

List all medications currently taken. \_\_\_\_\_

5. How often do you test your own blood sugar? \_\_\_\_\_

What are the results and the dates of the last 3 readings? \_\_\_\_\_

What are the dates and results of your last three HgA1c (glycohemoglobin) readings?

6. Describe any loss of work or disability associated with diabetes? \_\_\_\_\_

7. Have you ever had:

Provide details for any "yes" answers.

a) Diabetic Coma?.....  Yes  No

b) Insulin Shock?.....  Yes  No

c) Heart Trouble?.....  Yes  No

d) High Blood Pressure?.....  Yes  No

e) Kidney Trouble?.....  Yes  No

f) Neuropathy or numbness/tingling?  Yes  No

g) Retinopathy or eye problems?.....  Yes  No

8. Have you ever been hospitalized (except when first diagnosed) due to your diabetes?  Yes  No

If "Yes," provide details when, where and results. \_\_\_\_\_

9. What is your current height and weight? \_\_\_\_\_

I hereby represent, to the best of my knowledge and belief, that all of the above statements are complete and true, and I agree that they shall form a part of the application and are made to request that The Order of United Commercial Travelers of America issue the policy applied for.

**Signature of Proposed Insured:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Hypertension Questionnaire



THE ORDER OF  
UNITED  
COMMERCIAL  
TRAVELERS  
OF AMERICA

**Home Office:**

1801 Watermark Drive, Suite 100  
P.O. Box 159019  
Columbus, OH 43215

Phone: (614) 487-9680  
Toll-free: (800) 848-0123  
Fax: (614) 487-9675

**Name of Proposed Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

1. When was the high blood pressure diagnosed and how long has it been under control?

\_\_\_\_\_

2. What prescription medication is taken and what is the dosage?

\_\_\_\_\_

\_\_\_\_\_

3. How long on this medication? \_\_\_\_\_

4. Do you have any history of heart or circulatory problems?  Yes  No

5. Have you ever been hospitalized for high blood pressure or circulatory problems?  Yes  No

6. Please list your last 3 to 4 blood pressure readings and the dates. \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_\_

7. What is your current height and weight? H: \_\_\_\_\_ W: \_\_\_\_\_

What was your weight one year ago? \_\_\_\_\_

8. Please list the doctor's name, address, and phone number that treats you for high blood pressure:

\_\_\_\_\_

\_\_\_\_\_

9. Please list the dates of the last 3 times you had an office visit / consultation with the physician listed above.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby represent, to the best of my knowledge and belief, that all of the above statements are complete and true, and I agree that they shall form a part of the application and are made to request that The Order of United Commercial Travelers of America issue the policy applied for.

**Signature of Proposed Insured:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Physical History Questionnaire



THE ORDER OF  
UNITED  
COMMERCIAL  
TRAVELERS  
OF AMERICA

**Home Office:**

1801 Watermark Drive, Suite 100  
P.O. Box 159019  
Columbus, OH 43215

Phone: (614) 487-9680  
Toll-free: (800) 848-0123  
Fax: (614) 487-9675

**Name of Proposed Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Have you ever been diagnosed with or treated for:

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Heart Disorder      | <input type="checkbox"/> Nervous Disorder      | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> G.I. Tract Disorder | <input type="checkbox"/> Reproductive Disorder | <input type="checkbox"/> Tumor        |
| <input type="checkbox"/> Back Disorder  | <input type="checkbox"/> Urinary Disorder    | <input type="checkbox"/> Respiratory Disorder  | <input type="checkbox"/> Other: _____ |

Describe symptoms: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

What special tests were done? \_\_\_\_\_

What diagnosis was made? \_\_\_\_\_

Any malignancy?  Yes  No When? \_\_\_\_\_ Duration of illness? \_\_\_\_\_

What type of treatment did you receive:

- |             |  |                                |
|-------------|--|--------------------------------|
| Surgery:    | <input type="checkbox"/> Yes <input type="checkbox"/> No | What type? _____               |
| Radiation:  | <input type="checkbox"/> Yes <input type="checkbox"/> No | What type? _____               |
| Medication: | <input type="checkbox"/> Yes <input type="checkbox"/> No | What type? _____ Dosage? _____ |
| Other:      | <input type="checkbox"/> Yes <input type="checkbox"/> No | What type? _____               |

Are you currently under treatment?  Yes  No

Has additional treatment or surgery been suggested?  Yes  No

Have you been confined to the hospital?  Yes  No When? \_\_\_\_\_ How long? \_\_\_\_\_

Has your doctor suggested follow-up check-ups?  Yes  No

When did you last see your doctor? \_\_\_\_\_ Routine Check up?  Yes  No

Have there been any recurrences?  Yes  No How many? \_\_\_\_\_ Frequency? \_\_\_\_\_

Has the problem caused you to be disabled for more than one month?  Yes  No

Any associated diseases or complications?  Yes  No

Furnish blood pressure readings: Highest: \_\_\_\_ / \_\_\_\_ When? \_\_\_\_\_  
Lowest: \_\_\_\_ / \_\_\_\_ When? \_\_\_\_\_ Usual: \_\_\_\_ / \_\_\_\_  
Latest: \_\_\_\_ / \_\_\_\_ When? \_\_\_\_\_

Furnish names and addresses of all doctors and hospitals and indicate by "X" who has complete records.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Comment: \_\_\_\_\_

I hereby represent, to the best of my knowledge and belief, that all of the above statements are complete and true, and I agree that they shall form a part of the application and are made to request that The Order of United Commercial Travelers of America issue the policy applied for.

**Signature of Proposed Insured:** \_\_\_\_\_ **Date:** \_\_\_\_\_



THE ORDER OF  
**UNITED COMMERCIAL TRAVELERS OF AMERICA**

1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OH 43215-8619  
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

POLICY: \_\_\_\_\_

INSURED: \_\_\_\_\_

**LIFE**  
**Certificate of Health**

I hereby apply to The Order of United Commercial Travelers of America for my policy to be reinstated based on my written answers on my original application.

I understand and agree that this application will become a part of the policy contract; and that any person who submits an application or claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

To the best of my knowledge and belief, my medical history has not changed since the original application except as stated below.

<b>DATE</b>	<b>MEDICAL TREATMENT</b>	<b>NAME AND ADDRESS OF PHYSICIAN</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization EXCEPT to reinsurance companies, the Medical Information Bureau Inc. (MIB), or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medically-related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution, or person, that has my records or knowledge of my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original. I understand that when my medical records are disclosed pursuant to this Authorization, my medical record and the Information contained in those records may be subject to re-disclosure by the recipient and my no longer be protected by federal privacy laws. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43231-8619. I also understand that this authorization shall remain valid for 24 months from the date signed shown below if used in connection for the reinstatement of an insurance policy.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA**  
**HOME OFFICE • 1801 Watermark Drive, Suite 100, Columbus, Ohio 43215**  
**1-800-848-0123**

**IMPORTANT NOTICE:**  
**REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? \_\_\_ YES \_\_\_ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? \_\_\_ YES \_\_\_ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

\_\_\_\_\_.

I certify that the responses herein are, to the best of my knowledge, accurate:

\_\_\_\_\_  
Applicant's Signature and Printed Name Date

\_\_\_\_\_  
Producer's Signature and Printed Name Date

**I do not want this notice read aloud to me. \_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)**

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:** Are they affordable?  
Could they change?  
You're older—are premiums higher for the proposed new policy?  
How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:** New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid, you will incur costs for the new one.  
What surrender charges do the policies have?  
What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

**INSURABILITY:** If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.  
You may need a medical exam for a new policy.  
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.  
Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

How are premiums for both policies being paid?  
How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits?  
What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

Will you pay surrender charges on your old contract?  
What are the interest rate guarantees for the new contract?  
Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

What are the tax consequences of buying the new policy?  
Is this a tax free exchange? (See your tax advisor.)  
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

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## Supporting Document Schedules

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

**Satisfied - Item:** Flesch Certification

**Comments:**

Not applicable. These are questionnaires.

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

**Satisfied - Item:** Application

**Comments:**

The application in which these questionnaires will be used with is form # SPWL App-08 which was approved on 04/08/2008.

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

**Satisfied - Item:** Cover Letter

**Comments:**

**Attachment:**

AR Cover Letter.pdf

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

**Satisfied - Item:** Authorization Letter

**Comments:**

**Attachment:**

Auth 1-15-10.pdf

September 8, 2010

Arkansas Department of Insurance

**Re: The Order of United Commercial Travelers of America  
NAIC Company Code: 56383 FEIN Number: 31-4273120**

**Individual Life Forms Filing**

Form	Description
CADQ 0610	Coronary Questionnaire
DMQ 0610	Diabetes Questionnaire
DQ 0610	Drug Questionnaire
HYPQ 0610	Hypertension Questionnaire
PHQ 0610	Physical History Questionnaire
LIFE COH 0710	Life – Certificate of Health
LRP2008	Replacement of Life Insurance

Dear Sir or Madam:

Wakely Actuarial Services Inc. (“Wakely”) is submitting the above-referenced forms, filing for review and approval on behalf of The Order of United Commercial Travelers of America (“the Company”). A letter from the Company authorizing Wakely to conduct this filing is included with this submission.

The forms are individual life insurance forms. The questionnaire forms are intended to provide additional information to the Company’s underwriters based upon the initial answers given by applicants to certain health questions on the Company’s primary life insurance application(s). The other forms are used by the Company to provide certain life policyholder services.

The forms are new and do not replace any previously approved forms. They contain no unusual or controversial features or language that deviate from normal insurance industry standards.

The forms in which these questionnaires will be used with and their approval dates are listed below.

Form Number	Description	Approved
SPWL-08 ADB RDR-08	Single Premium Whole Life Policy Form	4-08-2008
SPWL App-08	Single Premium Whole Life Application	4-08-2008
WL-92	Whole Life Policy Form	8-09-1995

The forms are submitted in final printed format except for slight font and formatting variations that may occur due to the Company’s production printers. Further, the Company reserves the right to change the font and format of the forms, colors, logos, and paper type. Distribution and access may also be via hard copy or electronic media. Should such changes occur, they will not alter the content or meaning of any approved forms.

We greatly appreciate your assistance and prompt review of this filing submission. If you have any questions, or need any additional information to complete your review, please call me on our toll free line at 1-888-590-5504.

Sincerely,  
Katlyn Gorman



THE ORDER OF  
**UNITED COMMERCIAL TRAVELERS OF AMERICA**

1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OHIO 43215-8619  
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

January 15, 2010

J. Steven Keck, FSA, MAAA  
Wakely Actuarial Services, Inc.  
34125 US Highway 19 North, Suite 310  
Palm Harbor, FL 34684

Dear Mr. Keck:

The firm of Wakely Actuarial Services, Inc. is hereby authorized to submit form filings for approval to the Department of Insurance on behalf of The Order of United Commercial Travelers of America. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Thank you.

Sincerely,

A handwritten signature in blue ink, appearing to read "Joseph Hoffman", with a long horizontal line extending to the right.

Joseph Hoffman  
Chief Executive Officer