

SERFF Tracking Number: AMFT-126764624 State: Arkansas  
Filing Company: AmFirst Insurance Company State Tracking Number: 47618  
Company Tracking Number: AF-SLIFE-ENRFORM (6/10)  
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Supplemental Application Filing for Group Term Life  
Project Name/Number: Supplemental Application Filing for Group Term Life/AF-SLIFE-EnrForm (06/10)

## Filing at a Glance

Company: AmFirst Insurance Company

Product Name: Supplemental Application Filing SERFF Tr Num: AMFT-126764624 State: Arkansas  
for Group Term Life

TOI: L04G Group Life - Term

SERFF Status: Closed-Approved- State Tr Num: 47618  
Closed

Sub-TOI: L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium

Co Tr Num: AF-SLIFE-ENRFORM State Status: Approved-Closed  
(6/10)

Filing Type: Form

Reviewer(s): Linda Bird

Author: Rebecca Ewing

Disposition Date: 01/11/2011

Date Submitted: 12/30/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Supplemental Application Filing for Group Term Life

Status of Filing in Domicile: Pending

Project Number: AF-SLIFE-EnrForm (06/10)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 01/11/2011

State Status Changed: 01/11/2011

Deemer Date:

Created By: Rebecca Ewing

Submitted By: Rebecca Ewing

Corresponding Filing Tracking Number:

Filing Description:

Supplemental Application Filing for Group Term Life

Please find attached the following form for your review and approval:

AF-SLIFE-EnrForm (6/10)

This is a supplemental change/application form to be used with Group Term Life Insurance Policy, form number AF-

SERFF Tracking Number: AMFT-126764624 State: Arkansas  
 Filing Company: AmFirst Insurance Company State Tracking Number: 47618  
 Company Tracking Number: AF-SLIFE-ENRFORM (6/10)  
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -  
 Fixed/Indeterminate Premium  
 Product Name: Supplemental Application Filing for Group Term Life  
 Project Name/Number: Supplemental Application Filing for Group Term Life/AF-SLIFE-EnrForm (06/10)

GTLP (11/09), which was approved by your Department on December 3, 2009.

Thank you for your review of this filing. Please feel free to contact me if you have any questions or comments.

Sincerely,  
 Rebecca Ewing, FLMI, HIA, ACS, ACP  
 Compliance Consultant  
 Lewis & Ellis, Inc.

## Company and Contact

### Filing Contact Information

Rebecca Ewing, Compliance Consultant rewing@lewisellis.com  
 2929 N. Central Expy., Suite 201 972-850-3272 [Phone]  
 P. O. Box 851857 972-850-3273 [FAX]  
 Richardson, TX 75085

### Filing Company Information

AmFirst Insurance Company CoCode: 60250 State of Domicile: Oklahoma  
 P O Box 16708 Group Code: Company Type: Insurance  
 Company  
 Jackson, MS 39211 Group Name: State ID Number:  
 (601) 956-2028 ext. 167[Phone] FEIN Number: 64-0902785

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$0.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AmFirst Insurance Company	\$50.00	12/30/2010	43334624

SERFF Tracking Number: AMFT-126764624 State: Arkansas  
Filing Company: AmFirst Insurance Company State Tracking Number: 47618  
Company Tracking Number: AF-SLIFE-ENRFORM (6/10)  
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Supplemental Application Filing for Group Term Life  
Project Name/Number: Supplemental Application Filing for Group Term Life/AF-SLIFE-EnrForm (06/10)

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	01/11/2011	01/11/2011

*SERFF Tracking Number:* AMFT-126764624      *State:* Arkansas  
*Filing Company:* AmFirst Insurance Company      *State Tracking Number:* 47618  
*Company Tracking Number:* AF-SLIFE-ENRFORM (6/10)  
*TOI:* L04G Group Life - Term      *Sub-TOI:* L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
  
*Product Name:* Supplemental Application Filing for Group Term Life  
*Project Name/Number:* Supplemental Application Filing for Group Term Life/AF-SLIFE-EnrForm (06/10)

## **Disposition**

Disposition Date: 01/11/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.



SERFF Tracking Number: AMFT-126764624 State: Arkansas  
 Filing Company: AmFirst Insurance Company State Tracking Number: 47618  
 Company Tracking Number: AF-SLIFE-ENRFORM (6/10)  
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -  
 Fixed/Indeterminate Premium  
 Product Name: Supplemental Application Filing for Group Term Life  
 Project Name/Number: Supplemental Application Filing for Group Term Life/AF-SLIFE-EnrForm (06/10)

## Form Schedule

**Lead Form Number: AF-SLIFE-EnrForm(06/10)**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AF-SLIFE-EnrForm(6/10)	Application/Life Enrollment Form	Application/Life Enrollment/Change Form	Initial		61.800	AmFirst Supplemental Life Enrollment2.pdf

# AmFirst Insurance Company

5722 I-55 North Frontage Road, Jackson, Mississippi 39211, Telephone 601-956-2028

## Life Enrollment/Change Form

\*Denotes required fields for enrollment. For items with \*\* please select a Reason for Enrollment OR Change.

### EMPLOYER INFORMATION: To Be Completed By Employer

Company Name: \_\_\_\_\_ \*Group No.: \_\_\_\_\_  
Date Employed Full Time: \_\_\_\_\_ \*Effective Date of Coverage or Change \_\_\_\_\_  
Class # \_\_\_\_\_ REASON FOR ENROLLMENT OR CHANGE

ENROLL		TERMINATE COVERAGE	CHANGE
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Group Request	<input type="checkbox"/> Terminate Subscriber	<input type="checkbox"/> Name
<input type="checkbox"/> New Group	<input type="checkbox"/> Member Request	<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Address/Phone
<input type="checkbox"/> New Hire	<input type="checkbox"/> Qualifying Event (Reason)	<input type="checkbox"/> Deceased	
<input type="checkbox"/> COBRA	Date: ____/____/____	<input type="checkbox"/> Termination Reason: _____	
<input type="checkbox"/> Add Dependent	**List Reason: _____		

### EMPLOYEE STATUS:

Active  COBRA  Salary  Hourly Number of hours a week \_\_\_\_\_  Other \_\_\_\_\_

Benefits Administrator Approval: \_\_\_\_\_

Date: \_\_\_\_\_

### EMPLOYEE LIFE INSURANCE ELECTIONS <sup>1</sup>

Select the following Life Insurance options for myself:  Basic employee group term life coverage

Indicate dollar amount \$ \_\_\_\_\_ salary multiple \_\_\_\_\_

Supplemental Employee Life Insurance Elections:  Accidental Death and Dismemberment coverage (if offered)

Employee supplemental term life insurance (if offered): Indicate dollar amount \$ \_\_\_\_\_ salary multiple \_\_\_\_\_

If you are requesting a total coverage amount in excess of the guaranteed issue amount, you may be required to submit evidence of insurability.

### Dependent Life Insurance Elections (if offered):

From the options your employer has chosen to offer, please indicate your elections for your eligible dependents

Spouse term life coverage amount \$ \_\_\_\_\_; Child term life coverage amount \$ \_\_\_\_\_

Dependent Accidental Death and Dismemberment coverage

Type of Coverage :  Employee  Employee/Spouse  Employee/Child  Employee/Children  Employee/Spouse/Child(ren)

**Beneficiary Information** The Beneficiary(ies) you list below will apply to your Life and Accidental Death and Dismemberment benefits (if offered). Your beneficiary may be anyone you choose, and you may name more than one beneficiary. When more than one beneficiary is designated, payment will be made in equal shares, unless designated otherwise, to each surviving beneficiary, or the entire amount will be paid to the last survivor. Total percentage of beneficiary allocation must equal 100% and be in whole percentage points.

\*Name

\*Address

\*Relationship

\*Percentage Allocated

Below are the questions that must be answered for all person proposed for supplement group term life coverage.

1. Have you or anyone to be covered used any tobacco product within the past 5 years? Yes\_\_\_No\_\_\_
2. Is the main person proposed for coverage Actively at Work on a full-time at his/her normal place of employment? Yes\_\_\_No \_\_\_
3. Is any proposed dependent hospital confined and/or disabled (i.e. unable to perform normal daily functions)? Yes\_\_\_No\_\_\_
4. In the past 5 years, have you or anyone proposed for coverage been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex? Yes\_\_\_No \_\_\_
5. Has any person proposed for coverage had in the past 5 years: cancer or any malignancy which includes carcinoma (other than basil cell carcinoma skin cancer), sarcoma, Hodgkin's disease, leukemia, lymphoma, malignant tumor, cirrhosis, hepatitis B or C, blood disorder, emphysema, or chronic obstructive pulmonary disease (COPD)? Yes\_\_\_No\_\_\_
6. Has any person proposed for coverage had or been diagnosed within the last 5 years: heart attack, heart disease, heart surgery, congestive heart failure, angina or prescribed nitroglycerin, any other abnormality of the heart (other than high blood pressure) including coronary artery disease, peripheral vascular disease, stroke, transient ischemic attack, or any other cerebrovascular disease, any abnormal kidney function, kidney disease, renal failure or insufficiency, required dialysis, spina bifida, lupus, diabetes, or sickle cell anemia? Yes\_\_\_No\_\_\_
7. Has any person proposed for coverage had in the last 5 years: Epilepsy, Seizure, Paralysis of any kind, Alzheimer's Disease, Dementia, any degenerative neurological disorder, Multiple Sclerosis, Cerebral Palsy, Lou Gehrig's disease, Cystic Fibrosis, Parkinson's disease, Hemophilia, or Schizophrenia? Yes\_\_\_No\_\_\_

Any person proposed for coverage who answers yes to any question from number 2 through number 7 is not eligible for supplemental group term life under this policy.

Name\_\_\_\_\_ DOB \_\_\_\_\_Height\_\_\_\_\_ Weight \_\_\_\_\_ Gender \_\_\_\_\_

All proposed insureds must meet the height and weight guide for coverage. Height and Weight guide is attached to this application.

**LIFE WAIVER (only complete if waiving coverage)**

I understand that if I decide to apply for life coverage for myself and any applicable dependent(s) at a later date, neither my dependent(s) nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI.  
 Reason:  Waive Life  Myself  Spouse  Dependent(s)  Other Insurance  Spousal Coverage  Other Reason (please explain):

Employee Signature (only if you are waiving coverage)

Date

**EMPLOYEE INFORMATION**

\*Last Name \*First Name MI  
 \*Gender  Male  Female \*Birthdate \*Social Security Number  
 \*Address  
 \*City \*State \*Zip Code  
 Work Phone Home Phone

**E FAMILY MEMBERS TO BE COVERED OR DELETED** If address and phone numbers of covered dependents are different from those of policy holder, please attach that information on a separate sheet of paper.

FULL NAME (Last, First MI)		SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F	Spouse	/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -

**F EMPLOYEE SIGNATURE**

<sup>1</sup>Life insurance products are underwritten by AmFirst Insurance Company

**Fraud Notice**

**Arkansas** 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.

**Florida** 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, incomplete, or misleading information is guilty of a felony of the third degree.

**Louisiana** 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.

**Ohio** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

~~Oklahoma 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.~~

Tennessee It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

General Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

I represent that all information supplied in this application is true and correct. I have thoroughly reviewed, understand, and accurately responded to all questions and information on this application.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

SERFF Tracking Number: AMFT-126764624 State: Arkansas  
 Filing Company: AmFirst Insurance Company State Tracking Number: 47618  
 Company Tracking Number: AF-SLIFE-ENRFORM (6/10)  
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -  
 Fixed/Indeterminate Premium  
 Product Name: Supplemental Application Filing for Group Term Life  
 Project Name/Number: Supplemental Application Filing for Group Term Life/AF-SLIFE-EnrForm (06/10)

## Supporting Document Schedules

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

**Satisfied - Item:** Flesch Certification

**Comments:**

This is an "application only" filing. Only Flesch Certification needed for this filing. Please see base plan (Group Term Life) for R&R 19 and Consumer Information Notice).

**Attachment:**

Read-Cert-AFGrpLifeSuppApp.pdf

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

**Satisfied - Item:** Application

**Comments:**

Please see Forms Schedule Tab for application form.

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

**Satisfied - Item:** Third Party Authorization

**Comments:**

**Attachment:**

AmFirst-Authorization-2009.pdf

December 30, 2010

State of Arkansas

Re: Readability Certification for Policy Forms  
AmFirst Insurance Company

To Whom It May Concern:

The following forms have been tested for readability and meet the minimum reading ease score as required by the state of Arkansas.

<b>Form Number</b>	<b>Flesch Score</b>
AF-SLIFE-EnrForm (6/10)	61.8



---

Rebecca Ewing, FLMI, HIA ACS, ACP  
Compliance Consultant  
Lewis & Ellis, Inc. – Actuaries & Consultants



*AmFirst*  
*Insurance Company*

August 6, 2009

Lewis & Ellis, Inc.  
2929 North central Expressway, Suite 200  
P.O. Box 85187  
Richardson, Texas 75085

To Whom It May Concern:

This letter or a copy thereof, confirms the authority of Lewis & Ellis, Inc. to submit on behalf of AmFirst Insurance Company (the Company), the required forms and rates for any insurance products to the insurance departments of those jurisdictions in which the Company is licensed, and to represent the Company in the negotiation of the approval of said forms and rates, including the provision of necessary assurances and commitments regarding specific conditions of the forms to secure said approvals.

This authorization shall be valid until such time as it is revoked by the Company.

Sincerely,

  
Richard L. Eaton  
Chief Financial Officer  
AmFirst Insurance Company