

SERFF Tracking Number: CMLX-G126967670 State: Arkansas  
 Filing Company: Companion Life Insurance Company State Tracking Number: 47619  
 Company Tracking Number: AR001430100004  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: LIEM01GR10  
 Project Name/Number: LIEM01GR10/AR001430100004

## Filing at a Glance

Company: Companion Life Insurance Company

Product Name: LIEM01GR10

SERFF Tr Num: CMLX-G126967670

State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-Closed

State Tr Num: 47619

Sub-TOI: L08.000 Life - Other

Co Tr Num: AR001430100004

State Status: Approved-Closed

Filing Type: Form

Author: SPI CompanionLife

Reviewer(s): Linda Bird

Date Submitted: 12/30/2010

Disposition Date: 01/12/2011

Disposition Status: Approved-Closed

Implementation Date Requested: 12/30/2010

Implementation Date:

State Filing Description:

## General Information

Project Name: LIEM01GR10

Status of Filing in Domicile: Authorized

Project Number: AR001430100004

Date Approved in Domicile: 12/29/2010

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: 01/12/2011

State Status Changed: 01/12/2011

Deemer Date:

Created By: SPI CompanionLife

Submitted By: SPI CompanionLife

Corresponding Filing Tracking Number:

Filing Description:

Companion Life Insurance Company hereby files for your consideration and approval of our group insurance health statement (form number 97001-AR). This form is identical to the form your Department previously approved on November 28, 2006, except for the following revision:

1. At the top of the form, we changed "Employee" to "Employee's" and added a section for the Employee's Address.

Employee's Name: \_\_\_\_\_ Employee's SSN: \_\_\_\_\_

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Product Name: LIEM01GR10  
Project Name/Number: LIEM01GR10/AR001430100004  
Employee's Date of Birth: \_\_\_\_\_ Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Employee's Address: \_\_\_\_\_

2. Increased font size on the section that reads, "Check yes or no for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required."
3. We modified question #5. c. by adding additional language to the end of the sentence, question now reads, "Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV) or any other immune deficiency disorder?"
4. We added a new question to question #5, numbering the new question #5. e. and it reads, "Have you been diagnosed with, treated for (including any prescription medications) or lost time from work due to any condition relating to the following: Bone, Joint, Spine, Muscle or Connective Tissue?"
5. We modified question #7 by changing the word "sanitarium" to "mental health facility", the question reads, "Have you ever been a patient in a hospital, mental health facility, or institution?"
6. We added "(Continued on back)" to the bottom of first page. The form size changed from 8.5 x 14 to 8.5 x 11 (two sides).
7. We deleted #12 and reworded the question to flow as part of question #11. It reads in bold "List details in connection with questions 4-10 that were answered "Yes" on page 1:" We also added language where ask to give full details for each question answered "Yes" to include "Including Prognosis." And the section below the "List details..." section was renumbered from "3 through 9" to "4 through 10" to be consistent.
8. We changed the revision of the form in the lower right corner to "Rev. 8/10".

I have attached a copy of the previously approved form for your comparison and the final version for approval.

## Company and Contact

### Filing Contact Information

Yolanda Hudley, Contracts Compliance Specialist  
7909 Parklane Rd  
Columbia, SC 29223-5666  
Yolanda.Hudley@companiongroup.com  
803-735-1251 [Phone] 45001 [Ext]  
800-836-5433 [FAX]

SERFF Tracking Number: CMLX-G126967670 State: Arkansas  
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**Filing Company Information**

Companion Life Insurance Company CoCode: 77828 State of Domicile: South Carolina  
 7909 Parklane Rd, Suite 200 Group Code: 661 Company Type:  
 Columbia, SC 29223-5666 Group Name: Companion Life State ID Number:  
 Insurance Company  
 (803) 735-1251 ext. [Phone] FEIN Number: 57-0523959  
 -----

**Filing Fees**

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Companion Life Insurance Company	\$50.00	12/30/2010	43337138

SERFF Tracking Number: CMLX-G126967670 State: Arkansas  
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Product Name: LIEM01GR10  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/12/2011	01/12/2011

SERFF Tracking Number: CMLX-G126967670 State: Arkansas  
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Product Name: LIEM01GR10  
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## Disposition

Disposition Date: 01/12/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CMLX-G126967670 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Previous Approved Grp Ins Health Stmt 11-28-06, AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT		Yes
Form	Group Insurance Health Statement		Yes

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## Form Schedule

**Lead Form Number: 97001-AR**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	97001-AR	Application/Group Insurance Enrollment Health Statement Form	Initial		0.000	97001 Grp Ins Statement 8-10 AR.PDF



**Companion Life**  
Companion Life Insurance Company

P.O. Box 100102 • Columbia, S.C. 29202  
(803) 735-1251

**GROUP INSURANCE HEALTH STATEMENT**

Employee's Name: \_\_\_\_\_ Employee's SSN: \_\_\_\_\_

Employee's Date of Birth: \_\_\_\_\_ Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Employee's Address: \_\_\_\_\_

**You must provide the following health information to obtain the requested insurance coverage if:**

**(1) You are required by Companion Life to furnish evidence of insurability; (2) you previously declined or terminated coverage; or (3) (For Life, STD, LTD) your application for coverage is being made more than 31 days after you originally became eligible for this coverage. Please answer every question and complete every space. Complete for spouse and child(ren) (if applicable) if applying for Voluntary Life Insurance Coverage.**

Name and address of the Doctor or facility that has your medical records: \_\_\_\_\_ Employee's Doctor: \_\_\_\_\_ Spouse's Doctor: \_\_\_\_\_ Child's Doctor: \_\_\_\_\_

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

<p>Employee: Height: _____ Weight: _____</p> <p>Have you gained or lost more than 20 pounds in the last year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, amount <input type="checkbox"/> gained or <input type="checkbox"/> lost: _____ pounds</p> <p>(Explain below.)</p>	<p>Spouse: Height: _____ Weight: _____</p> <p>Have you gained or lost more than 20 pounds in the last year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, amount <input type="checkbox"/> gained or <input type="checkbox"/> lost: _____ pounds</p> <p>(Explain below.)</p>
--	--

	EMPLOYEE		SPOUSE		CHILD	
	Yes	No	Yes	No	Yes	No
<b>Check yes or no for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required.</b>						
1. Within the past 10 years has the proposed Insured:						
a. Had an application for life or health insurance, or for reinstatement thereof, declined or modified?	<input type="checkbox"/>					
b. Applied for or received any disability compensation?	<input type="checkbox"/>					
c. Flown or intended to fly as a pilot, student pilot or crew member?	<input type="checkbox"/>					
2. Has the proposed Insured used tobacco products in the past 12 months?	<input type="checkbox"/>					
3. Are you now actively employed on a full-time basis (30 hours or more per week)?	<input type="checkbox"/>					
4. To the best of your knowledge and belief, do you have any physical impairment or disease?	<input type="checkbox"/>					
5. Within the past 10 years, have you been diagnosed by a member of the medical profession as having, or been treated by a member of the medical profession for:						
a. Coronary artery disease, abnormal blood pressure, diabetes or cancer?	<input type="checkbox"/>					
b. Disorder of the respiratory, cardiovascular, hematological, endocrine or metabolic, gastrointestinal, genito-urinary or nervous system?	<input type="checkbox"/>					
c. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV) or any other immune deficiency disorder?	<input type="checkbox"/>					
d. Drug or alcohol dependency or abuse?	<input type="checkbox"/>					
e. Have you been diagnosed with, treated for (including any prescription medications) or lost time from work due to any condition relating to the following: Bone, Joint, Spine, Muscle or Connective Tissue?	<input type="checkbox"/>					
6. Do you have any other abnormality, deformity, disease or disorder not recorded above, including accidents?	<input type="checkbox"/>					
7. Have you ever been a patient in a hospital, mental health facility, or institution?	<input type="checkbox"/>					
8. Have you been absent for a period of 5 or more consecutive days during the last two years due to sickness or injury?	<input type="checkbox"/>					
9. Have you ever had any surgical operations or had surgery advised but not performed?	<input type="checkbox"/>					
10. To the best of your knowledge and belief, are you now pregnant?	<input type="checkbox"/>					

(Continued on back)

(Continued)

11. Give the name and address of your personal physician and the date and reason for your last consultation.

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

Reason: \_\_\_\_\_

**List details in connection with questions 4-10 that were answered "YES" on page 1:**

Question No.	Name	Date Mo. Yr.	Give Full Details for Each Question Answered "Yes" Including Nature of Illness or Injury, Number of Attacks, Duration, Severity, Treatment, Results and any Other Pertinent Information, Including Prognosis.	Name and Address of Physician or Hospital

I have \_\_\_\_\_(number) children eligible as defined in the group policy.

All eligible children are free of any sickness, disease or injury, as defined in Questions 4 through 10 above, except as follows (Write "none" if all children do not need treatment or are free of impairments.): \_\_\_\_\_

I hereby certify that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning any proposed insured's past or present health has been omitted. I agree that such answers will form a part of my application for group insurance and that such insurance will not become effective until such application has been approved by Companion Life Insurance Company.

**FRAUD WARNING:** 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.

**MEDICAL AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company and Medicare Part A and Part B carrier that has any records or knowledge of me, my spouse and all dependent children proposed for coverage, or our health, to give Companion Life Insurance Company or their reinsurers any such information. I understand that Companion Life Insurance Company will collect this information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Companion Life Insurance Company, P.O. Box 100102, Columbia, SC 29202. I understand that revocation may be a basis for denying insurance benefits or a claim for benefits. I understand that if I fail to sign this authorization Companion Life may not be able to evaluate or process my application or claim and may be a basis for denying my application or claim for benefits. I know that I have a right to receive a copy of this authorization upon request. A photostatic copy of this authorization shall be valid as the original.

Witness \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposed Insured (or, if below age 15, parent or guardian)



P.O. Box 100102  
Columbia, S.C. 29202  
(803) 735-1251

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Product Name: LIEM01GR10  
Project Name/Number: LIEM01GR10/AR001430100004

## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Previous Approved Grp Ins Health  
Stmnt 11-28-06, AR - NAIC  
TRANSMITTAL DOCUMENT, AR -  
NAIC FORM FILING  
ATTACHMENT

**Comments:**

**Attachments:**

Previous Approval 11-28-2006.PDF  
AR - NAIC TRANSMITTAL DOCUMENT.PDF  
AR - NAIC FORM FILING ATTACHMENT.PDF



COMPANION LIFE INSURANCE COMPANY  
 7909 Parklane Road, Suite 200, Columbia, South Carolina 29223-5666  
 P.O. Box 100102, Columbia, South Carolina 29202-3102  
 (803) 735-1251

RECEIVED  
 DEC 1 2006  
 COMPANION LIFE

Manager of Compliance  
 F. David Wythe, FLMI, HIA  
 David.Wythe@companiongroup.com  
 (803) 264-5008

November 15, 2006

RECEIVED

NOV 27 2006

LIFE AND HEALTH  
 ARKANSAS INSURANCE DEPARTMENT

Contracts Compliance Specialist  
 Vivian F. Frederic, FLMI, HIA, AIE (803) 264-6777  
 Vivian.Frederic@companiongroup.com  
 (800) 753-0404, Ex. 46777

Arkansas Department of Insurance  
 Life & Health Division  
 1200 West Third Street  
 Little Rock, Arkansas 72201-1904

APPROVED  
 NOV 28 2006  
 LIFE AND HEALTH  
 ARKANSAS INSURANCE DEPARTMENT

Re: Companion Life Insurance Company – NAIC Company 77828; FEIN – 57-0523959  
Form No. 97001 - Group Insurance Health Statement

Dear Sir or Madam:

Companion Life Insurance Company hereby files for your consideration and approval the above referenced group insurance health statement. This form is identical to the form your Department previously approved on May 5, 2004, except for the following revisions:

1. At the top of the form, we added this section.

Employee Name: _____	Employee SSN: _____
Employee Date of Birth: _____	Group Name: _____ Group #: _____

2. We modified question #1 by removing the words “Has proposed insured:” and replaced them with the words “Within the past 10 years has the proposed Insured.” In addition, we removed the word “Ever” from paragraphs a. and b. We modified the language in paragraph c. by adding the words “Has the proposed Insured.” We then made paragraph c. question #2. There was no change to paragraph d., except that it is now paragraph c.

3. We then renumbered questions 2 through 11. They are now questions 3 through 12.

No other revisions were made to the form. I have enclosed a copy of the previously approved form for your comparison.

Employee Name: Mary Doe Employee SSN: 123-45-6789  
Employee Date of Birth: 01/01/00 Group Name: ABC Company Group #: 123

You must provide the following health information to obtain the requested insurance coverage if:  
(1) You are required by Companion Life to furnish evidence of insurability; (2) you previously declined or terminated coverage; or (3) (For Life, STD, LTD) your application for coverage is being made more than 31 days after you originally became eligible for this coverage. Please answer every question and complete every space. Complete for spouse and child(ren) (if applicable) if applying for Voluntary Life Insurance Coverage.

Name and address of the Doctor or facility that has your medical records. Employee's Doctor: \_\_\_\_\_ Spouse's Doctor: \_\_\_\_\_ Child's Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_ Address: \_\_\_\_\_

Employee: Height: 5'7" Weight: 130  
Have you gained or lost more than 20 pounds in the last year?  
 Yes  No  
If yes, amount  gained or  lost \_\_\_\_\_ pounds  
(Explain below.)  
Spouse: Height: 6'0" Weight: 190  
Have you gained or lost more than 20 pounds in the last year?  
 Yes  No  
If yes, amount  gained or  lost \_\_\_\_\_ pounds  
(Explain below.)

Check *yes* or *no* for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required.

	EMPLOYEE		SPOUSE		CHILD	
	Yes	No	Yes	No	Yes	No
1. Within the past 10 years has the proposed Insured:						
a. Had an application for life or health insurance, or for reinstatement thereof, declined or modified?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Applied for or received any disability compensation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Flown or intended to fly as a pilot, student pilot or crew member?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Has the proposed Insured smoked cigarettes in the past 12 months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Are you now actively employed on a full-time basis (30 hours or more per week)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. To the best of your knowledge and belief, do you have any physical impairment or disease?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Within the past 10 years, have you been diagnosed by a member of the medical profession as having, or been treated by a member of the medical profession for:						
a. Coronary artery disease, abnormal blood pressure, diabetes or cancer?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Disorder of the respiratory, cardiovascular, hematological, endocrine or metabolic, gastrointestinal, genito-urinary or nervous system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Drug or alcohol dependency or abuse?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Do you have any other abnormality, deformity, disease or disorder not recorded above, including accidents?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Have you ever been a patient in a hospital, sanitarium, or institution?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Have you been absent for a period of 5 or more consecutive days during the last two years due to sickness or injury?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Have you ever had any surgical operations or had surgery advised but not performed?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. To the best of your knowledge and belief, are you now pregnant?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Give the name and address of your personal physician and the date and reason for your last consultation.	Name: <u>Dr. Feelgood</u> Address: <u>123 Main St., Any City, USA</u> Date: <u>01/01/00</u> Reason: <u>Annual Check-up</u>					
12. Details in connection with questions 3-8 answered "YES" above.						

Question No.	Name	Date Mo. Yr.	Give Full Details for Each Question Answered "Yes" Including Nature of Illness or Injury, Number of Attacks, Duration, Severity, Treatment, Results and any Other Pertinent Information	Name and Address of Physician or Hospital

I have 1 (number) children eligible as defined in the group policy.  
All eligible children are free of any sickness, disease or injury, as defined in Questions 3 through 9 above, except as follows (Write "none" if all children do not need treatment or are free of impairments.): \_\_\_\_\_

I hereby certify that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning any proposed insured's past or present health has been omitted. I agree that such answers will form a part of my application for group insurance and that such insurance will not become effective until such application has been approved by Companion Life Insurance Company.

**FRAUD WARNING** 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.

**MEDICAL AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, Medicare Part A and Part B carrier, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me, my spouse and all dependent children proposed for coverage, or our health, to give Companion Life Insurance Company or their reinsurers any such information. I understand that Companion Life Insurance Company will collect this information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Companion Life Insurance Company, P.O. Box 100102, Columbia, SC 29202. I understand that revocation may be a basis for denying insurance benefits or a claim for benefits. I understand that if I fail to sign this authorization Companion Life may not be able to evaluate or process my application or claim and may be a basis for denying my application or claim for benefits. I know that I have a right to receive a copy of this authorization upon request. A photostatic copy of this authorization shall be valid as the original.

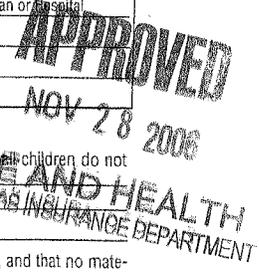
Witness: John A. Doe Date: 01/01/00 Signature of Proposed Insured (or, if below age 15, parent or guardian): Mary Doe Date: 01/01/00  
97001-AR 2/06

**PRE-NOTICE TO PROPOSED INSURED**

Information you provide will be treated as confidential except that Companion Life Insurance Company or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange in 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 MIB 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. (Medical information will be disclosed only to your attending physician.) 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 is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Companion 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.



**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Companion Life Insurance Company 7909 Parklane Rd, Suite 200 Columbia SC 29223-5666	SC		0661	77828	57-0523959	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Yolanda K. Hudley 7909 Parklane Rd Columbia SC 29223-5666	800-753-0404 Ext. 45001	800-836-5433	Yolanda.Hudley@companiongroup.com

<b>5. Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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<b>6. Company Tracking Number</b>	AR00143010004
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<b>7. <input checked="" type="checkbox"/> New Submission</b>	<input type="checkbox"/> Resubmission	Previous file # _____
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<b>8. Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise  Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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<b>9. Type of Insurance</b>	L08 Life - Other
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<b>10. Product Coding Matrix Filing Code</b>	L08.000 Life - Other
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<b>11. Submitted Documents</b>	<input checked="" type="checkbox"/> <b>FORMS</b> <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____  <input type="checkbox"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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<b>12.</b>	<b>Filing Submission Date</b>	12-30-2010
<b>13.</b>	<b>Filing Fee (If required)</b>	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number _____
<b>14.</b>	<b>Date of Domiciliary Approval</b>	12/29/2010
<b>15.</b>	<b>Filing Description:</b>	
<p>Companion Life Insurance Company hereby files for your consideration and approval of our group insurance health statement (form number 97001-AR). This form is identical to the form your Department previously approved on November 28, 2006, except for the following revision:</p> <p>1. At the top of the form, we changed "Employee" to "Employee's" and added a section for the Employee's Address.</p> <p>Employee's Name: _____ Employee's SSN: _____</p> <p>Employee's Date of Birth: _____ Group Name: _____ Group #: _____</p> <p>Employee's Address: _____</p> <p>2. Increased font size on the section that reads, "Check yes or no for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required."</p> <p>3. We modified question #5. c. by adding additional language to the end of the sentence, question now reads, "Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV) or any other immune deficiency disorder?"</p> <p>4. We added a new question to question #5, numbering the new question #5. e. and it reads, "Have you been diagnosed with, treated for (including any prescription medications) or lost time from work due to any condition relating to the following: Bone, Joint, Spine, Muscle or Connective Tissue?"</p> <p>5. We modified question #7 by changing the word "sanitarium" to "mental health facility", the question reads, "Have you ever been a patient in a hospital, mental health facility, or institution?"</p> <p>6. We added "(Continued on back)" to the bottom of first page. The form size changed from 8.5 x 14 to 8.5 x 11 (two sides).</p> <p>7. We deleted #12 and reworded the question to flow as part of question #11. It reads in bold "List details in connection with questions 4-10 that were answered "Yes" on page 1:" We also added language where ask to give full details for each question answered "Yes" to include "Including Prognosis." And the section below the "List details..." section was renumbered from "3 through 9" to "4 through 10" to be consistent.</p> <p>8. We changed the revision of the form in the lower right corner to "Rev. 8/10".</p> <p>I have attached a copy of the previously approved form for your comparison and the final version for approval.</p>		

<b>16.</b>	<b>Certification (If required)</b>	
<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p> <p>Print Name <u>Yolanda K. Hudley</u> Title <u>Contracts Compliance Specialist</u></p> <p>Signature <u></u> Date <u>12-30-2010</u></p>		

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>	AR001430100004	
<b>This filing corresponds to rate filing company tracking number</b>		

	<b>Document Name</b>	<b>Form Number</b>		<b>Replaced Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	Group Insurance Health Statement Used for Life, STD, LTD	97001-AR 8/10	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
02			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
03			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
04			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
05			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
06			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
07			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
08			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
09			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
10			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
11			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	