

SERFF Tracking Number: FDLR-126964445 State: Arkansas  
Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company State Tracking Number: 47610  
Company Tracking Number:  
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium  
Product Name: LA to AR  
Project Name/Number: /

## Filing at a Glance

Company: Fidelity Life Association, A Legal Reserve Life Insurance Company

Product Name: LA to AR

SERFF Tr Num: FDLR-126964445 State: Arkansas

TOI: L04G Group Life - Term

SERFF Status: Closed-Accepted State Tr Num: 47610

For Informational Purposes

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

Co Tr Num:

State Status: Filed-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Barbara Mooney

Disposition Date: 01/12/2011

Date Submitted: 12/30/2010

Disposition Status: Accepted For

Informational Purposes

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Informational

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Association

Overall Rate Impact:

Filing Status Changed: 01/12/2011

State Status Changed: 01/12/2011

Deemer Date:

Created By: Barbara Mooney

Submitted By: Barbara Mooney

Corresponding Filing Tracking Number:

Filing Description:

The purpose of this filing is to notify you of the intent to offer Louisiana coverage to residents of Arkansas who are members of a group domiciled in Louisiana.

## Company and Contact

### Filing Contact Information

SERFF Tracking Number: FDLR-126964445 State: Arkansas  
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Ciaran Brady, Vice President - Operations Ciaran.Brady@FLA-Life.com  
 1211 W 22nd St, Suite 209 630-522-0392 [Phone]  
 Oak Brook, IL 60523 630-522-0397 [FAX]

**Filing Company Information**

Fidelity Life Association, A Legal Reserve Life Insurance Company CoCode: 63290 State of Domicile: Illinois  
 1211 W 22nd St. Group Code: 3413 Company Type: Life  
 Suite 209 Group Name: State ID Number:  
 Oak Brook, IL 60523 FEIN Number: 36-1068685  
 (630) 522-0392 ext. [Phone]

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: 1 form at \$50.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fidelity Life Association, A Legal Reserve Life Insurance Company	\$50.00	12/30/2010	43318067

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Linda Bird Informational Purposes		01/12/2011	01/12/2011

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## Disposition

Disposition Date: 01/12/2011

Implementation Date:

Status: Accepted For Informational Purposes

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		Yes
Supporting Document	Actuarial Memo		No
Supporting Document	Filing Auth		Yes
Supporting Document	Compliance Cert		Yes
Supporting Document	Cover Letter		Yes
Form	Optional Accelerated Death Benefit for Long Term Care		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	W3006LA	Certificate	Optional Accelerated Initial Amendmen Death Benefit for t, Insert Long Term Care Page, Endorseme nt or Rider				LTC Opt Benefit W3006LA.pdf

# FIDELITY LIFE ASSOCIATION, A LEGAL RESERVE COMPANY

## OPTIONAL ACCELERATED DEATH BENEFIT FOR LONG TERM CARE

*This Benefit was elected by You as part of Your Coverage*

Please read this Benefit carefully. The waiting periods in the Suicide and/or Contestability Provisions are different from those in the Certificate and begin on the Date of Issue of the Benefit.

**TAX QUALIFICATION NOTICE:** The Accelerated Benefits offered under this Benefit are intended to provide a qualified Accelerated Death Benefit that is excluded from gross income for federal income tax purposes under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. To that end, the provisions of this Benefit and the Certificate are to be interpreted to ensure or maintain such tax qualification, notwithstanding any other provision to the contrary. We reserve the right to amend this Benefit or the Certificate to reflect any clarifications that may be needed or are appropriate to maintain such tax qualification or to conform this Benefit or Certificate to any applicable changes in such tax qualification requirements. We will send the Certificate Holder a copy of any such amendment. Whether any tax liability may be incurred when benefits are paid under this Benefit could depend on how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. Tax laws relating to Accelerated Benefits are complex. Certificate Holders are advised to consult with a qualified tax advisor about circumstances under which they could receive Accelerated Benefits excludable from income under federal law.

Receipt of an Accelerated Benefit may affect the Certificate Holder and the Certificate Holder's spouse or family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. Certificate Holders are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect his or her spouse and his or her family's eligibility for public assistance.

**NOTICE TO BUYER:** This Benefit may not cover all of the costs associated with long term care incurred by the Insured during the period of coverage. We advise that You carefully review all limitations of this Benefit as well as those of the Certificate to which it is attached in relation to the costs of long term care.

**NOTICE TO PERSONS ELIGIBLE FOR MEDICARE:** This is not a Medicare Supplement Certificate. If the Insured is eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

**CAUTION:** The insurance under this Benefit is based on the Certificate Holder's responses to questions on the Enrollment Form. A copy of the completed Enrollment Form is attached. If any answers are incorrect or untrue, We have the right to deny benefits or rescind Your Benefit. It is best to correct any answers before a claim arises. If, for any reason, any answers are incorrect or untrue, contact Us at the address or phone number shown below.

**Benefit Effective Date:** The effective and expiry dates of this Benefit are effective on the Coverage Date shown on the Certificate Schedule. Coverage under this Benefit will not be in effect unless the coverage to which it is attached becomes effective.

**Death Benefits, Surrender Values, and Loan Values, if any, will be reduced if an Accelerated Death Benefit is paid.** The Accelerated Death Benefit, related charges, interest, discounts or liens, if applicable, and the balance of the death benefit provided by the Certificate shall constitute full settlement on maturity or death of the Insured as provided under the Certificate. For term Certificates, no maturity payment is available at the end of the term period.

**Where to Get More Information, Correct Information on the Enrollment Form, or Make a Complaint:**

You can write Us at our Administrative Office: 17 Church St., Keene, NH 03431 or call 1-877-352-3303

**Benefit Part Of Coverage:** This Benefit is part of Your Coverage provided in response to Your Enrollment Form and payment of premiums for this Benefit. Those premiums are shown on the Certificate Schedule. All the provisions of the Certificate apply to this Benefit.

**Benefit:** This Benefit provides that You may elect to receive a portion of the Death Benefit provided by the Certificate and shown in the Certificate Schedule, when the Insured becomes eligible for benefits by being certified as a Chronically Ill Individual, Confined to a Nursing or Assisted Living Facility or receiving Home Health or Adult Day Care and the conditions of this Benefit are met.

**Guaranteed Renewable:** You have the right, subject to the terms and conditions of this Benefit, to continue this Benefit as long as You pay any required premiums and the Certificate is in force. We cannot change any of the terms of this Benefit on our own except We may increase the premium subject to the guaranteed maximum premium shown on the Certificate Schedule. Any change in premium will be made on the Benefit Coverage Date. The new premium will be based on the Insured's age and Premium Class on the Benefit Coverage Date. We must notify You at least 45 days before changing the premium. Notice will be mailed to Your last address as shown on Our records.

We may change premium rates only if We change them on all Benefits on this form in the state where the Benefit was issued. The current premium and the guaranteed maximum premium amounts are shown on the Certificate Schedule. We will make no change in premiums solely because of claims made under this Benefit, because of increased age or change in mental or physical health. While this Benefit is in force, We cannot change any of its provisions, cancel it, or refuse renewal.

## DEFINITIONS

In addition to the definitions contained in the Certificate, the following definitions apply.

**Activities of Daily Living** mean everyday activities. For the purposes of this Benefit, each of the following six (6) activities is considered an Activity of Daily Living:

1. **Bathing:** The Insured's ability to wash himself/herself by sponge bath; or in either a tub or shower, including the task of getting into and out of the tub or shower.
2. **Continence:** The Insured's ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
3. **Dressing:** The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. **Eating:** The Insured's ability to feed himself/herself by getting food into his/her body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
5. **Toileting:** The Insured's ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.
6. **Transferring:** The Insured's ability to move into or out of a bed, chair or wheelchair.

**Adult Day Care** means a program of social and/or health-related services provided on a less than 24-hour-a-day basis, provided in an Adult Day Care Center. The purpose of the program must be to support frail or impaired elderly, or other disabled adults who can benefit from care in a group setting outside the Home.

**Adult Day Care Center** means a facility, or part of a facility that provides Adult Day Care and is appropriately licensed or certified to provide such services, if required by the jurisdiction in which it is operating.

**Assisted Living Facility** means a facility engaged primarily in providing on-going care and related services that meets all of the following criteria:

1. It is appropriately licensed or certified to provide these services, if such licensing or certification is required by the state in which it operates; and
2. It provides twenty-four (24) hour a day care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or from Severe Cognitive Impairment; and
3. It has an awake, trained and ready-to-respond employee on duty in the facility at all times to provide care; and
4. It provides three meals a day and accommodates special dietary needs; and

5. It has written contractual arrangements or otherwise ensures that residents receive the medical care services of a Physician or Registered Professional Nurse in case of emergency; and
6. It has appropriate methods and procedures to assist residents in the self-administration of prescribed medications.

Examples of an Assisted Living Facility include, but are not limited to, residential care facilities, board and care facilities, adult foster homes, and hospice care facilities.

**The following entities cannot qualify as an Assisted Living Facility:**

1. a Hospital; or
2. a facility that is operated mainly for the treatment and care of:
  - (a) mental, nervous, psychotic or psychoneurotic deficiencies or disorders;
  - (b) or tuberculosis;
  - (c) or alcoholism;
  - (d) or drug addiction;
  - (e) or rehabilitation;
  - (f) or occupational therapy.

Determination of whether Confinement to an Assisted Living Facility is eligible for benefits is based on whether the facility meets the requirements set forth in this Certificate.

**Chronically Ill Individual** means an Insured who has been certified by a Licensed Health Care Practitioner as:

1. being Unable to Perform, without Substantial Human Assistance, at least two Activities of Daily Living (Bathing, Continence, Dressing, Eating, Toileting, and Transferring) for a period of at least equal to the Elimination Period for this Certificate as shown in the Certificate Schedule; **or**
2. the Insured has a Severe Cognitive Impairment that requires Substantial Supervision to protect the Insured from threats to his or her health and safety.

Certification by the Licensed Health Care Practitioner of the Chronically Ill Insured must occur at least once every 12 months.

**Confined or Confinement** means assigned to a bed and physically within a licensed Nursing or Assisted Living Facility as an overnight resident patient.

**Elimination Period** means the number of days during which the Insured must meet conditions 1, 2, 3, 5, 6 and 7 under the "Conditions on Eligibility for Payment of Certificate Benefits" provision and during which no benefits are payable under this Certificate. The Elimination Period starts from the first day that the Insured is certified by a Licensed Health Care Practitioner as: (1) being Unable to Perform without substantial Human Assistance at least two Activities of Daily Living (Bathing, Continence, Dressing, Eating, Toileting and Transferring); or (2) having a Severe Cognitive Impairment that requires Substantial Supervision to protect the Insured from threats to his or her health and safety. The Elimination Period for this Certificate is shown in the Certificate Schedule. The Elimination Period needs to be satisfied only once during the Insured's lifetime.

**Home** means any place where the Insured resides other than a Nursing Facility, Assisted Living Facility, Alzheimer's facility, Hospital, hospice facility, congregate care, or any other similar residential care facility.

**Home Health Care Agency** means an agency or organization that provides care and services in the Insured's Home and meets all of the following criteria:

1. It is, where required, licensed, certified, and/or accredited as a Home Health Care Agency; and
2. It provides Home Health Care services; and
3. It is, where required by its licensure, certification and/or accreditation, supervised by a Registered Professional Nurse or a Licensed Social Worker; and
4. It has employees who have appropriately specialized training; and
5. It keeps Plan of Care records, including Physician's orders where appropriate, on all patients; and
6. If providing Home Health Care services, it keeps clinical records on all patients.

**Home Health Care** means a program of professional, para-professional or skilled care provided by or through a Home Health Care Agency in the Insured's Home. It includes the following types of care: nursing services; physical therapy, occupational therapy, speech therapy, respiratory therapy, audiology services; and medical social services by a social worker or social work assistant.

**Hospital** means an institution which:

1. is licensed as a Hospital and is operating within the scope of its license; and
2. is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, or by the American Osteopathic Association; and
3. is primarily and continuously engaged in providing or operating medical, diagnostic and major surgical facilities which are located either on the Hospital's premises or in facilities controlled by such Hospital; and
4. is under the supervision of a duly licensed Physician; and
5. provides medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
6. provides 24-hour nursing service by or under the supervision of a Registered Professional Nurse.

**Hospital does not mean a place that is operated mainly for: rest; convalescence; care of the aged; custodial care; treatment and care of mental disorders, tuberculosis, alcoholism, or drug addiction; rehabilitation; or occupational therapy.**

**Immediate Family** means the Certificate Holder's or the Insured's spouse, child, brother, sister, parent, grandparent or grandchild.

**Insured** means the person who is the Insured under the Certificate to which this Benefit is attached.

**Licensed Health Care Practitioner** means any Physician, Registered Professional Nurse, or Licensed Social Worker.

**Licensed Social Worker** means a health care professional who is licensed by the state in which he or she practices and who is practicing within the scope of that license. It does **not** include a member of the Certificate Holder's or the Insured's Immediate Family, or anyone who normally resides in the Certificate Holder's or the Insured's Home or residence.

**Monthly Accelerated Death Benefit Amount** means the maximum amount that We will pay in any one calendar month while the Insured is confined in a Nursing or Assisted Living Facility or receiving Home Health or Adult Day Care and otherwise satisfies the terms set forth in the "Conditions on Eligibility for Payment of Certificate Benefits" provision.

**Medicare** means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**Nursing Facility** means a health care facility or a distinct part of a Hospital or other institution that meets all of the following standards:

1. It operates under a license issued by the appropriate licensing agency to provide nursing care and related services; and
2. It provides, in addition to room and board, 24-hour-a-day nursing care and related services on a continuing inpatient basis, to 6 or more individuals; and
3. It provides on a formal prearranged basis, a Registered Professional Nurse on duty or on call at all times; and
4. It provides, on a formal prearranged basis, that a duly licensed Physician will be available in case of emergency; and
5. It has a planned program of policies and procedures developed with the advice of and periodically reviewed by, at least one Physician; and
6. It maintains a clinical record of each patient.

**Nursing Facility does not mean a Hospital. It does not mean a facility that is operated mainly for the treatment and care of mental, nervous, psychotic or psychoneurotic deficiencies or disorders; or tuberculosis; or drug addiction; or rehabilitation, or occupational therapy.**

**Benefit Month** is the period from the Benefit Coverage Date to the first Benefit monthly anniversary or from one Benefit monthly anniversary to the next. An Benefit Month does not include the Benefit monthly anniversary day at the end of the Benefit Month.

**Physician** means an individual licensed to practice medicine and treat injury or illness in the state in which treatment is received and who is acting within the scope of that license. A Physician must be someone other than:

1. the Insured;
2. the Certificate Holder;
3. a person who lives with You or the Insured;
4. a person who is part of the Certificate Holder or the Insured's Immediate Family; or
5. anyone who has an ownership interest in a facility in which the Insured is Confined.

**Plan of Care** means a written individualized plan of services developed by a Licensed Health Care Practitioner.

**Registered Professional Nurse** means a health care professional who is licensed or registered as a professional graduate nurse by the state in which he or she practices and who is practicing within the scope of that license. It does not include a member of the Certificate Holder's or the Insured's Immediate Family, or anyone who normally resides in the Certificate Holder's or the Insured's Home or residence.

**Severe Cognitive Impairment** means a deficiency in: the Insured's short-term or long-term memory; orientation as to person, place and time; deductive or abstract reasoning; or judgment as it relates to safety awareness. Severe Cognitive Impairment is established by clinical evidence and standardized tests that reliably measure the Insured's loss. An example of Severe Cognitive Impairment covered under this Benefit is that resulting from Alzheimer's disease and similar forms of senility, senile dementia and irreversible dementia.

**Substantial Human Assistance** means actual hands-on assistance by another individual.

**Substantial Supervision** means continuous, arms-length supervision including, but not limited to, verbal cueing by another individual to protect the Insured from harming himself/herself or others, or from threats to the Insured's health and safety.

**Unable to Perform** an Activity of Daily Living means that the Insured cannot perform such activity without Substantial Human Assistance, even if the Insured uses some equipment.

**Waiting Period** means the Waiting Period shown in the Certificate Schedule that starts on the Certificate Coverage Date. No Certificate benefits will be payable for any sickness condition or Plan of Care that begins during the Waiting Period. There is no Waiting Period for accidents.

### **CONDITIONS ON ELIGIBILITY FOR PAYMENT OF CERTIFICATE BENEFITS**

We will pay You the applicable Benefit as stated below, subject to all of the following conditions:

1. The Insured:
  - a. is Confined in a Nursing or Assisted Living Facility and Confinement begins while this Certificate and Benefit are in force; or
  - b. receives Home Health Care services provided by a Home Health Care Agency with a minimum of [4] Home Health Care visits during each Benefit Month and while this Certificate and Benefit are in force; or
  - c. receives Adult Day Care provided in an Adult Day Care Center with a minimum of [4] Adult Day Care visits during each Benefit Month and while this Certificate and Benefit are in force; and
2. Confinement and Home Health Care or Adult Day Care services are included in the Insured's Plan of Care; and
3. the Insured is a Chronically Ill Individual; and
4. the Insured satisfies the Elimination Period; and
5. the Waiting Period has been met; and
6. the Certificate to which this Benefit is attached is in force; and
7. You have not assigned the Coverage provided by The Policy.

### **BENEFITS**

**Monthly Accelerated Death Benefit for Confinement:** The Monthly Accelerated Death Benefit for Confinement amount is shown in the Certificate Schedule. After We receive proof satisfactory to Us that the Insured has met the Conditions on Eligibility for Payment of Benefits described in this Benefit. We will pay You the Monthly Accelerated Death Benefit Amount for Confinement for each Benefit Month or fraction thereof during which the Insured continues to meet such eligibility requirements, subject to the Maximum Remaining Accelerated Death Benefit Amount and any Reduced Benefits Due To Unpaid Coverage Loans.

**Monthly Accelerated Death Benefit for Home Health Care or Adult Day Care:**

The Monthly Accelerated Death Benefit for Home Health Care or Adult Day Care amount is shown in the Certificate Schedule. After We receive proof satisfactory to Us that the Insured has met the Conditions on Eligibility for Payment of Benefits described in this Benefit, We will pay You the Monthly Accelerated Death Benefit for Home Health Care or Adult Day Care for each Benefit Month or fraction thereof during which the Insured continues to meet such eligibility requirements, subject to the Maximum Remaining Accelerated Death Benefit Amount and any Reduced Benefits Due To Unpaid Coverage Loans.

**Maximum Remaining Accelerated Death Benefit Amount:**

The Monthly Accelerated Benefit may not be larger than the Maximum Remaining Accelerated Death Benefit Amount. The Maximum Remaining Accelerated Death Benefit Amount equals the current death benefit provided by the Certificate, minus any outstanding loan and the total of all previous Monthly Accelerated Death Benefit Amounts paid under this Benefit to You. The current death benefit as used here does not include accidental death benefits, life insurance provided by any other Benefit provided by other Certificates, or any insurance provided on the life of someone other than the Insured.

**Monthly Accelerated Death Benefits Under Paid Up Options:** If premiums for the Certificate and this Benefit terminate resulting in a remaining paid-up life insurance death benefit under The Policy, Monthly Accelerated Death Benefit Amounts may continue to be payable if the Insured has met the Conditions on Eligibility for Payment of Benefits described in this Benefit. When a paid-up life insurance death benefit remains under the Certificate, the Maximum Remaining Accelerated Death Benefit Amount will equal this paid-up benefit, minus any outstanding loan and the total of all previous Monthly Accelerated Death Benefit Amounts paid under this Benefit to You. The current death benefit as used here does not include accidental death benefits, life insurance provided by any other Benefit provided by other Certificates, or any insurance provided on the life of someone other than the Insured.

**Reduced Benefits Due To Unpaid Coverage Loans:** We will require that a portion of any outstanding loan balance be deducted from any Monthly Accelerated Death Benefit payment. The portion will equal the outstanding unpaid loan balance multiplied by the ratio of the Monthly Accelerated Death Benefit payment to the Maximum Remaining Accelerated Death Benefit Amount.

**Waiver of Premium:** While the Insured is eligible for a Monthly Accelerated Death Benefit, We will waive the premiums due for the Coverage provided by The Policy and the premiums for Benefits attached to the Coverage.

**EFFECT ON THE POLICY BENEFITS IF CERTIFICATE BENEFITS ARE PAID**

**Adjusted Death Benefit Due to Acceleration:** The current death benefit payable at the death of the Insured under The Policy will be reduced by the total of all previous Monthly Accelerated Death Benefit Amounts paid under this Certificate to You. If the Insured dies while The Policy is in force, the remaining Death Benefit proceeds will be paid to the Beneficiary and no further payments under this Certificate will be made to You.

**Adjusted Cash Surrender and Loan Value Due to Acceleration:** Any Surrender Value payable under the Certificate will be reduced by an amount equal to (1) multiplied by (2):

1. The current death benefit minus the Adjusted Death Benefit
2. The ratio of the Surrender Value to the current death benefit.

Any Loan Value payable under The Policy will be reduced by an amount equal to (1) multiplied by (2):

1. The current death benefit minus the Adjusted Death Benefit
2. The ratio of the Loan Value to the current death benefit.

**Adjusted Premiums Due to Acceleration:** While the Insured is eligible for a Monthly Accelerated Death Benefit, We will waive the premiums due for the benefits provided to You by the Certificate. If the Insured later becomes ineligible for a Monthly Accelerated Death Benefit and a Maximum Remaining Accelerated Death Benefit Amount is still available, We will reduce the premium due for the Coverage and this Benefit attached to it. That reduced premium equals (1) multiplied by (2), plus (3):

1. The premium due on the Coverage and the benefits for this Benefit;
2. The ratio of the adjusted Death Benefit to the current death benefit for the Certificate;
3. The current premium for any other Benefit attached to the Coverage.

The Coverage policy fee will not be reduced.

**Termination of Coverage due to Acceleration:** If the Maximum Remaining Accelerated Death Benefit Amount is reduced to zero or less, either due to payment of a Monthly Accelerated Death Benefit or due to a reduction in the death benefit provided under The Policy, the Coverage provided by the Certificate and any Benefits will terminate with no further benefits payable, except as noted in the Delay of Termination Due to Scheduled Increase in Death Benefits provision.

**Delay of Termination Due to Scheduled Increase in Future Death Benefits:** The Certificate and any Benefits will not terminate due to the Termination of Coverage due to Acceleration provision if the life insurance Coverage provided by the Certificate is scheduled for a future guaranteed increase in death benefits with no corresponding increase in premium per the terms of the Certificate. In this case, The Certificate and this Benefit will continue in force until such time that the Maximum Remaining Accelerated Death Benefit Amount is increased due to the scheduled increase in death benefits. At that time, if the Insured is still eligible for a Monthly Accelerated Death Benefit, such payments may resume per the terms of this

Benefit. During this period, Waiver of Premium or adjusted Premiums Due to Acceleration continue per those provisions. Notwithstanding the provisions in this paragraph, The Certificate and any Benefits will immediately terminate upon the death of the Insured and payment of the adjusted Death Benefit, if any.

**Restriction on Changes to Certificate and Benefits:** While the Insured is eligible for a Monthly Accelerated Death Benefit no changes may be made to the Coverage provided by The Policy or to any Benefit attached to the Coverage.

**Effect on Accidental Death Benefit:** While the Coverage is in force, any Accidental Death Benefit under the Certificate will not be affected by the acceleration of benefits under this Benefit.

**Monthly Report Showing Effect of Benefit Payments:** While Benefit payments are being paid, We will provide You with a monthly report that shows the effect each Benefit payment has on Coverage values.

### EXCLUSIONS

We will not pay an Benefit for care that is received or loss incurred as a result of:

1. an intentionally self-inflicted injury, or attempted suicide; or
2. war or any act of war, declared or undeclared, or service in the armed forces of any country; or
3. the Insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the Insured's involvement in an illegal activity.

We will not pay an Benefit if the Confinement, Home Health Care service, or Adult Day Care service:

1. is received outside the United States and its territories; or
2. is provided by ineligible providers; or
3. for treatment of alcoholism and drug addiction; or
4. is rendered by members of the Certificate Holder's or the Insured's Immediate Family; or
5. are fully or partially reimbursed by a state or federal worker's compensation plan, Medicare, any other health insurance or other insurance plan, or any other governmental program, except Medicaid; or
6. would not be charged for in the absence of insurance.

### LIMITATIONS

The following limits apply to payment of an Accelerated Death Benefit under this Benefit:

1. We will not pay Accelerated Death Benefits under this Benefit for Confinement and Home Health Care or Adult Day Care simultaneously, even if the Insured otherwise qualifies for both benefits. In any given month the Insured qualifies for both benefits, We will pay the Monthly Accelerated Death Benefit for Confinement.
2. We will not pay any Accelerated Death Benefit for any sickness condition or Plan of Care that begins during the Waiting Period
3. We will not pay any Accelerated Death Benefit before the end of the Elimination Period.
4. We will not pay any Accelerated Death Benefit such that the total lifetime Accelerated Death Benefits payable exceed the current life insurance death benefit Coverage provided by The Policy.

### CERTIFICATE GENERAL PROVISIONS

**Notice of Claim:** You must notify Us in writing within 30 days of any eligible Confinement, Home Health Care service, or Adult Day Care service, for which You are claiming benefits. You must send written notice to our agent or Us and include the Insured's name and Certificate Number. If notice cannot reasonably be given within 30 days of a loss You must send the notice as soon as reasonably possible.

**Claim Forms:** After We receive Notice of Claim, We will send claim forms to You or Your authorized representative within 15 days. If the claim forms are not received within 15 days, We will accept Written Proof of Loss describing the nature and extent of the claim. Such initial and ongoing Written Proof of Loss must be received by Us within the time limit stated in the following paragraph.

**Written Proof of Loss:** We will pay benefits under this Certificate after We receive Written Proof of Loss satisfactory to Us. We must receive initial Written Proof of Loss within 90 days after expiration of the Elimination Period. If it is not reasonably possible to provide this information within such time, initial Written Proof of Loss must be submitted as soon as reasonably possible, but not later than one year from the time specified. We will require subsequent Written Proof of Loss satisfactory to Us to be submitted periodically while the Insured continues to be eligible to receive benefits under this

Certificate. Any such periodic Written Proof of Loss will not be required more frequently than once every 31 days. Any such periodic Written Proof of Loss due to a chronic illness will not be required more frequently than once every 90 days.

Written Proof of Loss means billing statements, invoices, or payment receipts to prove that the Insured was Confined or received Home Health Care or Adult Day Care services in accordance with a Plan of Care. Written Proof of Loss also means certification by a Physician that the Insured is chronically ill. Examples of Written Proof of Loss include Physician certification, Plan of Care records, attending Physician reports, medical records; and similar written documentation.

**Physical Examination:** At our expense, We reserve the right to have a Licensed Health Care Practitioner of our choosing examine the Insured while a claim is pending to determine the Insured's eligibility for benefits. In the event that the Licensed Health Care Practitioner We choose provides a different diagnosis of the Insured's condition, We reserve the right to rely on the certification from the Physician of our choosing for claim purposes.

**Appeals Process:** If you wish to file an appeal regarding a benefit determination, You must send a written request to us within 60 days of receiving Our notification of denial. We will complete Our review of Your appeal within 60 days after receiving Your appeal. The review period may be extended up to 120 days. You will receive advance written notice if the period is extended. Only one appeal regarding a benefit determination may be made.

**Time of Payment of Claims:** All benefits described in this Benefit will be paid monthly provided We have received Written Proof of Loss satisfactory to Us.

**Payment of Claims:** All Certificate benefits will be paid to You, unless You designate a different payee.

**Adjustment of the Death Benefit:** If Benefit payments are paid after the Insured has died, but before notification of death has been received by the Company, We will reduce the Death Benefit by the amount of the Benefit payments.

**Legal Actions:** No legal action may be brought to recover under this Benefit within 60 days after Written Proof of Loss has been provided to Us as required nor more than 3 years from the time Written Proof of Loss is required to be furnished.

**Consent For Benefit Payment:** We must obtain the consent of any irrevocable beneficiary or assignee of record before any Certificate benefit is paid.

**Contestability:** This Benefit , if in force for less than six months, may be rescinded, or a long-term care claim denied if misrepresentation that is material to the acceptance of the coverage is proven. If this Benefit is in force for at least six months, but less than two years, we may rescind the Benefit or deny a claim upon showing misrepresentation that is both material to the acceptance of coverage and which pertains to the condition for which benefits are sought. After a Benefit is in force for two years, it is not contestable upon the grounds of material misrepresentaiton alone; such Benefit may be contested only pon a showing that the material facts were knowingly and intentionally misrepresent3ed relating to the Insured's health. The contestability period will be measured from the Benefit Effective Date, as defined in this Optional Benefit.

**Suicide:** If the Insured dies by suicide, while sane or insane, within two years from the Benefit Effective Date under this Benefit, any premiums refunded under the Suicide Exclusion provision of the Certificate will be reduced by the amount of accelerated benefits paid, if any, under this Benefit.

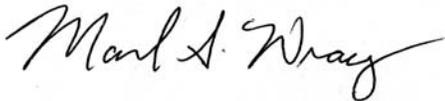
**Unintentional Lapse:** This Optional Benefit will be reinstated, upon lapse, if proof is provided that the Certificate Holder was cognitively impaired or had a loss of functional capacity before the Certificate grace period expiry date. This request, and submission of all past due premiums, must be made within five months after termination. Proof of cognitive impairment or loss of functional capacity shall be on the same basis as the benefit eligibility for cognitive impairment or loss of functional capacity as defined in this Optional Benefit.

**Termination of Coverage Provided by this Benefit:** Coverage provided by this Benefit terminates at the earliest of:

1. On the Expiry Date of this Benefit, as shown on the Certificate Schedule; or
2. When the Coverage matures or terminates for any reason including Termination of Coverage due to Acceleration; or
3. On the date You elect to terminate this Benefit; or
4. On the You assign the Coverage provided by The Policy; or
5. At the end of the 31 day grace period for an unpaid premium.

**Cancellation of this Benefit:** This benefit may be cancelled by a written request from You. Cancellation will take effect on the date We receive the written request at our Administrative Office. We will refund a pro rata part of any premium paid for this benefit beyond that date.

**FIDELITY LIFE ASSOCIATION, A LEGAL RESERVE COMPANY**



*Secretary*

Fidelity Life Association, A Legal Reserve Company  
1211 West 22<sup>nd</sup> Street, Suite 209  
Oak Brook, IL 60523



*President*

**Administrative Office**  
Fidelity Life Association  
17 Church Street, Keene, NH 03431

SERFF Tracking Number: FDLR-126964445 State: Arkansas  
 Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company State Tracking Number: 47610  
 Company Tracking Number:  
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: LA to AR  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> Readability.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b> Application form W6031 06-2010 will be used. This form was approved by your department on June 21, 2010.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Filing Auth		
<b>Comments:</b>		
<b>Attachment:</b> Filing Auth 052010.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Compliance Cert		
<b>Comments:</b>		
<b>Attachment:</b> Compliance Cert.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter		

SERFF Tracking Number: FDLR-126964445 State: Arkansas  
Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company State Tracking Number: 47610  
Company Tracking Number:  
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium  
Product Name: LA to AR  
Project Name/Number: /

**Comments:**

**Attachment:**

AR COVER LETTER.pdf

## READABILITY CERTIFICATION

I hereby certify that the following forms were tested for readability using Microsoft Word – Version 97 SR-1, and achieved the following test results.

**Company Name:** Fidelity Life Association, A Mutual Legal Reserve Company

**Form Number(s):** W3P06

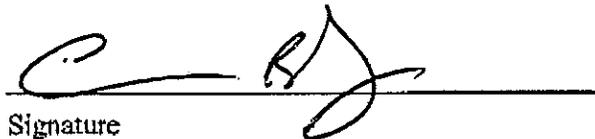
**Type of Form:** Accelerated Death Benefit for Long Term Care Rider

1. Number of Words: 5,339
2. Number of Characters: 26,780
3. Number of Paragraphs: 95
4. Number of Sentences: 260
5. Final Score: 51.1

**Form Number(s):** W3006

**Type of Form:** Optional Accelerated Death Benefit for Long Term Care

1. Number of Words: 5,313
2. Number of Characters: 26,892
3. Number of Paragraphs: 95
4. Number of Sentences: 266
5. Final Score: 50.4

  
Signature

Ciaran Brady

Typed Name

Vice President

Title

December 14, 2006

Date



Established 1896

Innovation Is Our Policy

Fidelity Life Association  
1211 West 22<sup>nd</sup> Street, Suite 209  
Oak Brook, IL 60528  
Tel 680.522.0892  
Fax 866.875.8175

May 4, 2010

Company NAIC Number: 63290  
Company FEIN Number: 95-1060502

Re: Group Life Insurance Policy, Certificate and Benefit Forms  
Letter of Authorization

To: All State Insurance Departments

The Fidelity Life Association, A Legal Reserve Life Insurance Company of 1211 West 22<sup>nd</sup> Street, Oak Brook, Illinois hereby authorizes Vision Financial Corporation to represent us in the submission of the captioned forms and to negotiate with insurance departments for their approval.

Sincerely,

A handwritten signature in black ink, appearing to be "Claran Brady", written over a horizontal line.

Claran Brady  
Vice President of Operations

**CERTIFICATION OF COMPLIANCE**

Form #	Form Name	Description
W3006LA	Optional Accelerated Death Benefit for Long Term Care and Terminal Illness	This Optional Benefit is attached to the Certificate of Coverage and allows the Certificate Holder to receive a portion of the death benefit of the policy in advance of death when a chronically ill insured receives long term care in an eligible facility or through an eligible provider or should the insured become diagnosed with a qualifying Terminal Illness.

I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify that they are in compliance with the applicable statutes, regulations, and bulletins of the State of Arkansas. I further certify that they will be revised and/or discontinued in the event of future changes in the statutes, regulations, or bulletins, which would prohibit the use of such forms.

  
 Stefan Brady, Vice President  
 Fidelity Life Association

December 27, 2010

December 30, 2010

Arkansas Insurance Department  
1200 West 3<sup>rd</sup> St.  
Little Rock, AR 72201

RE: Fidelity Life Association  
NAIC No.: 63290  
FEIN Number: 36-1068685  
Lifetime Benefit Term Insurance – Out of State Group

Dear Sir or Madame:

I am submitting an informational filing for the attached Accelerated Death Benefit for Long Term Care that will be used in conjunction with out-of-state Employer Group business, primarily a group domiciled in Louisiana.

These forms will be marketed to residents of the State of Arkansas who are members of Employer Groups enrolled outside of the State of Arkansas.

Whenever an Out-of-State Certificate is issued to a resident of the State of Arkansas, the following statement will appear on the Cover Page of the Certificate: “The benefits of the Policy providing your coverage are governed primarily by the law of a state other than your state of residence”.

Thank you for your assistance with this filing. If you have any questions, please call me at 1-800-635-4467, ext 209.

Sincerely,

Crystle Harmon  
Compliance Coordinator  
Vision Financial Corporation  
Telephone: 800-635-4467, ext. 209  
Fax: 603-357-0250  
Email: [charmon@visfin.com](mailto:charmon@visfin.com)

Enc.