

SERFF Tracking Number: META-127684520 State: Arkansas  
Filing Company: TIAA-CREF Life Insurance Company State Tracking Number: 50095  
Company Tracking Number: W11-65 BW (T-C LIFE)  
TOI: LTC06 Long Term Care - Other Sub-TOI: LTC06.000 Long Term Care - Other  
Product Name: Individual Long Term Care  
Project Name/Number: C11-IB-T-C LIFE/W11-65 BW (T-C LIFE)

## Filing at a Glance

Company: TIAA-CREF Life Insurance Company

Product Name: Individual Long Term Care SERFF Tr Num: META-127684520 State: Arkansas  
TOI: LTC06 Long Term Care - Other SERFF Status: Closed-Approved State Tr Num: 50095  
Sub-TOI: LTC06.000 Long Term Care - Other Co Tr Num: W11-65 BW (T-C LIFE) State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Donna Lambert

Authors: Cherise Crittenden, Disposition Date: 10/25/2011

Andrea DeAlmeida

Date Submitted: 10/24/2011 Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 11/25/2011

State Filing Description:

## General Information

Project Name: C11-IB-T-C LIFE  
Project Number: W11-65 BW (T-C LIFE)  
Requested Filing Mode:  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 10/25/2011  
State Status Changed: 10/25/2011  
Created By: Cherise Crittenden  
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Cherise Crittenden

Filing Description:

This is a filing of individual long-term care insurance coverage change application forms. Please see our filing letter for details.

## Company and Contact

### Filing Contact Information

Thomas F. O'Connor, Sr, Analyst-Contracts tocnnor1@metlife.com

Dev.

57 GREENS FARMS ROAD 203-221-3834 [Phone]

WESTPORT, CT 06880 203-221-3348 [FAX]

### Filing Company Information

SERFF Tracking Number: META-127684520 State: Arkansas  
 Filing Company: TIAA-CREF Life Insurance Company State Tracking Number: 50095  
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 Project Name/Number: C11-IB-T-C LIFE/W11-65 BW (T-C LIFE)  
 TIAA-CREF Life Insurance Company CoCode: 60142 State of Domicile: New York  
 730 Third Avenue Group Code: Company Type:  
 New York, NY 10017 Group Name: State ID Number:  
 (212) 578-2944 ext. 2944[Phone] FEIN Number: 13-3917848

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**Filing Fees**

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
TIAA-CREF Life Insurance Company	\$50.00	10/24/2011	53116987

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/25/2011	10/25/2011

*SERFF Tracking Number:*      *META-127684520*                      *State:*                      *Arkansas*  
*Filing Company:*              *TIAA-CREF Life Insurance Company*              *State Tracking Number:*      *50095*  
*Company Tracking Number:*      *W11-65 BW (T-C LIFE)*  
*TOI:*                      *LTC06 Long Term Care - Other*              *Sub-TOI:*                      *LTC06.000 Long Term Care - Other*  
*Product Name:*              *Individual Long Term Care*  
*Project Name/Number:*      *C11-IB-T-C LIFE/W11-65 BW (T-C LIFE)*

## **Disposition**

Disposition Date: 10/25/2011

Implementation Date: 11/25/2011

Status: Approved

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved	Yes
<b>Supporting Document</b>	Certification	Approved	Yes
<b>Supporting Document</b>	Filing Letter	Approved	Yes
<b>Supporting Document</b>	Authorization	Approved	Yes
<b>Supporting Document</b>	NAIC Transmittal Form	Approved	Yes
<b>Form</b>	Application	Approved	Yes

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## Form Schedule

**Lead Form Number: CC11-IB-TIAA**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/25/2011	CC11-IB-TIAA	Application/ Enrollment Form	Application/ Enrollment Form	Initial		52.000	CC11 IB TIAA CREF FRD-filng.pdf

**Metropolitan Life Insurance Company, ("MetLife") • New York, NY**

as administrator for:

**TIAA-CREF Life Insurance Company (TIAA-CREF)  
Long-Term Care Insurance (LTCI)  
Coverage Change Packet**

**Table of Contents**

**Application** \_\_\_\_\_

- Part A Insurability Questions
- Part B Person Applying for Coverage
- Part C Coverage Change Selections
- Part D Health Questions
- Part E Agreement and Acknowledgement

**Required Forms and Notices** \_\_\_\_\_

- AUTH Medical Authorization

**Questions? Call [1-888-748-4824]  
[Individuals with a TTY may call 1-800-638-1004]**

Please submit the entire application to MetLife at:  
**[Metropolitan Life Insurance Company]  
[P.O. Box 937, Westport, CT 06881-0937]**

**[COVERAGE CHANGE PACKET SUBMISSION INSTRUCTIONS]**

**To avoid a delay in processing your application:**

- Print all answers in blue or black ink.
- Answer all questions completely.
- Additional medical information can be submitted on a separate sheet of paper. Be sure to include your name and identification number (Social Security or Employee I.D. or Membership number) on all sheets. Information provided on additional sheets will become a part of the application and will be considered by MetLife in determining your eligibility for insurance.
- Please complete and sign Part G, Agreement and Acknowledgement.
- Complete the Medical Authorization.
- Contingent on any required state approval, this application is subject to change.]

**PART A - INSURABILITY QUESTIONS**

(Please answer these questions BEFORE you continue with this application.)

If you have any doubt about your answers, please ask your doctor.	YES	NO
[1.]Have you <b>ever</b> had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke, Transient Ischemic Attack (TIA) <b>within the past [2 years]</b> , multiple TIAs; Alzheimer’s disease; dementia/ organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson’s disease/syndrome; Multiple Sclerosis; Muscular Dystrophy; Amyotrophic Lateral Sclerosis (ALS); Huntington’s chorea; or insulin dependent diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
[2.]Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
[3.]Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
[4.]Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
[5.]Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>



**If you answered YES to any of PART A, questions [1-5], PLEASE DO NOT CONTINUE. We regret that you are not eligible to increase or add to your Long-Term Care Insurance coverage at this time. If you answered “NO” to all of PART A, questions [1-5], please CONTINUE.**

**PART B - PERSON APPLYING FOR COVERAGE CHANGE**

(You must complete ALL information below.)

[1.]  Mr.     Mrs.     Ms.     Dr. (check one)

[2.] First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Last Name \_\_\_\_\_

[3.] Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

[4.] Preferred Contact Phone Number (\_\_\_\_) \_\_\_\_\_  
Additional Phone Number (\_\_\_\_) \_\_\_\_\_  
Best time to call     Morning     Afternoon     Evening

[5.] E-mail address \_\_\_\_\_

[6.] Gender     Male     Female

[7.] Date of Birth \_\_\_\_\_ (mm/dd/yyyy)  
[Place of Birth \_\_\_\_\_ (State & Country)]

[8.] [Social Security Number] \_\_\_\_\_

[9.] Marital Status     Single/Widowed/Divorced  
                                   Married/Civil Union Partner  
                                   Domestic Partner

10. Do you have a Spouse or Civil Union Partner or Domestic Partner or household member who has an Individual LTC Insurance policy issued by MetLife?     YES     NO

**IF YES** please identify and provide requested information.  
Name \_\_\_\_\_  
[Social Security Number] \_\_\_\_\_

11. Policy number of coverage you wish to increase  
\_\_\_\_\_

**PART C - COVERAGE CHANGE SELECTIONS****To make a change to your current coverage:****STEP 1**

- Please call the phone number listed on the cover of this application to speak with a customer service member to discuss the options available to you. Coverage change options are limited to the amounts and features available at the time of your request.

**STEP 2**

- Based on your phone call with the customer service member, please fill in the information below.

Increase my coverage as follows: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please Note:**

[If your policy includes a Survivor feature and/or Shared Care Rider, please review your policy for information on any applicable requirements for maintaining identical coverage.]

If you currently have a Partnership policy, please check the minimum requirements for Partnership qualification.

I understand that if my application contains a request for a coverage change that is not currently available for my policy, including any misquoted amount or feature, my application for increased coverage will be denied.

**PART D - HEALTH QUESTIONS**

(Provide additional information in the DETAILS section on [page 5], if needed.)

**Primary Care Physician (with most of your records)**

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**All Physician Specialists (excluding podiatrists, dentists) seen within the past [5] years**

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**You are required to answer all the questions in this section.** Missing information will result in underwriting delays. We will review all the information we receive regarding your health status and make a decision whether to approve your request for coverage. **If you have any doubt about your answers in Part D, please ask your doctor.**

**[Underwriting requirements:** A pharmacy screen, phone or in-person (in your place of residence) health interview and medical records will be required at the underwriter’s discretion based on your age and/or medical conditions.]

[1.] Have you **ever** had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

	YES	NO
Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease / condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack / angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery / angioplasty	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
TIA	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory / lung condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney / bladder condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes / Endocrine condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Seizures / brain condition(s) / head injury	<input type="checkbox"/>	<input type="checkbox"/>
Spine/back condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Depression / anxiety / bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Joint replacement / fractures / falls	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Connective tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
Lupus / Scleroderma / CREST	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis / amputation/weakness	<input type="checkbox"/>	<input type="checkbox"/>
Bladder / bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / fainting	<input type="checkbox"/>	<input type="checkbox"/>
Muscle disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Tremor/imbalance / gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Polymyalgia rheumatica	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss / forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis / Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
Liver condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis / cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>

**PART D - HEALTH QUESTIONS - continued**

(Provide additional information in the DETAILS section on [page 5], if needed.)

					YES	NO
[2.] Do you have any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?					<input type="checkbox"/>	<input type="checkbox"/>
[3.] Within the past [12] months, have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, Continuous Positive Airway Pressure (CPAP))?					<input type="checkbox"/>	<input type="checkbox"/>
[4.] Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?					<input type="checkbox"/>	<input type="checkbox"/>
[5.] Have you ever resided in, or used: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?					<input type="checkbox"/>	<input type="checkbox"/>
[6.] Have you ever had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?					<input type="checkbox"/>	<input type="checkbox"/>
[7.] Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?					<input type="checkbox"/>	<input type="checkbox"/>
[8.] Did you answer YES to any question above or on the previous page [1-7]? IF YES provide details for each question below.					<input type="checkbox"/>	<input type="checkbox"/>
Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)		
[9.] Have you taken any medications (excluding vitamins) or supplements within the past [12] months? If YES provide details below for each medication taken.					<input type="checkbox"/>	<input type="checkbox"/>
Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional			
[10.] Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) within the past [2] years? IF YES indicate date of last use. _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
[11.] Do you consume alcoholic beverages? How often? _____ How much? _____					<input type="checkbox"/>	<input type="checkbox"/>
[12.] Have you ever been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? IF YES indicate date of last treatment. _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
[13.] Height _____ Weight _____						
[14.] Have you had a weight gain or loss of [10] pounds or more within the past [12] months? If YES please specify: Pounds lost _____ Pounds gained _____					<input type="checkbox"/>	<input type="checkbox"/>
[15.] Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? If YES please describe.					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I am employed:		<input type="checkbox"/> I participate in other activities:				
Job/Title _____		Other Activities _____				
Hours/Week _____		Hours/Week _____				



<i>SERFF Tracking Number:</i>	<i>META-127684520</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>TIAA-CREF Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50095</i>
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<i>TOI:</i>	<i>LTC06 Long Term Care - Other</i>	<i>Sub-TOI:</i>	<i>LTC06.000 Long Term Care - Other</i>
<i>Product Name:</i>	<i>Individual Long Term Care</i>		
<i>Project Name/Number:</i>	<i>C11-IB-T-C LIFE/W11-65 BW (T-C LIFE)</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> Attached is the Flesch Certification <b>Attachment:</b> ARCERTREAD.pdf	Approved	10/25/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved	10/25/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Health - Actuarial Justification <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved	10/25/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved	10/25/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Certification <b>Comments:</b> Attached is the Certification <b>Attachment:</b>	Approved	10/25/2011

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 ARCERTREG19.pdf

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Filing Letter	Approved	10/25/2011
<b>Comments:</b>	Attached is the Filing Letter		
<b>Attachment:</b>	Filing Letter - TC Life.pdf		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Authorization	Approved	10/25/2011
<b>Comments:</b>	Attached is the Authorization		
<b>Attachment:</b>	T-C Life Authorization Letter.pdf		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	NAIC Transmittal Form	Approved	10/25/2011
<b>Comments:</b>	Attached is the NAIC Transmittal Form		
<b>Attachment:</b>	NAIC Transmittal - TC Life.pdf		



TIAA-CREF Life Insurance Company  
NAIC Company Number: 60412  
NAIC Group Number: 1216

**ARKANSAS FLESCH CERTIFICATION**

I certify that the form shown below has achieved the Flesch Reading Ease Score shown below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form No.	Form Description	Flesch Score
CC11-IB-TIAA	Application Form for Coverage Changes	52.00

Michael F. Tietz  
Vice President



Metropolitan Life Insurance Company  
NAIC Company Number: 65978  
NAIC Group Number: 241

**ARKANSAS CERTIFICATION**  
**Rule and Regulation 19**  
**Unfair Sex Discrimination in the Sale of Insurance**

I certify that this submission meets the provisions of Rule and Regulation 19, and all applicable requirements of the Arkansas Department of Insurance.

A handwritten signature in black ink, appearing to read "Michael F. Tietz".

Michael F. Tietz  
Vice President

Metropolitan Life Insurance Company  
Institutional Contracts – **MSC #39.087**  
1095 Avenue of the Americas  
New York, NY 10036-6796  
Tel 212 578-2944 Fax 212 578-6247  
[Croth@metlife.com](mailto:Croth@metlife.com)



**Carolyn J. Roth**  
Director  
Institutional Business Contracts

October 24, 2011

Arkansas Department of Insurance  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904

Re: TIAA-CREF Life Insurance Company ("T-C Life")  
Individual Long-Term Care Insurance Coverage Change Application  
NAIC Company No.: 60142  
FEIN: 13-3917848

Dear Sir/Madam:

The referenced filing is being submitted by Metropolitan Life Insurance Company ("MetLife") as administrator on behalf of T-C Life under an administrative services agreement between MetLife and T-C Life that became effective on May 1, 2004. A letter authorizing MetLife to submit this filing on behalf of T-C Life is included in this filing.

The following individual long-term care insurance form is submitted for your review and approval for use in your state.

This form is new, and does not replace any forms previously filed with your Department. Please note that the submitted form is intended to be used to administer coverage changes for a closed block of business.

<b>Form Number</b>	<b>Description</b>
CC11-IB-TIAA	Application form for coverage change requests by individuals currently covered under individual long-term care insurance policies insured by T-C Life and administered by MetLife.

#### **Readability Score**

The form has been tested for readability and achieved the following Flesch Reading Ease score, as certified by the MetLife officer signing below:

<b>Form Number</b>	<b>Score</b>
CC11-IB-TIAA	52

**Variable Material**

The variable material contained in each of the filed forms is indicated by brackets.

**Filing Fees**

We enclose the required filing fee.

**Filing Correspondence Instructions**

Please address all correspondence regarding this filing as follows:

Metropolitan Life Insurance Company  
Institutional Contracts – MSC #39.087  
1095 Avenue of the Americas  
New York, NY 10036-6796

If you have any questions or comments that you feel could best be handled by contacting MetLife, please feel free to contact Thomas F. O'Connor via telephone(203) 221-3834, or e-mail (toconnor1@metlife.com).

Filer insert his or her information.

Thank you for your attention to our filing. We look forward to hearing from you.

Sincerely,



Carolyn Roth  
Director



Michael F. Tietz  
Vice President



Steven Maynard, FLMI, ChFC, CLU, PMP  
VP, COO (Chief Operating Officer)  
TIAA-CREF Life Insurance Company  
8500 Andrew Carnegie Boulevard  
Charlotte, NC 28262-8500  
Tel: 704-988.6757  
[smaynard@tiaa-cref.org](mailto:smaynard@tiaa-cref.org)

September 12, 2011

RE: TIAA- CREF Life Insurance Company (“TIAA-CREF Life”)  
Company NAIC # 60142

TO: All State Insurance Departments

This letter sets forth the conditions under which Metropolitan Life Insurance Company (“MetLife”), or any designee thereof, is authorized to act on behalf of TIAA-CREF Life Insurance Company (“TIAA-CREF Life”) with respect to the long-term care insurance coverage change form filings (the “LTC Coverage Change Form Filings”), and outlines the relationship between MetLife and TIAA-CREF Life with respect to the LTC Coverage Change Form Filings.

Please be advised that MetLife is the reinsurer of the TIAA-CREF Life long-term care insurance policies (“Reinsured Policies”), which are the subject of the LTC Coverage Change Form Filings, pursuant to an Indemnity Reinsurance Agreement and an Assumption Reinsurance Agreement entered into by MetLife and TIAA-CREF Life on May 1, 2004. In addition, pursuant to the terms of that Assumption Reinsurance Agreement, MetLife has used its reasonable best efforts to effectuate the novation of the Reinsured Policies subject to required and appropriate regulatory approval. Those Reinsured Policies which have not been novated and which are the subject of the LTC Coverage Change Form Filings are currently reinsured by MetLife on a 100% indemnity coinsurance basis, and MetLife also serves as the administrator of those policies pursuant to an Administration Agreement entered into by MetLife and TIAA-CREF Life on May 1, 2004.

In connection with the LTC Coverage Change Form Filings, and subject to MetLife’s agreement to act in accordance with the applicable terms and conditions of the Indemnity Reinsurance Agreement, the Administration Agreement, and the Assumption Reinsurance Agreement referenced above, TIAA-CREF Life hereby authorizes MetLife to enter into written and/or oral communication, including the submission and receipt of written materials, with all state insurance departments, for the purpose of completing the filing process with respect to the LTC Coverage Change Form Filings and responding to each department’s review of the LTC Coverage Change Form Filings.

Sincerely,

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

<b>1.</b>	<b>Prepared for the State of</b>	<b>ARKANSAS</b>
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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 #
	<b>TIAA-CREF Life Insurance Company</b> 630 Third Avenue New York, NY 10017	NY		1216	60142	13-3917848	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	<b>Thomas F. O'Connor</b> Metropolitan Life Insurance Co. 57 Greens Farms Road Westport, Connecticut 06880	(203) 221-3834	(203) 221-3348	Toconnor1@metlife.com

<b>5.</b>	<b>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.</b>	<b>Company Tracking Number</b>	<b>W11-65 BW (T-C Life)</b>
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<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b>	Previous file # _____
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<b>8.</b>	<b>Market</b>	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise  <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input 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.</b>	<b>Type of Insurance (TOI)</b>	<b>LTC06</b>
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<b>10.</b>	<b>Sub-Type of Insurance (Sub-TOI)</b>	<b>LTC06.000</b>
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<b>11.</b>	<b>Submitted Documents</b>	<input 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  <u><b>Rates</b></u> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <u><b>SUPPORTING DOCUMENTATION</b></u> <input type="checkbox"/> Articles of Incorporation <input checked="" type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____
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12.	<b>Filing Submission Date</b>	<b>October 24, 2011</b>	
13	<b>Filing Fee (If required)</b>	Amount <u>\$50.00</u>	Check Date <u>EFT Submission</u>
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	<b>Date of Domiciliary Approval</b>	<b>Not Applicable</b>	
15.	<b>Filing Description:</b>		
<p><b>This is a filing of individual long-term care insurance coverage change application forms. Please see our filing letter for details.</b></p>			

16.	<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>			
Print Name <u>Michael F. Tietz</u>		Title <u>Vice President</u>	
Signature 		Date: <u>October 24, 2011</u>	

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		<b>W11-65 BW (T-C Life)</b>
<b>This filing corresponds to rate filing company tracking number</b>		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Application for coverage change – individual long-term care insurance	CC11-IB-TIAA	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

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18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name Description	Affected Form Numbers		Previous State Filing Number
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + 45% - ____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	

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