

SERFF Tracking Number: LMLI-127804912 State: Arkansas
Filing Company: Landmark Life Insurance Company State Tracking Number: 50227
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: SIFE application
Project Name/Number: /

Filing at a Glance

Company: Landmark Life Insurance Company

Product Name: SIFE application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: LMLI-127804912 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 50227

Co Tr Num:

Author: Judy Tait

Date Submitted: 11/09/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 11/15/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Judy Tait

Filing Description:

Landmark Life Insurance Company

General Use Application Filing

Form Number: AR11 SIFE App

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Texas is State of
Domicile. Form is being filed simultaneously.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/15/2011

State Status Changed: 11/15/2011

Created By: Judy Tait

Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Judy Tait,

jtait@ruddwisdom.com

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PO Box 204209 512-346-1590 [Phone]
 9500 Arboretum Blvd, Ste 200
 Austin, TX 78720-4209

Filing Company Information

Landmark Life Insurance Company CoCode: 82252 State of Domicile: Texas
 PO Box 40 Group Code: Company Type: Life Accident & Health Insurer
 Brownwood, TX 76804-0040 Group Name: State ID Number: 2724
 (800) 299-5433 ext. [Phone] FEIN Number: 75-1185065

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: This is the Arkansas required fee. The State of Domicile, Texas, requires the same amount.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Landmark Life Insurance Company	\$50.00	11/09/2011	53611928

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/15/2011	11/15/2011

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Disposition

Disposition Date: 11/15/2011

Implementation Date:

Status: Approved-Closed

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		No
Form	General Use Application		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
	AR11 SIFE App	Application/General Use Enrollment Form	Application	Initial		51.400	AR11 SIFE App.pdf

___ New Application
 ___ Reinstatement of Policy
 # _____

Application for Individual Life Insurance
LANDMARK LIFE INSURANCE COMPANY
 [PO Box 40 - Brownwood - Texas - 76804-0040]

___ Change to Policy
 # _____
 TI# _____

Proposed Insured	Name (First/Middle/Last)		SS#	
	Mailing Address (Street/Apt/City/State/Zip)			Birth State
	Telephone	Date of Birth	Age	Sex
Primary Beneficiary	Name (First/Middle/Last)	SS# (If Available)		Relationship
Contingent Beneficiary	Name (First/Middle/Last)	SS# (If Available)		Relationship
Owner, If Not Insured	Name (First/Middle/Last)		SS#	
	Mailing Address (Street/Apt/City/State/Zip)		Birth State	Relationship
Contingent Owner	Name (First/Middle/Last)	SS# (If Available)		Relationship
Payor	Name (First/Middle/Last)	Mailing Address (Street/Apt/City/State/Zip)		
Insurance Plan: [PLAN NAME]	Face Amount: \$ _____ Initial Premium: \$ _____ Policy Fee: \$ _____ Plan: <input type="checkbox"/> Whole Life <input type="checkbox"/> Single <input type="checkbox"/> 5-Pay <input type="checkbox"/> 10-Pay <input type="checkbox"/> 20-Pay Mode: <input type="checkbox"/> Mo <input type="checkbox"/> Qtr <input type="checkbox"/> SA <input type="checkbox"/> Ann Pmt Method: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Direct Bill <input type="checkbox"/> Gov't Debit* <i>*Only available billing date for Government Debit Cards (e.g. Direct Express) is account funding date.</i> *Date to Bill: _____ Draft 1st Mo. Premium: <input type="checkbox"/> Yes <input type="checkbox"/> No Requested Effective Date: _____			
Doctor/Clinic Usually Consulted	Name (First/Middle/Last)		Last Consulted	Telephone
	Address (City/State/Zip)			
List Current Prescription Medications				

Has the Proposed Insured smoked any form of tobacco in the past 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please Complete the Health Questions Below <i>(A Policy WILL NOT Be Issued if Any Question or Part of a Question is Answered "YES")</i>		
1. Is the Proposed Insured:	Yes	No
a. Incarcerated, confined to a bed, hospitalized, or been hospitalized 2 or more times in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
b. Using hospice or home nursing care, or have they resided in a nursing facility in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
c. Using oxygen or respiratory equipment (excluding inhaler), or have they used the same in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
d. Waiting for a medical diagnosis or been advised to have medical care or testing not yet completed?	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 24 months has the Proposed Insured been diagnosed by a medical professional with, or treated for:		
a. Weight loss of more than 15 lbs, without the aid of diet or exercise?	<input type="checkbox"/>	<input type="checkbox"/>
b. An organ transplant, or any form of cancer (other than basal cell skin cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
c. A stroke, TIA, heart attack, angina, heart or circulatory surgery, pacemaker, or aneurism?	<input type="checkbox"/>	<input type="checkbox"/>
d. Muscular dystrophy, "failure to thrive", Emphysema or COPD (Chronic Obstructive Pulmonary Disease)?	<input type="checkbox"/>	<input type="checkbox"/>
e. Complications of diabetes including but not limited to: insulin shock, diabetic coma, amputation, or eye, kidney or liver disorder, or poorly controlled or uncontrolled diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 24 months has the Proposed Insured used barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician; received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs; or has attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the Proposed Insured been diagnosed by a medical professional with, or been treated in the past 5 years for:		
a. Congestive heart failure, cirrhosis, chronic liver failure, renal failure, renal insufficiency, or dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
b. HIV, AIDS or AIDS Related Complex (ARC) or a terminal illness?	<input type="checkbox"/>	<input type="checkbox"/>
c. Dementia, Alzheimer's disease, Lou Gehrig's Disease (ALS), or Huntington's Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Home Office Corrections: (Note: Changes to Plan, Face, Age, Gender, Class or Benefits requires approval of Owner and Proposed Insured.)		

Is the Proposed Insured applying for the Waiver of Premium Rider? Yes No
(An Waiver of Premium Rider **WILL NOT** be issued if the following question is answered "Yes")

Does the Proposed Insured use a wheelchair, walker, or power chair, do they need assistance with daily activities of living, such as feeding, bathing or dressing themselves, or getting in or out of a bed or chair, or has the Proposed Insured received treatment from a member of the medical profession for osteoporosis or memory loss? Yes No

Does the Proposed Insured have life insurance or an annuity with any company? Yes No If Yes, Company/Policy No: _____
_____ Is the Insurance applied for here intended to replace any life insurance policy or annuity? Yes No

Comments; Explanations; Special Instructions: _____

I HAVE READ THIS APPLICATION and the answers and statements hereon and fully understand what I have read, and the statements and answers are true and complete to the best of my knowledge and belief.

I UNDERSTAND THAT: The answers and statements on this application will be the basis for the policy issued, and no information about the answers and statements will be considered to have been given to Landmark Life Insurance Company (LLIC) unless such information is stated in this application; No sales representative has authority to accept risk, pass on insurability, or make, waive, or change any conditions or provisions of the application, policy, or receipt; Federal law requires that Owners provide sufficient information to identify the parties to this application, and failure to provide the same could result in the policy being delayed, declined, or terminated after issue; I have 30 days to examine the policy once delivered, and I may return the policy during such time for a full refund; LLIC has no liability until a policy is issued on this application and delivered to and accepted by the Owner while each Proposed Insured is in the same health as shown on this application, and the first premium is paid in full; Checks and money orders must be made payable to LLIC and should not be made payable to the Agent, nor should I leave the payee blank; Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law; State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy is issued, or within a period of time after the policy was issued.

I RECEIVED a Notice of Information Practices and a receipt for premiums paid at the time I signed the application for insurance.

HIPAA Authorization to Disclose Medical Information to Landmark Life Insurance Company

I AUTHORIZE any licensed physician, medical practitioner, nurse, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, or other medical facility, the Medical Information Bureau (MIB), reinsurance company, division of motor vehicles, or the Veterans Administration, having information as to diagnosis, treatment or prognosis with respect to my physical or mental condition or having non-medical information concerning me, to release and disclose the entire medical record and any other protected health or other information concerning me within the past seven (7) years, without restrictions, to Landmark Life Insurance Company (LLIC) or its reinsurers. This includes information on the treatment of alcohol, drug and tobacco abuse, AIDS/HIV diagnosis and treatment, and psychiatric diagnosis and treatment.

I UNDERSTAND that the protected information is to be disclosed under this authorization so that LLIC may underwrite my application for life insurance, determine eligibility for insurance, risk rating or policy issuance determinations, obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have, or have applied for, with LLIC. Any protected information obtained will not be released by LLIC or its reinsurers.

I UNDERSTAND that this authorization shall remain in force for thirty (30) months from the date shown below if used in connection with an application for an insurance policy or reinstatement of an insurance policy, a request for change in policy benefits, or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

I UNDERSTAND and agree that a copy of this authorization is as valid as the original and that I or my authorized representative will receive a copy of this authorization with my policy. I understand and agree that this authorization may be revoked by me at any time by sending a written notice of revocation to Landmark Life Insurance Company, [PO Box 40, Brownwood, TX 76804]. I agree that LLIC shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation or to the extent that LLIC has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

Signed At (City and State) _____, this _____ day of _____,

Proposed Insured*: _____ Owner: _____ Payor: _____

*Parent, Guardian, or Legal Rep. if Proposed Insured is a Minor or Otherwise Unable to Contract (Explain relationship and reason unable to contract)

All signatures herein are e-signatures fully compliant with the Federal Electronic Signature statute, Title 15, U.S.C., Chap. 96, Sec. 7001 et seq., and are therefore legal and valid as original signatures.

AGENT'S STATEMENT

Do you have knowledge or reason to believe that replacement of existing insurance is involved? Yes No

(Provide all information and documentation regarding replacements as required by the laws of the state where the policy will be delivered.)

I WITNESSED the signatures above and accurately recorded the information supplied herein. I delivered the Notification and Receipt at the time the application was signed. If this application is on a relative I have disclosed the same. Yes No

AGENT SIGNATURE _____ AGENT NO. _____ Mail _____ Deliver _____

Authorization to Honor Checks Drawn By Landmark Life Insurance Company

ATTACH VOIDED CHECK *****

[PO Box 40, Brownwood, TX 76804 800-299-5433]

******* ATTACH VOIDED CHECK**

I authorize you to pay my policy premiums via electronic debits drawn and payable to Landmark Life Insurance Company. You are fully protected in honoring these payments until you receive written notice cancelling this authorization.

Name of Bank: _____ Bank Telephone No. _____ Date: _____

Signature _____ Acct No: _____ Routing No: _____

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Sub-TOI: L08.000 Life - Other

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Project Name/Number: /

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

FLESCH for AR11 SIFE App.pdf

Item Status:

Status

Date:

Bypassed - Item: Application

Bypass Reason: The form being filed is a general use application form.

Comments:

FLESCH READABILITY SCORE CERTIFICATION

LANDMARK LIFE INSURANCE COMPANY

I, Eddie Mire, am a consulting actuary doing work for Landmark Life Insurance Company. I certify that the following form has been tested and meets the minimum required reading ease score.

Form Number

Flesch Score

AR11 SIFE App

51.4



November 9, 2011

Date

Eddie Mire
Rudd and Wisdom, Inc.