

SERFF Tracking Number: SHLI-127839414 State: Arkansas
Filing Company: Shelter Life Insurance Company State Tracking Number: 50312
Company Tracking Number: 03L10511
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Individual Life Conversion Application
Project Name/Number: Conv App/L10410

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: Individual Life Conversion Application SERFF Tr Num: SHLI-127839414 State: Arkansas

TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- Closed State Tr Num: 50312

Sub-TOI: L071.101 Fixed/Indeterminate Co Tr Num: 03L10511 State Status: Approved-Closed

Premium - Single Life

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Dina Krofta, Berdetta Moore Disposition Date: 11/28/2011

Date Submitted: 11/21/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Conv App

Project Number: L10410

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/28/2011

State Status Changed: 11/28/2011

Created By: Berdetta Moore

Corresponding Filing Tracking Number:
03L10411

Filing Description:

Life insurance application used only to apply for conversions of term policies. This form will only be used by our sales agents for applications submitted electronically to our Home Office. Before the application is submitted, agents will give applicants a printed copy of the application for their review. Once the application data is verified, agents will obtain a wet signature from the applicant and send the signature page to our Home Office. A full, signed copy of the application will be included with the policy.

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 Product Name: Individual Life Conversion Application
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Company and Contact

Filing Contact Information

Berdetta Moore, Actuarial Administrative Assistant
 1817 W. Broadway
 Columbia, MO 65203
 blmoore@shelterinsurance.com
 573-214-4832 [Phone]
 573-214-6942 [FAX]

Filing Company Information

Shelter Life Insurance Company
 1817 W. Broadway Street
 Columbia, MO 65203
 (800) 743-5837 ext. [Phone]
 CoCode: 65757
 Group Code: 123
 Group Name:
 FEIN Number: 43-0740882
 State of Domicile: Missouri
 Company Type: Life and Health
 State ID Number:

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	\$50.00	11/21/2011	53940871

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	\$0.00	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/28/2011	11/28/2011

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Drop Down Answers		Yes
Form	Individual Life Conversion Application		Yes

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Form Schedule

Lead Form Number: L-968

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-968	Application/Individual Life Enrollment Conversion Form Application	Initial		51.200	L-968 AR Conversion Application.pdf



SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

Individual Life Conversion Application

Converting Term/Rider

Policy Number:

Agent Name:

Agent Number:

Applicant's Family Number:

Personal Information

1. Name: Gender: SSN:
 2. Birth Date: Age: Phone Number:
 3. Physical Address: County:
 3a. Mailing Address: County:

Coverage Information

4. Policy Number being converted: Face Amount of original policy or rider:
 4a. Conversion of:
 4b. If the full face amount is not being converted, what should be done with the balance?
 5. Plan: Specified Amount: Rate Class:
 6. Accidental Death*: AD Amount: Waiver of Monthly Deduction*:
 7. Option: New Policy Increase to UL Policy #
 8. Target Premium: Planned Premium: Planned premium after increase:

* If the Insured wants Accidental Death or Waiver of Monthly Deduction benefits and they are not included in the policy or rider converted, an application must be completed to provide evidence of insurability.

9. Payment Mode: Premium with application:
 9a. Details:

Coverage Information

4. Policy Number being converted: Face Amount of original policy or rider:
 4a. Conversion of:
 4b. If the full face amount is not being converted, what should be done with the balance?
 5. Plan: Face Amount: Rate Class:
 6. Waiver of Premium*: Accidental Death*: AD Amount:
 7. Automatic Premium Loan: Dividend Option: Mode Premium:
 8. Paid-Up Additional Insurance Rider Amount**:

* If the Insured wants Accidental Death or Waiver of Premium benefits and they are not included in the policy or rider converted, an application must be completed to provide evidence of insurability.

** Based on the amount of the Paid-Up Additional Insurance Rider, the Home Office will determine if an application is needed to provide evidence of insurability.

9. Payment Mode: Premium with application: PUA Rider Prem. Collected:
 9a. Details:

Policy Information

- 10a. Primary Beneficiary:
 10b. Contingent Beneficiary:
 10c. Payor:
 10d. Owner:
 10e. Successor Owner:

Underwriting Information

11. Have you used tobacco in any form in the last 12 months? Yes No
 12. Is the Insured now disabled? Yes No
 Details:
 Physician Information:

Signatures/Declaration

The statements and answers given on this application are true and complete to the best of my knowledge and belief.
I agree that these statements and answers will form the basis of any insurance issued on this application.

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.

Dated this _____ day of _____ at _____

 A.M.
P.M. in the city of _____ State of _____
Month Year Time

Signature of Insured

Signature of Joint Insured, if Joint Policy is converted

Signature of Owner, if other than Proposed Insured

Owner's Social Security Number

Print Name of Writing Agent

Signature of Writing Agent

Agent's Number

**Authorization for Use or Disclosure
Of Protected Health Information**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.
2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.
3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

Print Name and Date of Birth of Proposed Insured

Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Date

Print Name and Date of Birth of Spouse, If Applying

Signature of Spouse, If Applying

Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR CERTIFICATION .pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Attachment: L-968 AR Conversion Application.pdf		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: Not applicable. This is an application.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Drop Down Answers		
Comments:		
Attachment: Drop Downs - Conversion.xls		



**SHELTER
INSURANCE
COMPANIES**

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

I, Dina C. Krofta, FSA, MAAA, herby certify that we have reviewed our processes regarding Ark. Code Ann. 23-79-138, Bulletin 6-87 and Bulletin 11-88 and found them to be in compliance. We have also reviewed our procedures and are in compliance with Regulation 49 and Regulation 19§10B.

<u>Form No.</u>	<u>Name</u>	<u>Score</u>
L-968	Individual Life Conversion Application	51.2

Signed **Dina C.
Krofta**

Dina C. Krofta, FSA, MAAA
Senior Life Actuary
Shelter Life Insurance Company

Digitally signed by Dina C. Krofta
DN: cn=Dina C. Krofta, o=Shelter Life
Insurance Company, ou=Shelter Life
Insurance Company,
email=dkrofta@shelterinsurance.com,
c=US
Date: 2011.11.21 13:06:21 -06'00'



SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

Individual Life Conversion Application

Converting Term/Rider

Policy Number:

Agent Name:

Agent Number:

Applicant's Family Number:

Personal Information

1. Name: Gender: SSN:
 2. Birth Date: Age: Phone Number:
 3. Physical Address: County:
 3a. Mailing Address: County:

Coverage Information

4. Policy Number being converted: Face Amount of original policy or rider:
 4a. Conversion of:
 4b. If the full face amount is not being converted, what should be done with the balance?
 5. Plan: Specified Amount: Rate Class:
 6. Accidental Death*: AD Amount: Waiver of Monthly Deduction*:
 7. Option: New Policy Increase to UL Policy #
 8. Target Premium: Planned Premium: Planned premium after increase:

* If the Insured wants Accidental Death or Waiver of Monthly Deduction benefits and they are not included in the policy or rider converted, an application must be completed to provide evidence of insurability.

9. Payment Mode: Premium with application:
 9a. Details:

Coverage Information

4. Policy Number being converted: Face Amount of original policy or rider:
 4a. Conversion of:
 4b. If the full face amount is not being converted, what should be done with the balance?
 5. Plan: Face Amount: Rate Class:
 6. Waiver of Premium*: Accidental Death*: AD Amount:
 7. Automatic Premium Loan: Dividend Option: Mode Premium:
 8. Paid-Up Additional Insurance Rider Amount**:

* If the Insured wants Accidental Death or Waiver of Premium benefits and they are not included in the policy or rider converted, an application must be completed to provide evidence of insurability.

** Based on the amount of the Paid-Up Additional Insurance Rider, the Home Office will determine if an application is needed to provide evidence of insurability.

9. Payment Mode: Premium with application: PUA Rider Prem. Collected:
 9a. Details:

Policy Information

- 10a. Primary Beneficiary:
 10b. Contingent Beneficiary:
 10c. Payor:
 10d. Owner:
 10e. Successor Owner:

Underwriting Information

11. Have you used tobacco in any form in the last 12 months? Yes No
 12. Is the Insured now disabled? Yes No
 Details:
 Physician Information:

Signatures/Declaration

The statements and answers given on this application are true and complete to the best of my knowledge and belief.
I agree that these statements and answers will form the basis of any insurance issued on this application.

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.

Dated this _____ day of _____ at _____

 A.M.
P.M. in the city of _____ State of _____
Month Year Time

Signature of Insured

Signature of Joint Insured, if Joint Policy is converted

Signature of Owner, if other than Proposed Insured

Owner's Social Security Number

Print Name of Writing Agent

Signature of Writing Agent

Agent's Number

**Authorization for Use or Disclosure
Of Protected Health Information**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.
2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.
3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

Print Name and Date of Birth of Proposed Insured

Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Date

Print Name and Date of Birth of Spouse, If Applying

Signature of Spouse, If Applying

Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
when application is written.

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Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

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