

SERFF Tracking Number: AMLC-126940167 State: Arkansas
Filing Company: Liberty National Life Insurance Company State Tracking Number: 47864
Company Tracking Number: A273AR - APPLICATION FOR CANCER POLICY
TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only
Product Name: Application for Cancer Policy
Project Name/Number: Application for Cancer Policy/A273AR

Filing at a Glance

Company: Liberty National Life Insurance Company

Product Name: Application for Cancer Policy SERFF Tr Num: AMLC-126940167 State: Arkansas

TOI: H071 Individual Health - Specified Disease - Limited Benefit SERFF Status: Closed-Approved- Closed State Tr Num: 47864

Sub-TOI: H071.002A Dread Disease - Cancer Only Co Tr Num: A273AR - APPLICATION FOR CANCER POLICY State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Pattie Church, Donna Kennedy

Disposition Date: 02/15/2011

Date Submitted: 02/02/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Application for Cancer Policy

Project Number: A273AR

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 01/26/2011

Domicile Status Comments: This form was approved in Nebraska, our state of domicile, on 1/26/11

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 02/15/2011

State Status Changed: 02/15/2011

Deemer Date:

Submitted By: Donna Kennedy

Filing Description:

Created By: Donna Kennedy

Corresponding Filing Tracking Number:

Re: Form A273AR – Application for Cancer Policy

Liberty National Life Insurance Company FEIN: 63-0124600

NAIC Company Code and Group Number: 65331/0290

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Enclosed for your review and approval is a copy of the above referenced form. This form is new and will replace form LCANLS-AP(03) previously approved by your Department on 11/04/09. This form was approved in Nebraska, our state of domicile, on 1/26/11.

Form A273AR is an application designed for use with our Lump Sum Cancer Policy, Form LCANLS-2, approved by your Department on 11/04/09. This plan is marketed through our Branch Agency distribution systems.

To the best of our knowledge and belief this form complies with the laws and regulations of your state. This form does not contain any language that is unusual in terms of normal company or industry standards. The Flesch score for this form is 50.

Included with this filing are transmittal documents or other documents required by your State.

Should you require additional information or if you should have any questions, please do not hesitate to contact me at 1-800-288-2722, extension 4919 or by email at regulatory@libnat.com.

Company and Contact

Filing Contact Information

Pattie Church, Compliance Analyst regulatory@libnat.com
100 Concourse Parkway 205-325-4919 [Phone]
Suite 350 205-325-2720 [FAX]
Hoover, AL 35244

Filing Company Information

Liberty National Life Insurance Company CoCode: 65331 State of Domicile: Nebraska
P.O. Box 2612 Group Code: 290 Company Type: Life and Health
Birmingham, AL 35202 Group Name: Liberty National Life State ID Number:
(205) 325-4307 ext. [Phone] FEIN Number: 63-0124600

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No

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Fee Explanation: We are paying \$50 for filing one application.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty National Life Insurance Company	\$50.00	02/02/2011	44337790

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/15/2011	02/15/2011

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Disposition

Disposition Date: 02/15/2011

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	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application for Cancer Policy	Approved-Closed	Yes

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Form Schedule

Lead Form Number: A273AR

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/15/2011	A273AR	Application/ Enrollment Form Application for Cancer Policy	Initial		50.000	A273AR.pdf

LIBERTY NATIONAL LIFE INSURANCE COMPANY

A Nebraska Stock Company
Application for: Cancer Policy

IF PD MODE SELECTED, COMPLETE THIS SECTION:			
Franchise Number	Employment Date MM YY	Cafeteria Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Requested Effective Date MM DD YY
Payroll Deduction Frequency:	1. <input type="checkbox"/> Weekly 2. <input type="checkbox"/> Bi-Weekly	3. <input type="checkbox"/> Semi-Monthly 4. <input type="checkbox"/> Monthly	

MODE: A SA Q GA
 BB (Attach Authorization) PD (Attach Authorization if required)
 WD LNL Emp.# _____

Client Number		Mailing Address		Apt. #	City
Branch	Agency	Agent Number	State	Zip	Email @
Telephone Numbers		Home: ()	Work: ()	Cell: ()	

THE PROPOSED INSURED WILL BE THE OLDER SPOUSE FOR A FAMILY PLAN

Proposed Insured	First	Middle	Last	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Age
Spouse Proposed Insured	First	Middle	Last	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Age
Child 1	First	Middle	Last			Date of Birth / /	
Child 2	First	Middle	Last			Date of Birth / /	
Child 3	First	Middle	Last			Date of Birth / /	
Child 4	First	Middle	Last			Date of Birth / /	
Child 5	First	Middle	Last			Date of Birth / /	
Child 6	First	Middle	Last			Date of Birth / /	
Child 7	First	Middle	Last			Date of Birth / /	
Child 8	First	Middle	Last			Date of Birth / /	

Cancer Plan Desired 1. <input type="checkbox"/> Cash Cancer 2. <input type="checkbox"/> _____ Type of Coverage 1. Individual <input type="checkbox"/> 1. 2. Single Parent <input type="checkbox"/> 2. 3. Family <input type="checkbox"/> 3.	Amount Collected for Cancer Coverage \$	Amount	1 Unit \$10,000	2 Units \$20,000	3 Units \$30,000	4 Units \$40,000	5 Units \$50,000
		Individual	<input type="checkbox"/> 1A.	<input type="checkbox"/> 2A.	<input type="checkbox"/> 3A.	<input type="checkbox"/> 4A.	<input type="checkbox"/> 5A.
		Single Parent	<input type="checkbox"/> 1B.	<input type="checkbox"/> 2B.	<input type="checkbox"/> 3B.	<input type="checkbox"/> 4B.	<input type="checkbox"/> 5B.
		Family	<input type="checkbox"/> 1C.	<input type="checkbox"/> 2C.	<input type="checkbox"/> 3C.	<input type="checkbox"/> 4C.	<input type="checkbox"/> 5C.

A. Is the insurance applied for intended to replace or change any coverage now in force with this or any other company? If "Yes," comply with the applicable Replacement Regulation or Rule. Old LNL Policy# _____ **Yes No**
 A

B. A recorded phone interview may be necessary as part of the underwriting of this application.

The most convenient time and place for the phone interview is:

Preferred Phone: Home Work Cell Preferred Time: 8AM-NOON NOON-6PM 6PM-9PM

(Application Continued)

A273AR

0111

RECEIPT (not to be detached unless premium deposit collected)

We have received from _____ the sum of \$ _____ as a deposit on an application (detached herefrom and bearing the same date as this receipt) for a cancer policy. This payment is made and accepted subject to the conditions set out on the back of this receipt.

PLEASE READ THESE CONDITIONS CAREFULLY. ALL PREMIUM DEPOSIT CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

THE HOME OFFICE MAY CALL YOU TO VERIFY APPLICATION INFORMATION

Branch No. _____ Agency No. _____ By (Agent) _____

Dated at _____, State of _____, Date _____, 20_____.

Unless you receive a policy or your money is refunded within 60 days from the date of this receipt, please notify the Company, (Liberty National Life, P.O. Box 2612, Birmingham, Alabama 35202) giving the amount paid, date of payment, and the name of the Agent shown above.

A273AR

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If the answer to any question (1-3) is "YES", the proposed insured is not eligible for coverage.

1. Has the Proposed Insured or any family member to be covered under this policy ever been diagnosed or treated by a physician for internal or skin cancer, leukemia, Hodgkin's disease, melanoma, malignant growth or premalignant lesions?

Primary Insured YES/NO	Spouse YES/NO	Child1 YES/NO	Child2 YES/NO	Child3 YES/NO	Child4 YES/NO	Child5 YES/NO	Child6 YES/NO	Child7 YES/NO	Child8 YES/NO
1. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>								

2. Has the Proposed Insured or any family member to be covered under this policy ever been treated for, diagnosed, or tested positive as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or immune deficiency related disorders or tested positive for antibodies to the AIDS (HIV) virus?

Primary Insured YES/NO	Spouse YES/NO	Child1 YES/NO	Child2 YES/NO	Child3 YES/NO	Child4 YES/NO	Child5 YES/NO	Child6 YES/NO	Child7 YES/NO	Child8 YES/NO
2. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>								

3. Is any person to be insured under this policy awaiting medical test results, or within the past two years has any person to be insured been advised by a physician to have medical tests, examinations or surgery which has not yet been performed?

Primary Insured YES/NO	Spouse YES/NO	Child1 YES/NO	Child2 YES/NO	Child3 YES/NO	Child4 YES/NO	Child5 YES/NO	Child6 YES/NO	Child7 YES/NO	Child8 YES/NO
3. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>								

4. Is any person(s) to be insured under this policy presently covered by a Liberty National lump sum Cash Cancer Policy?..... YES NO 4.

I hereby declare that the statements recorded herein are true and complete with respect to any proposed insured. I agree that: (1) subject to the terms of the conditional receipt, if applicable, no coverage will be effective until a policy is delivered to the Proposed Insured, and unless on the date of such delivery, each proposed insured is alive and his/her health remains as stated in the application; (2) no agent has authority to accept risks on behalf of the Company or make or change contracts or waive the Company's rights or requirements; (3) receipt of the outline of coverage, if required by my state, is hereby acknowledged; (4) the policy has pre-existing condition limitations. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the proposed insured.

I understand that no benefits are payable for a diagnosis of cancer or if symptoms of cancer are manifested in the first 30 days after the effective date of this policy.

IMPORTANT NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have paid to the agent the sum of \$ _____ .

_____ Date _____ Application State _____ Signature of Applicant _____ 0111

AGENT'S STATEMENT

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 1. Do you have any reason to believe that any response to the health questions is not accurate?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any knowledge or reason to believe that the insurance applied for herein may be to replace or change existing insurance coverage with this or any other company?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Was the application signed in your presence?..... | <input type="checkbox"/> | <input type="checkbox"/> |

_____ Signed _____, Agent
Print or Type Agent's Name

If on the date of application the proposed insured(s) are alive and are risks acceptable to the Company under its rules, limits and standards for the plan applied for, then the insurance applied for will take effect on the date of the application. Unless the Company has declined to issue the insurance applied for, the insurance provided under this receipt will continue in force until the earliest of: (a) the expiration of the period covered by the payments received for herein; or (b) the issuance of the policy applied for, or (c) the expiration of 60 days. If the application is accepted and a policy issued, the premium deposit will be applied toward payment of the premium thereon. If the Company declines to issue any policy applied for, the amount of the premium deposit for such policy will be returned to the applicant. No insurance will become effective unless the application to which this receipt is attached is received by the Company at its home office.

No agent has authority to accept risks on behalf of the Company or make or change contracts or waive the Company's rights or requirements. This receipt is issued on the condition that any check, draft or other order for payment of money be honored when it is first presented. This receipt is not transferable and will not be valid for any purpose if any erasures or alterations have been made in the printed form.

Only the information which the applicant has given in the answers to the questions on the application, or contained in the Company's records will be used to evaluate the eligibility for this insurance. This information will not be disclosed to any other company or person without written authorization.

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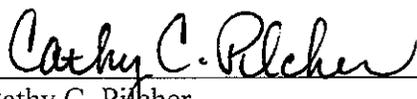
Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: See Attached Attachment: AR Readability Certification for A273AR.pdf	Approved-Closed	02/15/2011
Bypassed - Item: Application Bypass Reason: See Forms Section the application is being filed for approval. Comments:	Approved-Closed	02/15/2011
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A - This is an application filing. Comments:	Approved-Closed	02/15/2011
Bypassed - Item: Outline of Coverage Bypass Reason: N/A - this is an application filing only. Comments:	Approved-Closed	02/15/2011

STATE OF ARKANSAS
READABILITY CERTIFICATION

<u>FORM NO.</u>	<u>DESCRIPTION</u>	<u>SCORE</u>	<u>SCORED SEPARATELY</u>
A273AR	Application for Cancer Policy	50	X

This is to certify that the above listed forms have achieved the Flesch Ease Score indicated, and that to the best of my knowledge and belief comply with the requirements to **Ark. Stat. Ann. Sec. 66-3251** through **66.3258**, cited as the Life and Disability Insurance Policy Language Simplification Act.



Cathy C. Pilcher
Second Vice President, Compliance
Liberty National Life Insurance Company

2-2-11
Date