

<i>SERFF Tracking Number:</i>	<i>SHLI-127037994</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shelter Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48002</i>
<i>Company Tracking Number:</i>	<i>03L10111</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.203 Specified Age or Duration - Single Premium - Single Life</i>
<i>Product Name:</i>	<i>Jr. Special Application</i>		
<i>Project Name/Number:</i>	<i>Jrsp E-App/L10111</i>		

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: Jr. Special Application

TOI: L04I Individual Life - Term

SERFF Tr Num: SHLI-127037994 State: Arkansas

SERFF Status: Closed-Approved-Closed
State Tr Num: 48002

Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life

Co Tr Num: 03L10111

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Dina Krofta, Berdetta Moore

Disposition Date: 02/23/2011

Date Submitted: 02/16/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Jrsp E-App

Project Number: L10111

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: 02/23/2011

State Status Changed: 02/23/2011

Created By: Berdetta Moore

Corresponding Filing Tracking Number:
03L10111

Filing Description:

Form L-962 is our application for our Junior Special Life Insurance policy. 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.

SERFF Tracking Number: SHLI-127037994 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 48002
 Company Tracking Number: 03LI0111
 TOI: L04I Individual Life - Term Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life
 Product Name: Jr. Special Application
 Project Name/Number: Jrsp E-App/LI0111

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$0.00
 Retaliatory? Yes
 Fee Explanation: \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	\$50.00	02/16/2011	44760662

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/23/2011	02/23/2011

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TOI: L04I Individual Life - Term Sub-TOI: L04I.203 Specified Age or Duration - Single
Premium - Single Life
Product Name: Jr. Special Application
Project Name/Number: Jrsp E-App/L10111

Disposition

Disposition Date: 02/23/2011

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		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Drop Down Answers		Yes
Form	Individual Life Insurance Application		Yes

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Form Schedule

Lead Form Number: L-962

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-962	Application/ Individual Life Enrollment Insurance Application Form	Initial		50.400	L-962.pdf



Personal Information

1. Name: _____ Gender: _____ SSN: _____
 2. Physical Address: _____ County: _____
 3. Phone Number: _____ Best Time to Contact: _____
 4. Birth Date: _____ Age: _____ US Citizen or Permanent Resident: Yes No

Policy Information

5. Face Amount: _____
 6. Payment Mode: _____ Premium Attached: _____
 6a. Details: _____
 7. Primary Beneficiary: _____
 Contingent Beneficiary: _____
 Payor: _____
 Owner: _____
 Successor Owner: _____

Existing Insurance Information

8. Total individual life insurance in force or pending (excluding this application):
 With Shelter Life: _____ With Other Companies: _____
 9. Do you have existing life insurance policies or contracts? Yes No
 If yes, please send Replacement Form L-243.29 with this application.
 10. Will this application replace an existing policy or contract? Yes No
 If yes, please send Replacement Form L-243.33 with this application.

Underwriting and Medical Information

11. Does the proposed insured have a heart or circulatory disease or disorder? Yes No
 Details: _____
 Physician Information: _____
 12. Does the proposed insured have a birth defect or mental abnormality? Yes No
 Details: _____
 Physician Information: _____
 13. Does the proposed insured have a chronic illness or condition which requires ongoing care or treatment? Yes No
 Details: _____
 Physician Information: _____

If any questions 11-13 are answered Yes, then attach a signed Authorization for Use or Disclosure of Protected Health Information.

Signatures/Declaration

The Owner declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

- (a) this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;
- (b) any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;
- (c) only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;
- (d) no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and
- (e) except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
 - (1) a policy is delivered to the Owner during the lifetime of the person proposed for insurance; and
 - (2) to the best of the Owner's knowledge there has been no material change in the answers herein since the date of this application of the completion of all medical examination requirements.

The Owner declares that the Conditional Coverage Receipt has been detached from this application and given to him or her.

Yes No

This application is a legal document. The policy may be altered or rescinded if the questions are not answered correctly and truthfully.

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.

Signature of Owner (Parent Grandparent Legal Guardian)

(Print Name of Owner)

(Date)

(Owner's Social Security Number)

(Owner's Address - List only if other than listed in question 2)

I hereby certify that I personally asked every question of the Owner and accurately recorded the answers given and that I witnessed the signature above.

(Signature of Writing Agent)

(Print Name of Writing Agent)

(Agent 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, 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.
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.
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.

Signature of Parent or Legal Guardian

Print Name of Parent or Legal Guardian

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
or Owner **ONLY IF** premium is collected with application.

Conditional Coverage Receipt

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER
UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount \$ _____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West
Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount \$ _____

by _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE
CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do
not accept, the payment will be returned.

PAYMENT BY CREDIT OR DEBIT CARD - Payment will be charged to your card on the date and time of the application. If
Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not
accept, the payment will be returned by company check.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a
required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions
are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom
coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the
policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we
deliver your policy while all persons in the application are alive; (2) to the best of your knowledge there has been no material
change in your answers on the application since the application date; and (3) you have paid any additional premium and/or
signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be
insured under the policy applied for prior to delivery will not exceed the lesser of: (a) \$250,000, including accidental death
benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF
THIS RECEIPT.

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<i>Company Tracking Number:</i>	<i>03LI0111</i>		
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<i>Product Name:</i>	<i>Jr. Special Application</i>		
<i>Project Name/Number:</i>	<i>Jrsp E-App/LI0111</i>		

Supporting Document Schedules

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

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Attachment:		
L-962.pdf		

	Item Status:	Status Date:
Satisfied - Item: Drop Down Answers		
Comments:		
Attachment:		
Drop Downs - Jr Spec.pdf		



**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-962	Jr. Special Application	50.4

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



SHELTER LIFE INSURANCE COMPANY
 1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

Owner's Family # _____

**APPLICATION FOR LIFE INSURANCE
 JUNIOR SPECIAL**

Personal Information

1. Name: _____ Gender: _____ SSN: _____
 2. Physical Address: _____ County: _____
 3. Phone Number: _____ Best Time to Contact: _____
 4. Birth Date: _____ Age: _____ US Citizen or Permanent Resident: Yes No

Policy Information

5. Face Amount: _____
 6. Payment Mode: _____ Premium Attached: _____
 6a. Details: _____
 7. Primary Beneficiary: _____
 Contingent Beneficiary: _____
 Payor: _____
 Owner: _____
 Successor Owner: _____

Existing Insurance Information

8. Total individual life insurance in force or pending (excluding this application):
 With Shelter Life: _____ With Other Companies: _____
 9. Do you have existing life insurance policies or contracts? Yes No
 If yes, please send Replacement Form L-243.29 with this application.
 10. Will this application replace an existing policy or contract? Yes No
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Underwriting and Medical Information

11. Does the proposed insured have a heart or circulatory disease or disorder? Yes No
 Details: _____
 Physician Information: _____
 12. Does the proposed insured have a birth defect or mental abnormality? Yes No
 Details: _____
 Physician Information: _____
 13. Does the proposed insured have a chronic illness or condition which requires ongoing care or treatment? Yes No
 Details: _____
 Physician Information: _____

If any questions 11-13 are answered Yes, then attach a signed Authorization for Use or Disclosure of Protected Health Information.

Signatures/Declaration

The Owner declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

- (a) this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;
- (b) any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;
- (c) only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;
- (d) no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and
- (e) except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
 - (1) a policy is delivered to the Owner during the lifetime of the person proposed for insurance; and
 - (2) to the best of the Owner's knowledge there has been no material change in the answers herein since the date of this application of the completion of all medical examination requirements.

The Owner declares that the Conditional Coverage Receipt has been detached from this application and given to him or her.

Yes No

This application is a legal document. The policy may be altered or rescinded if the questions are not answered correctly and truthfully.

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.

Signature of Owner (Parent Grandparent Legal Guardian)

(Print Name of Owner)

(Date)

(Owner's Social Security Number)

(Owner's Address - List only if other than listed in question 2)

I hereby certify that I personally asked every question of the Owner and accurately recorded the answers given and that I witnessed the signature above.

(Signature of Writing Agent)

(Print Name of Writing Agent)

(Agent 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, 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.
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.
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.

Signature of Parent or Legal Guardian

Print Name of Parent or Legal Guardian

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
or Owner **ONLY IF** premium is collected with application.

Conditional Coverage Receipt

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UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount \$ _____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West
Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount \$ _____

by _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE
CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do
not accept, the payment will be returned.

PAYMENT BY CREDIT OR DEBIT CARD - Payment will be charged to your card on the date and time of the application. If
Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not
accept, the payment will be returned by company check.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a
required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions
are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom
coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the
policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we
deliver your policy while all persons in the application are alive; (2) to the best of your knowledge there has been no material
change in your answers on the application since the application date; and (3) you have paid any additional premium and/or
signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be
insured under the policy applied for prior to delivery will not exceed the lesser of: (a) \$250,000, including accidental death
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NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF
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Term

Question Number	Question Description	Additional questions generated by a yes answer	Drop-down options	Misc. Notes
--	Family Number	none	none	For internal use only Family numbers are variable and will be assigned by the Home Office
--	Application Number	none	none	The application number will appear at the top of each page of the application. This number will differ for each application and will be assigned by the Home Office.
--	Relationship	if "Other" selected, will provide a text box for description	Self Spouse Child Parent Sibling Grandparent Grandchild Business Trust Other	same drop-down options for each party to contract (insured, owner, payor, primary and contingent beneficiaries, successor owner, custodian)
1	Gender	none	Male/Female	
2	State	none	List of all 50 states	
2	County	none	List of applicable counties based on state selection	
5	Face Amount	none	\$5,000 \$7,500 \$10,000 \$12,500 \$15,000 \$20,000	
6	Payment Mode	Details field if PAC, Special Billing, or Payroll Deduction selected	Annual, Semi-Annual, Quarterly, PAC (Pre-Authorized Check), Special Billing, Government Allotment, Payroll Deduction	Details will print at question #6a; this question will not appear if there are no remarks
7	Beneficiary	if "unequal shares" selected, display box for percent of proceeds to each named beneficiary if "other" selected, display text box for instructions	Equally or to Survivor(s) Equally Per Stirpes Equally Per Capita Unequally Other	options appear for both primary and contingent beneficiaries
7	Contingent Beneficiary	if "unequal shares" selected, display box for percent of proceeds to each named beneficiary if "other" selected, display text box for instructions	Equally or to Survivor(s) Equally Per Stirpes Equally Per Capita Unequally Other	If none selected, will print "none" on the application.
9	Replacement	Company drop-down*, company name, policy number, face amount, reason for replacement	*Shelter or other; if other, then will provide text box for name of company	info from this question will also populate the replacement form
10	Heart/cirulatory disease	Details and physician information	none	
11	Birth defect/mental abnormality	Details and physician information	none	
12	Chronic illness or condition	Details and physician information	none	