

SERFF Tracking Number: ASWX-G126992930 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 47742
Company Tracking Number: G126992930
TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other
Product Name: ASC (Voluntary Products)
Project Name/Number: ASC (Voluntary Products)/AR01353FI00016

Filing at a Glance

Company: Time Insurance Company

Product Name: ASC (Voluntary Products)

SERFF Tr Num: ASWX-
G126992930

State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-
Closed

State Tr Num: 47742

Sub-TOI: L04I.500 Other

Co Tr Num: G126992930

State Status: Approved-Closed

Filing Type: Form

Author: SPI
AssurantHealthandEmployeeBenef

Reviewer(s): Linda Bird

Disposition Date: 03/03/2011

Date Submitted: 01/19/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: 02/16/2011

Implementation Date:

State Filing Description:

General Information

Project Name: ASC (Voluntary Products)

Project Number: AR01353FI00016

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: SPI AssurantHealthandEmployeeBenef

Filing Description:

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)

Application for Term Life Insurance: 30500-AR

Dear Sir or Madam:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 03/03/2011

State Status Changed: 03/03/2011

Created By: SPI

AssurantHealthandEmployeeBenef

Corresponding Filing Tracking Number:

The above-referenced form is submitted for your review seeking approval. The form is being filed for general use to market term life insurance to individuals by independent agents licensed in your state.

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This form is subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Please see the enclosed Statement of Variability for additional information on form adaptability.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168

Company and Contact

Filing Contact Information

Katie Porter, Administrative Assistant II
501 W. Michigan St. 800-800-1212 [Phone]
Milwaukee, WI 53203 414-299-6168 [FAX]

Filing Company Information

Time Insurance Company CoCode: 69477 State of Domicile: Wisconsin
501 W. Michigan St. Group Code: 19 Company Type:
Milwaukee, WI 53203 Group Name: State ID Number:
(800) 800-1212 ext. [Phone] FEIN Number: 39-0658730

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	\$20.00	01/19/2011	43903121
Time Insurance Company	\$30.00	01/21/2011	43982656

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/03/2011	03/03/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	01/21/2011	01/21/2011			

SERFF Tracking Number: ASWX-G126992930 *State:* Arkansas
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Product Name: ASC (Voluntary Products)
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Disposition

Disposition Date: 03/03/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ASWX-G126992930 *State:* Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Life & Annuity - Acturial Memo	No	No
Supporting Document	Flesch Certification	No	No
Supporting Document	Application	Yes	Yes
Supporting Document	Cover Letter	Yes	Yes
Form	Application	Yes	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 01/21/2011
Submitted Date 01/21/2011
Respond By Date 02/21/2011

Dear Katie Porter,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Regulation 57 was revised effective January 2010, the filing is now \$50.00 per form. We will hold your filing in a pending status until the additional \$30.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Form Schedule

Lead Form Number: 30500-AR

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	30500-AR	Application/ Enrollment Form	Initial		0.000	30500-AR (FINAL 1_2011).PDF

**[Term Life][with][Critical Illness]
[Accelerated Benefits] Application]**

Time Insurance Company
[P.O. Box 624]
[501 West Michigan]
[Milwaukee, WI 53203][1][-0624]
[PLEASE PRINT IN BLACK INK]

PERSON(S) TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed below.
[Label additional dependents starting with the letter "E" and after.]

	Last Name	First Name	MI	Sex	Birthdate (MM/DD/YY)	[State of Birth]	[Social Security Number]
1. Primary							[]
[2.]Spouse[/Domestic Partner][/Civil Union]						[]	[]
[3.] [Dependents (List Relationship Below)]	[Last Name	First Name	MI]	[Sex]	[Birthdate: (MM/DD/YY)]	[Full time student?]	[Social Security Number]
[A.] []	[]	[]	[]	[]	[]	[]	[]
[B.] []	[]	[]	[]	[]	[]	[]	[]
[C.] []	[]	[]	[]	[]	[]	[]	[]
[D.] []	[]	[]	[]	[]	[]	[]	[]

[4.][Resident Address: _____]
(No P.O. Boxes) (Street) (City) (State) (Zip)

[5.][Phone Number: (____) _____] [6.][Email Address: _____]
[By providing your email address you agree that you may receive your policy[and][/][or][other policy correspondence] electronically.]

[7[a.]] [Work Number: (____) _____] [7[b.]] [Other Phone Number: (____) _____]

[8.][Are][Is][any of] the proposed insured[s] covered by, or has application been made for any type of [medical][,][or][,][life][,][or][critical illness][,][or][any other type of supplemental] insurance? Yes No]
[If "Yes", complete the section below.]

[Proposed Insured's Name]	[Insurance Company Name]	[Group or Individual]	[Type of Coverage]	[Effective Date (MM/DD/YY)]	[Termination Date (MM/DD/YY)]	[Is this coverage being replaced by proposed coverage?]

[9][a.]] [Primary Insured Occupation: _____][Industry: _____]

[Company Name: _____ [Work Number: (____) _____]

[Duties: _____]

[Is the Primary Insured [Self-Employed][or][a sole proprietor]? Yes No]

[Is the Primary Insured covered by Workers' Compensation? Yes No]

[9][b.]] [Spouse[/Domestic Partner][/Civil Union] Occupation: _____]

[Industry: _____]

[Company Name: _____ [Work Number: (____) _____]

[Duties: _____]

[Is the Spouse[/Domestic Partner][/Civil Union] [Self-Employed][or][a sole proprietor]? Yes No]

[Is the Spouse[/Domestic Partner][/Civil Union] Insured covered by Workers' Compensation? Yes No]

[FAX ALL PAGES[EXCEPT "IMPORTANT NOTICES"] TO [414-299-6020]]

Assurant Health [501 West Michigan],[P.O. Box 624] Milwaukee, WI 53203][1][-0624]
Assurant Health is the brand name for products underwritten and issued by Time Insurance Company

[REQUESTED EFFECTIVE DATE]

[10.] [Requested effective date: _____]

[HEALTH STATEMENT]

[[11.]Build]

	Height	Weight
Primary Insured		
Spouse [/Domestic Partner] [/Civil Union]		

[Primary Insured] [Spouse] [/Domestic Partner] [/Civil Union] [A.] [B.] [C.] [D.] [Enter dependent information in the same order as page 1.]

[[12.]Has any proposed adult insured used tobacco products in any form or nicotine substitutes within the last 12 months?] [Yes] [No]

[[13.]Have any of the proposed insureds been declined, postponed or rescinded for critical illness [or][life] insurance?] [Yes] [No]

[Note: The plan cannot be issued to any person who answers YES to any of the following questions.]

[[14.] Have more than one of your natural parents or siblings been diagnosed with the same condition(s) before age 60 based on the following list? [Yes] [No]

- [Alzheimer's Disease]
- [Diabetes]
- [Cardiovascular Disease]
- [Cerebrovascular Disease][/][Stroke]
- [Cancer]

[[15.]In the last [12-24] months, has any proposed insured: [Yes]

- [been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed?] [No]
- [had any testing with abnormal findings?]
- [had tests for which you have not received results?]
- [had any unexplained: weight loss, anemia, fatigue, chest pain, shortness of breath, palpitations, chronic cough, gastrointestinal bleeding, lumps in the breast, tumors/growths, dizziness or loss of consciousness?]
- [been totally and permanently disabled and/or receiving long-term disability benefits?]

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Assurant Health [501 West Michigan,][P.O. Box 624] Milwaukee, WI 53203[1][1]-0624
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HEALTH STATEMENT (CONTINUED) [Enter information for all person(s) to be insured in the same order as page 1.]

[Answer this question if applying for coverage:]

[[16.][a.][For any of the following conditions [within the last [5-10] years],
have you [or any person to be insured] [ever] received any abnormal
test results or medical or surgical treatment, or consulted
a health care professional, or taken medication for:

[Yes]
[No]
[Not Asked]

- [Heart disorder][, excluding][Mitral Valve Prolapse (MVP)][or][surgically corrected or closed][Atrial Septal Defect (ASD)][/][Ventricular Septal Defect (VSD)]
- [Stroke][or][Brain Aneurysm]
- [Peripheral Vascular Disease (PVD)][or] [Peripheral Arterial Disease (PAD)]
- [Crohn's Disease][or] [Ulcerative Colitis]
- [Liver disorders][,][excluding fully recovered Hepatitis A]
- [Kidney disorders][, excluding kidney stones]
- [Emphysema][,][or][Chronic Obstructive Pulmonary Disease (COPD)][,][or][Fibrotic Lung Disease][or] [Primary Pulmonary Hypertension]
- [Coronary Artery Disease]
- [Blood disorders]
- [Transient Ischemic Attack (TIA)]
- [Nervous System and/or Cognitive Disorders]
- [Systemic Lupus Erythematosus (SLE)]
- [Diabetes][, excluding Gestational Diabetes]
- [Basal Cell Carcinoma with recommended surgery that has not been completed]
- [Cancer][or][Tumor]
- [Alcoholism][,][or][Alcohol or Chemical Dependency][,][or][Drug or Alcohol Abuse]
- [Acquired Immune Deficiency Syndrome (AIDS)][or] [tested positive for Human Immunodeficiency Virus (HIV)]
- [Multiple Sclerosis (MS)]
- [Tuberculosis (TB)]
- [Any condition that resulted in a surgery or procedure whose purpose is to promote weight-loss]
- [Autism Spectrum Disorders][,][or][Autism][,][or] [Asperger's Disorder][,][or][Rett's Syndrome][,][or] [Pervasive Developmental Disorders][,][or] [Pervasive Developmental Delay]]
- [Organ][or][Stem Cell Transplants]
- [Permanent or progressive loss of vision or hearing]]

[Answer this question if applying for this coverage with a Health Access product:]

[[16.][b.][For any of the following conditions [within the last [5-10] years],
have you or [any person to be insured] [ever] received any abnormal
test results or medical or surgical treatment, or consulted
a health care professional, or taken medication for:

[Yes]
[No]
[Not Asked]

- [Heart disorder][, excluding][Mitral Valve Prolapse (MVP)][or][surgically corrected or closed][Atrial Septal Defect (ASD)][/][Ventricular Septal Defect (VSD)]
- [Stroke][or][Brain Aneurysm]
- [Peripheral Vascular Disease (PVD)][or] [Peripheral Arterial Disease (PAD)]
- [Crohn's Disease][or] [Ulcerative Colitis]
- [Liver disorders][,][excluding fully recovered Hepatitis A]
- [Kidney disorders][, excluding kidney stones]
- [Emphysema][,][or][Chronic Obstructive Pulmonary Disease (COPD)][,][or][Fibrotic Lung Disease][or] [Primary Pulmonary Hypertension]
- [Coronary Artery Disease]
- [Blood disorders]
- [Transient Ischemic Attack (TIA)]
- [Nervous System and/or Cognitive Disorders]
- [Systemic Lupus Erythematosus (SLE)]
- [Diabetes][, excluding Gestational Diabetes]
- [Basal Cell Carcinoma with recommended surgery that has not been completed]
- [Cancer][or][Tumor]
- [Alcoholism][,][or][Alcohol or Chemical Dependency][,][or][Drug or Alcohol Abuse]
- [Acquired Immune Deficiency Syndrome (AIDS)][or] [tested positive for Human Immunodeficiency Virus (HIV)]
- [Multiple Sclerosis (MS)]
- [Tuberculosis (TB)]
- [Any condition that resulted in a surgery or procedure whose purpose is to promote weight-loss]
- [Autism Spectrum Disorders][,][or][Autism][,][or] [Asperger's Disorder][,][or][Rett's Syndrome][,][or] [Pervasive Developmental Disorders][,][or] [Pervasive Developmental Delay]]
- [Organ][or][Stem Cell Transplants]
- [Permanent or progressive loss of vision or hearing]]

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Assurant Health [501 West Michigan,][P.O. Box 624] Milwaukee, WI 53203][1]-0624
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[

[ADDITIONAL[MEDICAL] DETAILS]

]

[FAX ALL PAGES[EXCEPT "IMPORTANT NOTICES"] TO [414-299-6020]]

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[BENEFICIARY DESIGNATION]

[The Policyholder may designate one or more Beneficiaries. Any benefits payable to Beneficiaries will be divided equally among all surviving named Beneficiaries unless a percentage is specified or otherwise required by law.]

Beneficiary Name (Last, First, MI)	(Street)	(City)	(State)	(ZIP)	(Percent)
					[]
					[]
					[]
					[]

[AUTHORIZATIONS]

[My[enrollment form][,] [recorded Authorizations][,] [recorded personal health history] [and any amendments] shall be the basis for the contract.]

[I understand the insurance plan is subject to underwriting.] [The insurance[, if approved by Time Insurance Company,] will be in force only when issued by Time Insurance Company.] [The effective date is assigned by Time Insurance Company.] [The first full premium must be paid.] [A change in the [eligibility] [health] of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company.] [I understand and agree that any information I provide through this enrollment process may be shared with persons necessary to facilitate issuing this plan, including but not limited to my agent or broker.] [If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of this plan and the full extent of its liability shall be limited to the sum received.]

[I agree that a photocopy of this authorization shall be valid for [two] [year[s]] from the date signed.]

[[In order to determine my (our) eligibility for insurance,] I hereby authorize any health care provider or medically related facility, pharmacy[, pharmacy benefit manager] or pharmacy related facility, [MIB, Inc.,] [(“MIB”)] [formerly known as the Medical Information Bureau] [,] consumer reporting agency, insurance or reinsurance company or employer having information about me [or my minor children] to provide all such information[including information regarding [employment,] [other insurance coverage,] [personal information,] [medical or pharmacy care, advice, treatment, or medication use]] as may be requested to Time Insurance Company [(or any consumer reporting agency authorized by Time Insurance Company)], its legal representative or any medical records retrieval service Time Insurance Company may engage[,] including, but not limited to, [Examination Management Services, Inc.] [(EMSI),] [and its agents]] [.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, Human Immunodeficiency Virus (HIV) testing and treatment, sexually transmitted disease (STD) testing and treatment, sickle cell testing and treatment, prescription history, lab data and electrocardiograms (EKGs). This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me [and/or my minor children] [or for Time Insurance Company’s underwriting or risk rating determinations.] If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, [P.O. Box 3050][,] [501 West Michigan] [,] [Milwaukee, WI 53203] [1][]-3050]. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[FAX ALL PAGES[EXCEPT “IMPORTANT NOTICES”] TO [414-299-6020]]

Assurant Health [501 West Michigan,]P.O. Box 624 Milwaukee, WI 53203[1][]-0624
Assurant Health is the brand name for products underwritten and issued by Time Insurance Company

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

[I acknowledge receiving the notification regarding [MIB, Inc.] [("MIB")] [and] [the Abbreviated Notice of Insurance Information Practices [and] [the Outline of Coverage for this plan][,][if required].]

[I acknowledge that I have read the completed enrollment form. I attest that all statements and answers on this enrollment form are complete, true and correct. I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form, recorded Authorizations, recorded personal health history and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

[Signature of Primary Proposed Insured]

[Signature of Spouse[/Domestic Partner][/Civil Union] or Other *(if proposed to be insured)*]

[Signature of Other Dependent(s) 18 or Over] *[(if proposed to be insured)]*

[Premium Amount Sent: \$ _____]

Date and Time signed (including a.m./p.m.)

City and State Signed in

[Attention: (Agent)]

I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of my knowledge, there

IS IS NOT

a replacement of [medical][,][or][life] [or][critical illness] insurance involved in this transaction.

Licensed Resident Agent's Signature

Print Agent's Name

_____ Initial here if you witnessed the signing of this form by the proposed insured.]

[FAX ALL PAGES[EXCEPT "IMPORTANT NOTICES"] TO [414-299-6020]]

Assurant Health [501 West Michigan,][P.O. Box 624] Milwaukee, WI 53203[3][1][-0624]
Assurant Health is the brand name for products underwritten and issued by Time Insurance Company

[ARE YOU AN EXISTING CUSTOMER?]

[POLICY # _____]

[What do you want to do?]

[Add Dependent]

[Policy/Benefit Change to an Existing Policy]

[List type of change requested: _____]

[Reinstatement of this plan]

[Internal Replacement]

[Conversion (over-age dependent/divorce)]

[AGENT/AGENCY INFORMATION]

Agent Name: _____

Agent Number: _____

Key Agency Contact: _____

Phone Number: _____ [Fax Number: _____]

E-mail address: _____

Agency Name: _____

Agency Number: _____

[Policy should be mailed to: Agent] [Agency] [Policyholder]

[FAX ALL PAGES[EXCEPT "IMPORTANT NOTICES"] TO [414-299-6020]]

Assurant Health [501 West Michigan,][P.O. Box 624] Milwaukee, WI 53203[1]1[-0624]
Assurant Health is the brand name for products underwritten and issued by Time Insurance Company

IMPORTANT NOTICES - LEAVE WITH CUSTOMER

[NOTIFICATION REGARDING [MIB, Inc. [(“MIB”)] formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers 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].

Time 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].]

[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, [Underwriting Department,][501 West Michigan, Milwaukee, Wisconsin, 53203.]]

[FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.]

[PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]]

LEAVE THIS PAGE WITH THE CUSTOMER DO NOT FAX

Assurant Health [501 West Michigan,][P.O. Box 624] Milwaukee, WI 53203][1][-0624]
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(New 1/2011)

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TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other
Product Name: ASC (Voluntary Products)
Project Name/Number: ASC (Voluntary Products)/AR01353FI00016

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: Please see form schedule.		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment: Cover Letter.PDF		



ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

January 19, 2011

www.assurant.com

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, AR 72201

RE: **TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)**
Application for Term Life Insurance: 30500-AR

Dear Sir or Madam:

The above-referenced form is submitted for your review seeking approval. The form is being filed for general use to market term life insurance to individuals by independent agents licensed in your state.

This form is subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Please see the enclosed Statement of Variability for additional information on form adaptability.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168