

SERFF Tracking Number: CAKN-127013804 State: Arkansas  
Filing Company: Catholic Financial Life State Tracking Number: 48303  
Company Tracking Number: CNO 111  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Reinstatement application  
Project Name/Number: REIN APP/CNO-111

## Filing at a Glance

Company: Catholic Financial Life

Product Name: Reinstatement application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: CAKN-127013804 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 48303

Co Tr Num: CNO 111

State Status: Approved-Closed

Reviewer(s): Linda Bird

Author: Donna Peterson

Disposition Date: 03/23/2011

Date Submitted: 03/22/2011

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: REIN APP

Project Number: CNO-111

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/08/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 03/23/2011

State Status Changed: 03/23/2011

Created By: Donna Peterson

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Donna Peterson

Filing Description:

Catholic Financial Life, a fraternal benefit society, is filing this reinstatement application (form 2011 REIN APP) for use with our life products.

This form will be used when reinstating a whole life, term life or universal life product. The form is in final printed format.

## Company and Contact

### Filing Contact Information

Donna Peterson,

[donna.peterson@catholicfinanciallife.org](mailto:donna.peterson@catholicfinanciallife.org)

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1100 W Wells Street 414-278-6509 [Phone]  
 Milwaukee, WI 53233

**Filing Company Information**

Catholic Financial Life CoCode: 56030 State of Domicile: Wisconsin  
 1100 West Wells Street Group Code: Company Type: Fraternal  
 Milwaukee, WI 53233 Group Name: State ID Number: 2796  
 (414) 273-6266 ext. 6509[Phone] FEIN Number: 39-0201015

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: Wisconsin, our state of domicile does not charge product filing fees.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Catholic Financial Life	\$50.00	03/22/2011	45855360

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/23/2011	03/23/2011

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## **Disposition**

Disposition Date: 03/23/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>CAKN-127013804</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Catholic Financial Life</i>	<i>State Tracking Number:</i>	<i>48303</i>
<i>Company Tracking Number:</i>	<i>CNO 111</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Reinstatement application</i>		
<i>Project Name/Number:</i>	<i>REIN APP/CNO-111</i>		

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		No
<b>Form</b>	Reinstatement Application		Yes

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## Form Schedule

### Lead Form Number: 2011 REIN APP

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	2011 REIN APP	Application/ Reinstatement Enrollment Application Form	Initial		50.100	APP REIN fld.pdf



Catholic Financial Life  
 1100 West Wells Street  
 Milwaukee, Wisconsin 53233  
 (800) 927-2547

Reinstatement for Certificate No: \_\_\_\_\_

Any other insured covered by a rider under the certificate must complete an Application for Reinstatement

**A. Insured**

Name: \_\_\_\_\_  
First Middle Initial Last

Address: \_\_\_\_\_  
Street City State Zip

Driver's License: \_\_\_\_\_ State: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Where can you be reached for additional information?

Home phone: \_\_\_\_\_ Work/cell phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

**B. INSURED MUST COMPLETE ALL QUESTIONS. ALL "YES" ANSWERS MUST BE FULLY EXPLAINED AND REFERENCED IN REMARKS.**

Has or does the insured:	Yes	No
1) a. Drink alcoholic beverages? If yes, how much per week? _____ <small>(one drink = 12 oz. beer, 4 oz. wine, or 1 oz. hard liquor) Amount _____</small>	<input type="checkbox"/>	<input type="checkbox"/>
b. Now or ever used heroin, cocaine, marijuana, or illegal, restricted or controlled substance, except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
2) a. Made within the past 5 years a claim for or received benefits compensation, or pension for any injury, sickness, disability, or impaired condition?	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 5 years been unable to work, attend school, or perform normal activities of like age and gender, or been confined at home	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you now use or have you used tobacco or nicotine in any form within the past 3 years? If yes, indicate the type of tobacco used:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> cigar <input type="checkbox"/> chewing tobacco <input type="checkbox"/> other _____		
4) Full name and complete address of personal physician; the date, reason last seen and diagnosis:		
_____		
_____		
_____		
_____		

AIDS TEST RESULTS OBTAINED AT AN ANONYMOUS COUNSELING AND TESTING SITE DESIGNATED BY THE STATE EPIDEMIOLOGIST OR AT A SIMILAR FACILITY IN ANOTHER JURISDICTION OR HOME TESTING ARE CONFIDENTIAL AND NEED NOT BE DISCLOSED. NONE OF THESE APPLICATION QUESTIONS SHOULD BE INTERPRETED AS ASKING ABOUT AIDS, UNLESS THE QUESTION SPECIFICALLY MENTIONS AIDS.

Within the past 5 years has the person insured under this certificate:	Yes	No
5) Been diagnosed or treated by a member of the medical profession for a disorder, disease or persistent discomfort of the following systems:		
a. Respiratory (lungs, bronchi, trachea, etc.) Such as, but not limited to, TB, asthma, emphysema, bronchitis, shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
b. Circulatory (heart, blood, arteries, veins, etc.) such as, but not limited to, high blood pressure, heart attack, chest pains, murmur?	<input type="checkbox"/>	<input type="checkbox"/>
c. Digestive (Throat, esophagus, stomach, intestine, liver, gall bladder, etc.) such as, but not limited to, ulcer, colitis, cirrhosis, hemorrhoids, bleeding?	<input type="checkbox"/>	<input type="checkbox"/>

POLICY DATE	POLICY NUMBER	SERIAL NO
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**C. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I UNDERSTAND that this certificate has lapsed for non-payment of premium and that reinstatement may be made only upon (1) evidence of insurability satisfactory to Catholic Financial Life, (2) upon payment of any due premium related to this certificate. I AGREE that this Application for Reinstatement shall be contestable at any time within two years from the effective date of the reinstatement.

I AUTHORIZE the following to release information about me to Catholic Financial Life or its reinsurers. Those authorized include a physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, a consumer reporting agency, and/or employers.

I UNDERSTAND that this information may include diagnosis, treatment, and prognosis with respect to any physical or mental condition and/ or treatment, and other non-medical information (such as credit reports and employer reports) concerning me. I authorize all sources, except MIB, to give records or knowledge to any agency employed by Catholic Financial Life. I authorize them to collect and transmit such information. I UNDERSTAND they will use the information obtained through this Authorization to determine eligibility for insurance. Any information obtained will not be released to any person or entity EXCEPT to reinsuring companies, or other persons or organization performing business or legal services with my application. The Society may release this information when lawfully requires, or as I further authorize.

I declare that all statements and answers in this application or declaration of insurability completed in connection with this application are, to the best of my knowledge and belief, true, complete, and correctly recorded. A copy of this application will be made a part of the insurance issued upon it, and will be used to determine if coverage will be reinstated.

**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.**

\_\_\_\_\_  
Signature of Insured (Parent or Guardian if under age 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Owner (If other than Insured)

\_\_\_\_\_  
Witnessed by

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## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Flesch Rein app.pdf



## READABILITY CERTIFICATION

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of the Policy Language Simplification Act.

Form Number	Score
2011 REIN APP	50.1

A handwritten signature in blue ink, appearing to read "Daniel H. Strasburg", is written over a horizontal line.

Daniel H. Strasburg, FSA, MAAA  
Vice President and Chief Actuary

January 12, 2011