

SERFF Tracking Number: KCLF-127075338 State: Arkansas
Filing Company: Old American Insurance Company State Tracking Number: 48295
Company Tracking Number: A2887 REVISED
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: A2887 Revised
Project Name/Number: A2887 Revised/A2887 Revised

Filing at a Glance

Company: Old American Insurance Company

Product Name: A2887 Revised

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: KCLF-127075338 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 48295

Co Tr Num: A2887 REVISED

State Status: Approved-Closed

Author: Kathleen Frese

Reviewer(s): Linda Bird

Date Submitted: 03/21/2011

Disposition Date: 03/28/2011

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: A2887 Revised

Project Number: A2887 Revised

Requested Filing Mode: Informational

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 03/28/2011

State Status Changed: 03/28/2011

Created By: Kathleen Frese

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Kathleen Frese

Filing Description:

Old American Insurance Company

NAIC # 67199-588 FEIN # 44-0376695

RE: A2887-AR Application for Life Insurance

A2878-P Application for Life Insurance

Attached for your information are the above-referenced applications.

These applications will be used when applying for individual life insurance policies.

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These applications have been previously approved by your Department. A2887-AR was approved on 03/26/2009 and A2878 was approved on 04/28/1998.

We have made very minor changes to these forms and they are as follows:

Form A2887-AR, the change we made was to add two more plans under the Plan section at the top of the first page. These are the IBL 10 and IBL 20 plans. Also, we added a blank line to the Plan section in case we have future plans that use this application.

Form A2878-P, the only changes we made were to change "Amount Paid with this Application" to "Amount of Premium for Application" at the top of the first page. Under the question "Is the Owner the legal guardian of the Proposed Insured?" on the second page we deleted "(If not and amount of Insurance requested is \$5,000, please complete consent form)". Also, we added a check box to check to draft initial premium in the Special Information or Requests on the second page.

We have added a revision date to the lower right hand corner of both applications.

Nothing else has been changed on these applications.

Company and Contact

Filing Contact Information

Kathleen Frese, Compliance Analyst III kfrese@kclife.com
3520 Broadway 816-753-7299 [Phone] 8283 [Ext]
Kansas City, MO 64111 816-753-3018 [FAX]

Filing Company Information

Old American Insurance Company CoCode: 67199 State of Domicile: Missouri
3520 Broadway Group Code: 588 Company Type: Life and Health
PO Box 218573 Group Name: State ID Number:
Kansas City, MO 64121-8573 FEIN Number: 44-0376695
(816) 753-4900 ext. [Phone]

Filing Fees

SERFF Tracking Number: KCLF-127075338 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Old American Insurance Company	\$50.00	03/21/2011	45813928
Old American Insurance Company	\$50.00	03/22/2011	45860575

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/28/2011	03/28/2011

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	03/22/2011	03/22/2011			

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Disposition

Disposition Date: 03/28/2011

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		No
Supporting Document	Application		No
Form	Application for Life Insurance		Yes
Form	Application for Life Insurance		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/22/2011
Submitted Date 03/22/2011
Respond By Date 04/22/2011

Dear Kathleen Frese,

This will acknowledge receipt of the captioned filing.

Objection 1

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

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Form Schedule

Lead Form Number: A2887-AR

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	A2887-AR	Application/ Enrollment Form	Application for Life Insurance	Initial	0.000	A2887-AR.pdf
	A2878-P	Application/ Enrollment Form	Application for Life Insurance	Initial	0.000	A2878_AR.pdf

APPLICATION FOR LIFE INSURANCE TO: OLD AMERICAN INSURANCE COMPANY

3520 Broadway • P.O. BOX 218573 • KANSAS CITY, MISSOURI 64121-8573

FR:AP1130

OWNER'S NAME _____
FIRST NAME INITIAL LAST NAME

PLAN
 BMQ BMS 20 BMP - Single Level 20 - Single
 BMS BMS 10 POM - Guaranteed
 IBL 10 IBL 20 _____

ADDRESS _____ **PHONE #** _____
CITY _____ **SSN** _____
STATE _____ **ZIP** _____

AMOUNT OF PREMIUM FOR APPLICATION \$ _____ Annual Semiannual Quarterly P.A.P.

First Insured's Name**					Relationship to Owner S.S.N.			*Primary Beneficiary - Relationship
Plan	Amount	ABR CTR ADB WPNH	Sex	Height	Weight	Place of Birth (State)	Date of Birth	*Contingent Beneficiary - Relationship
Second Insured's Name					Relationship to Owner S.S.N.			*Primary Beneficiary - Relationship
Plan	Amount	ABR CTR ADB WPNH	Sex	Height	Weight	Place of Birth (State)	Date of Birth	*Contingent Beneficiary - Relationship

*Unless otherwise stated benefits are payable equally to the named beneficiary(s) or to the survivors or survivor.

HEALTH QUESTIONS - Below, the word "you" refers to all persons to be insured listed above.	PERSON TO BE INSURED			
	First		Second	
1. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you had: a. a stroke or heart attack in the past 12 months?..... b. congestive heart failure in the past 36 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you had or been treated for cancer (other than skin cancer) at any time in the past 24 months or have you ever been diagnosed as having cancer of the lung?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you used home oxygen in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. In the past 12 months have you been hospitalized two or more times for the same disease/disorder; or been confined to a nursing facility; or received home health care or in the last 30 days needed assistance performing regular activities of daily living (ADL) such as bathing; dressing; eating; taking medications; or moving about?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. In the past 24 months have you had liver disease including cirrhosis, kidney failure, kidney dialysis or renal insufficiency or alcohol or drug abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have: a. diabetes diagnosed before age 40 and requiring use of insulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. any chronic lung disease, including chronic asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease or tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you had a stroke, heart attack, angina or any other heart or circulatory disease in the past 24 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever been declined, rated, or postponed for life insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Have you used any form of nicotine/tobacco in the past 12 months? (cigar, pipe, smokeless tobacco, cigarettes, nicotine patch, nicotine gum)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you had: a. Ulcerative colitis or Crohn's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Alzheimer's disease, senility, Parkinson's disease or brain tumor (benign)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Multiple sclerosis or paralysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Do you have diabetes?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. Was diabetes diagnosed before age 40?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Do you require the use of insulin?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Have you ever sought advice, been treated or arrested for the use of alcohol or drugs (including prescription drugs)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Have you had in the past 5 years: a. Cancer (other than skin cancer)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Heart attack or stroke.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. In the past 12 months have you been diagnosed as having high blood pressure or has your blood pressure medication changed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Have you had arthritis or a bone, joint or muscle disorder in the past 36 months which necessitated surgery or use of a wheelchair or walker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Health questions are continued on reverse side

HEALTH QUESTIONS (continued) 17. In the past 24 months have you: a. had a body scan, CT scan or MRI?	PERSON TO BE INSURED			
	First		Second	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. been confined to a nursing home or long term care facility?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. been advised to have surgery or other treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Personal Doctor for First Insured Name:	Street address:	City	Initials of First	Initials of Second
			State	Zip Code
Personal Doctor for Second Insured Name:	Street address	City	State	Zip Code

AGENT'S SECTION

If you believe special consideration should be given to either applicant, please give details of all questions answered yes.

Question#	Date and Nature of Diagnosis or Treatment	Name and Address of Treating Physician/Hospital

OTHER INSURANCE

If issued, will this policy replace or change any other life insurance or annuity you now carry? If your answer is yes, give details on a separate sheet of paper, including name of insurance company.

PERSON TO BE INSURED			
First		Second	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

AUTHORIZATION

I(we) authorize the following to give information (defined below) to Old American Insurance Company or any person or group acting on the part of Old American Insurance Company: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. "Information" means facts of: a medical nature regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Old American Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

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.

AGREEMENT AND SIGNATURE

The statements and answers given in this application are true and complete. They are deemed to be representations and not warranties. Unless otherwise stated in a receipt of the Company issued in exchange for the first premium, this coverage shall take effect on the Effective Date shown in the policy, only if it is delivered to the Owner and the first premium is paid during the Insured's lifetime. I(we) acknowledge receipt of the Notice with Regard to the Medical Information Bureau. **I(we) understand that the agent is not authorized to accept risks or pass on insurability, to make or modify contracts or waive the Company's rights and requirements including the requirement that the adult proposed insured(s) personally sign this application in the agent's presence. PLEASE NOTE: Before signing, read and review your answers for accuracy.**

_____ Signature of OWNER	_____ Date	_____ Signature of First Insured - if other than owner	_____ Date
		_____ Signature of Second Insured - if other than owner	_____ Date

<p>SPECIAL INFORMATION OR REQUESTS</p> <p>**If the Insured is different than the Owner please provide the address and phone number of the Insured.</p> <p><input type="checkbox"/> Check box to draft initial premium.</p> <p><input type="checkbox"/> Please check box if you request the policy be sent directly to the Agent.</p> <p>Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Application number _____ of _____</p>
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AGENT'S CERTIFICATION

I hereby certify that, to the best of my knowledge, the insurance hereby applied for () will () will not replace any existing insurance. I further certify that: (1) the above answers are full, complete and true to the best of my knowledge; (2) I know of no factors affecting the insurability of the proposed insured(s) except as stated; and (3) the above signatures are those they are represented to be and were signed in my presence.

_____ Licensed Agent	_____ Code Number
_____ Agency	_____ Code Number
_____ Signed At	_____ City
	_____ State

All premium checks must be made payable to Old American Insurance Company. Do not make check payable to the agent or leave the payee blank.

APPLICATION FOR LIFE INSURANCE TO: OLD AMERICAN INSURANCE COMPANY

3520 Broadway • P.O. BOX 218573 • KANSAS CITY, MISSOURI 64121-8573

FR:AP820

OWNER'S NAME _____
FIRST NAME INITIAL LAST NAME

PLAN

Peace of Mind for Tomorrow – 10 Pay Juvenile

ADDRESS _____

AMOUNT OF INSURANCE \$5,000 \$10,000

CITY _____ **STATE** _____

AMOUNT OF PREMIUM FOR APPLICATION \$ _____

SOC. SEC.# _____ **ZIP** _____

PREMIUM PAYMENT PLAN SELECTED

PHONE # _____ Best time to call: _____

Annual Semiannual Quarterly P.A.P.

Insured's Name	Sex	Height	Weight	Place of Birth (state)	*Primary Beneficiary - Relationship
Insured's Address		City	State	ZIP Code	*Contingent Beneficiary - Relationship
Insured's Phone Number	Social Security Number		Date of Birth	Relationship to Owner	

*Unless otherwise stated benefits are payable equally to the named beneficiary(s) or to the survivor or survivors.

HEALTH QUESTIONS

1. Has the Proposed Insured ever been treated for or told they have any of the following conditions: anemia, leukemia, diabetes, nervous disorder, ulcers, tumors, cancer, high blood pressure, or diseases of the heart, liver, kidney, stomach, lungs or any physical or mental impairments? Yes No
2. Within the past 2 years has the Proposed Insured sought treatment or advice from a member of the medical profession for any illness? Yes No
 If yes, give particulars: _____

3. Has the Proposed Insured been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), or tested HIV positive? Yes No

AGENT'S SECTION

If you believe special consideration should be given to this Proposed Insured, please give details of all questions answered yes.

Question#	Date and Nature of Diagnosis or Treatment	Name and Address of Treating Physician/Hospital

