

SERFF Tracking Number: PSEN-127089035 State: Arkansas  
 Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company State Tracking Number: 48321  
 Company Tracking Number: FLA F1048E ELECTRONIC APPLICATION  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: F1048E Electronic Application  
 Project Name/Number: /

## Filing at a Glance

Company: Fidelity Life Association, A Legal Reserve Life Insurance Company  
 Product Name: F1048E Electronic Application SERFF Tr Num: PSEN-127089035 State: Arkansas  
 TOI: L04I Individual Life - Term SERFF Status: Closed-Approved-Closed State Tr Num: 48321  
 Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium Co Tr Num: FLA F1048E State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Linda Bird  
 Authors: Barbara Ritzke, Chuck Ritzke, Deb Howver, Jean Nickelle Disposition Date: 03/29/2011  
 Date Submitted: 03/23/2011 Disposition Status: Approved-Closed  
 Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Pending  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Individual Market Type:  
 Overall Rate Impact: Filing Status Changed: 03/29/2011  
 State Status Changed: 03/29/2011  
 Deemer Date: Created By: Deb Howver  
 Submitted By: Barbara Ritzke Corresponding Filing Tracking Number:  
 Filing Description:  
 On behalf of Fidelity Life Association, a Legal Reserve Life Insurance Company, form F1048E, an electronic application for individual life insurance is submitted for your review and approval. No part of this filing contains unusual or possibly controversial items from normal industry standards. The submitted form is new and does not replace any form previously approved in your state.

Fidelity Life Association will offer the following individual life insurance products using this form:

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- F4000 Level Death Benefit Term Life Insurance (Rapid Decision Express) approved on 01/26/11 via SERFF tracking number PSEN-126998043 and state tracking number 47768.
- Individual life riders: F3014 (Dependent Child Rider) approved on 09/29/05 under SERFF tracking number SERT-6FZMXL425 and F3020 (04/06) AR (Accidental Death Benefit Rider) approved on 05/08/06 under SERFF tracking number SERT-6NNTKNB255.
- Future approved individual life insurance plans.

This form has also been filed for approval with the Interstate Compact Commission.

Electronic application F1048E will be completed via phone by a licensed life insurance agent or electronically by the applicant. Fidelity Life uses computer software to assist in completing the application.

Sections that do not apply to an applicant will not be displayed in the final printed application. For example, the credit card section will only print if a credit card is being used for payment of premium; if there are no dependents, then the dependent section will be bypassed; the applicant must answer the first question about replacement and if answered affirmatively the applicant will be required to answer the remaining questions; and only elected riders will be printed.

Every applicable question from the filed application is asked and, where appropriate, the system prompts for additional details about each response provided. This process of making follow-up inquiries of an applicant to obtain more detail in relation to a question is the electronic equivalent of the approach used with paper applications by life insurance agents. Detailed responses to health-related and other questions will appear under each question to which an affirmative response is given.

In order to improve the sales experience for potential applicants, Fidelity Life would like the right to modify the format of the application questions from time-to-time as described below. Such modification in format will not change the content of the filed application unless specifically noted, nor will such modification be applied in an unfairly discriminatory manner.

First, the order and format of the application questions may be modified. This will allow for variable length and wrapping and allow questions to be grouped together in a logical way dictated by the specific product for which the application will be used. For example, an affirmative response to a given question may disqualify a customer for coverage on one product, while it may not disqualify a customer for a different product. In this instance, the question would be grouped with other, similar "knockout" questions for that particular product.

Second, specific questions may be deleted as dictated by the requirements of the product for which the application will be used. For example, the question regarding mortgage or refinance activity would appear with future use of the

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application in conjunction with a mortgage term policy. The question will not appear, however, when the application is used in conjunction with form F4000.

Third, some questions may be consolidated into fewer, albeit longer questions. Likewise, some questions may be deconsolidated into shorter, more numerous questions. This will be done without changing the content of the questions themselves. For example, a given question may ask "Have you in the past five years been diagnosed as having medical condition a, b, or c?" We may revise this question so that a separate question is asked for each condition (three questions instead of one) without changing the meaning of the question.

Fourth, specific medical conditions may be deleted from the application prospectively from the date of approval. However, new conditions will not be added without prior approval.

All responses and details gathered are transferred to an electronic version of the filed application. This password protected application is then provided to the applicant for review and electronic signature. No "drop down" boxes are seen by the applicant.

Fidelity Life has security procedures in place sufficient to verify that an electronic signature is that of a specific person and to assure that the information has not been altered in its transmission. A click-through signature will be provided by an applicant on each application in accordance with federal law; no signature pad will be used. The applicant will see that his or her electronic signature has been transmitted to each form signed. The applicant's electronic signature will not be transmitted to any other forms. Fidelity Life uses Secure Sockets Layer (SSL) for all of its data transfers. Secure Sockets Layer (SSL) is a 128 Bit cryptographic protocol that provides secure communications on the internet for such things as web browsing, internet faxing, instant messaging and other data transfers. SSL allows applications to communicate across a network in a way designed to prevent eavesdropping, tampering, and message forgery. SSL provides endpoint authentication and communications privacy with mutual authentication based on a public key infrastructure (PKI) deployment provided by VeriSign.

## Company and Contact

### Filing Contact Information

Debbie Howver, deb@myactuary.com  
35W841 Burr Oak Lane 224-402-2156 [Phone]  
West Dundee, IL 60118 847-551-1795 [FAX]

### Filing Company Information

(This filing was made by a third party - problemsolvingenterprises)

Fidelity Life Association, A Legal Reserve Life CoCode: 63290

State of Domicile: Illinois

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Insurance Company  
 1211 West 22nd Street  
 Suite 209  
 Oak Brook, IL 60523  
 (630) 533-0392 ext. [Phone]

Group Code:  
 Group Name:  
 FEIN Number: 36-1068685

Company Type:  
 State ID Number:

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: 1 form @ \$50.00/form = \$50.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fidelity Life Association, A Legal Reserve Life Insurance Company	\$50.00	03/23/2011	45899010

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/29/2011	03/29/2011

*SERFF Tracking Number:* PSEN-127089035 *State:* Arkansas  
*Filing Company:* Fidelity Life Association, A Legal Reserve Life *State Tracking Number:* 48321  
*Insurance Company*  
*Company Tracking Number:* FLA F1048E ELECTRONIC APPLICATION  
*TOI:* L04I Individual Life - Term *Sub-TOI:* L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
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## **Disposition**

Disposition Date: 03/29/2011

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 - Actuarial Memo		Yes
Supporting Document	F1048E Statement of Variability		Yes
Supporting Document	Third Party Authorization Letter		Yes
Form	Electronic Application		Yes

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## Form Schedule

### Lead Form Number: F1048E

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	F1048E	Application/	Electronic Application	Initial Enrollment		51.500	FLA_F1048E Electronic Life Application_1 10322_Final.pdf

Application for Individual Life Insurance  
[RD Express Term Life Insurance]

NEW ISSUE     REINSTATEMENT of Policy # \_\_\_\_\_

<b>PROPOSED INSURED</b>	Full Legal Name of the Proposed Insured _____ Gender: _____
	Legal Residence Address: _____
	Best Time to Call: _____ Preferred #: _____ Alternate #: _____
	Email Address: _____
	Date of Birth: _____ Place of Birth (Country): _____ Social Security Number: _____
	Drivers License Number: _____ State of Issue: _____

<b>COVERAGE</b>	Face Amount: \$ _____
	Term Period: <input type="checkbox"/> 5 years <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years <input type="checkbox"/> 30 years <input type="checkbox"/> 40 years
	<input type="checkbox"/> Accelerated Death Benefit for Terminal Illness: \$ _____
	<input type="checkbox"/> Accidental Death Benefit: \$ _____
	<input type="checkbox"/> Accident Disability Income Rider
	<input type="checkbox"/> Dependent Child Rider: \$ _____
	<input type="checkbox"/> Involuntary Unemployment Rider
	<input type="checkbox"/> Return of Premium/Cash Value (where applicable) Rider
	<input type="checkbox"/> Waiver of Premium on Total Disability Rider
<input type="checkbox"/> Other Rider or Option	

<b>OTHER COVERAGE</b>	Do you have any existing life insurance or annuity contracts in force or is any application for life insurance or reinstatement, now pending with Fidelity Life or any other company? ..... <input type="checkbox"/> Yes. <input type="checkbox"/> No.
	If this policy is issued, will any other existing life insurance or annuity with Fidelity Life or any other company be cancelled, terminated, lapsed or not renewed ?..... <input type="checkbox"/> Yes.. <input type="checkbox"/> No
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced: <input type="checkbox"/> Yes. <input type="checkbox"/> No.
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced: <input type="checkbox"/> Yes. <input type="checkbox"/> No.
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced: <input type="checkbox"/> Yes. <input type="checkbox"/> No.

<b>POLICY OWNER</b>	Policyowner ( <i>Different than the Proposed Insured</i> )
	Name of Policyowner: _____ Relationship to Insured: _____ SSN/Tax ID: _____
	Policyowner Address: _____
	Trust Name: _____ Authorized Signature Name: _____
	SSN/Tax ID: _____
	Policyowner Address: _____

<b>SECONDARY ADDRESSEE</b>	Secondary Addressee ( <i>This person will receive copies of your overdue premium and lapse notices</i> )
	Secondary Addressee Name: _____ Secondary Mailing Address: _____

**NAME OF PROPOSED INSURED:**

<b>MAILING ADDRESS</b>	Mailing Address <i>(The address to which the policy should be sent.)</i>			
	Addressee Name: _____			
	Mailing Address: _____			

<b>BENEFICIARY</b>	Beneficiary <i>(Complex beneficiary designations should be dealt with within the context of a Will)</i>			
	Primary:	% of Benefit:	Relationship to Insured:	SSN/Tax ID:
	_____	_____	_____	_____
	Primary:	% of Benefit:	Relationship to Insured:	SSN/Tax ID:
	_____	_____	_____	_____
	Contingent:	% of Benefit:	Relationship to Insured:	SSN/Tax ID:
_____	_____	_____	_____	

Application for Individual Life Insurance  
[RD Express Term Life Insurance]

NAME OF PROPOSED INSURED:

QUESTIONS TO THE PROPOSED INSURED	For any 'Yes' response, additional information may be requested:	
	1. Is the Proposed Insured completing this application and paying the premium? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Are you a legal U.S. resident and have you resided in the U.S. for more than 2 years? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Have you had a Mortgage or a Refinance approved within the last 13 months? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. Are you currently employed? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Do you have a Primary Care Physician? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Have you seen a Physician within the past 5 years? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	7. What is your Height? _____ ft/in	
	8. What is your Weight? _____ lbs	
	9. Has your weight changed in the past year? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	10. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed with or had any known indication of : Irregular Heart Beat (Arrhythmia), Blockage or Narrowing of the Arteries or Stroke or Congestive Heart Failure (CHF), Atherosclerosis, Coronary Artery Disease (CAD), Malignant Neoplasm, Lymphoma, Melanoma or Leukemia, Pancreatitis, Hyperthyroidism, Memory Loss or Dysfunction, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease), Cerebral Palsy, Chronic Bronchitis, Bipolar disease or Mood Disorder, Drug or Alcohol abuse, Systemic Lupus Erythematosus (SLE), Lupus, Scleroderma, Cystic Fibrosis, Alzheimer's Disease, Schizophrenia, Dementia or Mental Retardation (including Down's Syndrome) OR any disease or disorder of the following: Blood, Kidney (other than kidney stones), Pancreas, Liver, Brain, Immune System or Connective Tissue? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	11. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or received a positive result from a test administered by a member of the medical profession for Human Immunodeficiency Virus (HIV)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	12. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed with or had any known indication of ; Chest Pain, Heart Murmur, Heart Attack (Myocardial Infarction), Transient Ischemic Attack (TIA or mini stroke) or Aneurysm, Thrombosis, Circulatory Disorder, or any other Disease or Disorder of the Heart, Aorta, Coronary Arteries, Peripheral Vascular System, or Blood Vessels?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	13. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed with or had any known indication of: Rheumatoid Arthritis, any degenerative muscle or nerve disease or disorder, Muscular Atrophy, Muscular System Disorder, Myasthenia Gravis or Paralysis? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	14. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed with or had any known indication of: Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea, Emphysema, Asthma or other Respiratory or Chronic Lung Disease or Disorder? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed with or had any known indication of: Learning Disorders, major Depression or Anxiety that required psychiatric treatment, Eating Disorder or other Psychological (Emotional), Mental or Nervous Disorder? ..	<input type="checkbox"/> Yes <input type="checkbox"/> No	

NAME OF PROPOSED INSURED:

QUESTIONS TO THE PROPOSED INSURED (Continued)	16. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed with or had any known indication of: a Tumor or Cancer (excluding basal cell or squamous cell carcinoma of the skin), Cyst, Seizures, Hepatitis, Disorder of the Breast, Crohn's Disease, Colitis, Abnormal PAP Test, Anemia, Ulcer, or any Disorder of the Bladder, Digestive System, Skeletal System, Stomach, Genito-Urinary Tract, Prostate, Blood or Platelets? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	17. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed with or had any known indication of: Diabetes or Elevated Blood Sugar, Sugar in the Urine, Elevated Cholesterol or Hypertension (High Blood Pressure)? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	18. Have you, within the past 5 years, been treated for, advised to Discontinue, Decrease or seek treatment for Drug or Alcohol Use? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	19. Do you currently take more than 2 prescription medications for pain; or do you consume, on average, more than 3 alcoholic beverages per day?.....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	20. Have you, within the past 5 years, used Controlled Substances such as Narcotics, Cocaine, Heroin, Marijuana, Amphetamines, Hallucinogens or Barbiturates not prescribed by a Physician or have you abused over the counter Medications?.....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	21. Have you, within the last 24 months, used any form of Tobacco, Nicotine or Nicotine Products of any kind? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	22. Have you, within the past 5 years, been a patient in any Dependency Program or Halfway House? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	23. Have you, within the past 5 years, been admitted to an Emergency Room (ER) or Urgent Care Facility, or been a patient in any Hospital, Clinic, Nursing Home, Assisted Living Facility or other Medical Facility?.....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	24. Have you, within the past 5 years, been advised by a member of the medical profession to have any Diagnostic Tests (except HIV tests), Treatments, Hospitalizations, Surgical Operations or medical or mental evaluations or consultations with any Medical Professionals, which have yet to be completed, or are you waiting for a diagnosis?...	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	25. Have you within the past 5 years requested or received a worker's compensation or Social Security disability or disability income payment for more than 90 consecutive days, excluding a pregnancy related payment, or have you been disabled for more than 30 days? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	26. Within the past 5 years, have you been prescribed any medication, suffered from any disease or received any Medical, Mental or Surgical health treatment for any condition that you have not previously disclosed? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	27. Have you, within the past 5 years, had an Application for Life or Health Insurance Rated Up, Postponed, Declined or Denied Reinstatement? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	28. Have you, within the past 5 years, been convicted of, pled guilty or no contest to a Felony, misdemeanor or been incarcerated or served in a probation or parole program or do you have criminal charges pending?.....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	29. Have you, within the past 5 years, had a Drivers License Denied, Suspended, Revoked or been convicted of more than three Moving Violations? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	30. Have you, within the past 5 years, been convicted of, or pled guilty or no contest to Reckless Driving or Driving while Under the Influence of Alcohol or Drugs or driving while intoxicated or do you have charges pending?.....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	31. Have you, within the past 2 years, engaged in, or do you plan within the next 2 years to engage in, any Aviation Activity other than as a Fare-Paying Passenger on commercial airlines?..	<input type="checkbox"/> Yes. <input type="checkbox"/> No.
	32. Have you, within the past 2 years, engaged in, or do you plan within the next 2 years to engage in, any form of, Skin or Scuba Diving, Hang-Gliding, Ultralight Flying, Cave Exploration, Parachuting or Sky Diving, Mountain, Rock or Ice Climbing, Rodeo, Bungee Jumping, Ballooning, Competitive Skiing, Snowmobiling or Snowboarding, Motor Racing, or any other hazardous or extreme sports? .....	<input type="checkbox"/> Yes. <input type="checkbox"/> No.

NAME OF PROPOSED INSURED:

QUESTIONS TO THE PROPOSED INSURED (Continued)	33. To the best of your knowledge or belief has any Natural Parent or Sibling died of Diabetes, Cancer or Heart Disease prior to age 60? .....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	34. Do you intend to Travel, Live or Work outside the United States or Canada within the next 2 years? .....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	35. Have you, within the last 12 months, received, advised to receive or are you currently receiving Chemo, Radiation or any other therapy for Cancer? .....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	36. Have you, within the last 12 months, been diagnosed by a member of the medical profession as having a life expectancy of 24 months or less?.....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	37. Have you, within the last 12 months, been subject of any voluntary or involuntary bankruptcy proceedings or are you currently in bankruptcy? .....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	38. Do you require any assistance with two or more of the following activities: bathing, dressing, toileting, indoor or outdoor mobility, eating or do you use oxygen for a medical condition? .....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	39. Are you a member of the armed forces including the reserves and are you currently or expecting to be Deployed outside of the US? .....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	40. Have you, within the past 5 years, been treated by a Physician for, or been diagnosed as having Kidney Stones, Fibromyalgia, Gaucher's Disease, Gastro Esophageal Reflux Disease, Gout, Hypothyroid, Hyperlipidemia or Migraine? .....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	41. In the past 2 years, have you been hospitalized or evaluated in an emergency room or immediate care center for a chronic illness requiring ongoing treatment or care by a physician? .....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.
	42. Have you, in the past 6 months, been hospitalized or admitted to a nursing facility?.....	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.

NAME OF PROPOSED INSURED:

<b>DEPENDENT CHILD RIDER</b>	Dependent Children to be Insured:		
	Full Legal Name of Dependent Child: _____	Gender: _____	Date of Birth: _____
	Full Legal Name of Dependent Child: _____	Gender: _____	Date of Birth: _____
	Full Legal Name of Dependent Child: _____	Gender: _____	Date of Birth: _____
	1. Has any Child to be insured have been diagnosed with, or treated by a Physician for any Physical Disability, Mental Retardation or Special Need? ..... <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
2. Has any Child to be insured been diagnosed with, or treated by a Physician for any Disorder of the Heart, or has any Surgeries or Hospitalization been suggested, which has yet to be completed? ..... <input type="checkbox"/> Yes. <input type="checkbox"/> No.			

<b>ADDITIONAL INFORMATION</b>	Additional Information from the Proposed Insured(s):
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NAME OF PROPOSED INSURED:

As a convenience to me, I authorize Fidelity Life Association, A Legal Reserve Life Insurance Company (Fidelity Life) to make electronic debits or other forms of preauthorized withdrawals from my financial institution as indicated below. I understand that if a debit or withdrawal is not honored by the financial institution, Fidelity Life will consider the premium unpaid. Any debit or withdrawal returned due to insufficient funds may be re-deposited by Fidelity Life at its sole discretion. This authorization will remain in effect until written notice by the depositor/card holder is received by Fidelity Life. I further agree that if any such debit or withdrawal is not honored, whether with or without cause, Fidelity Life shall be under no liability whatsoever even though such dishonor results in the lapse of insurance, in accordance with the grace period.

Payor is \_\_\_\_\_

Name of Payor: \_\_\_\_\_ Payor Address: \_\_\_\_\_

Mode of Payment: \_\_\_\_\_ Draw Date (Day of the Month): \_\_\_\_\_

Payment Method: \_\_\_\_\_

Amount paid with application: \$ \_\_\_\_\_

**PRE-AUTHORIZED CHECK** *(This selection will apply to all payments)*

I request that my premium payments be debited from my bank account as shown.

Name of Bank: \_\_\_\_\_ Transit Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

**PRE-AUTHORIZED CREDIT / DEBIT CARD** *(This selection will apply to all payments)*

I request that my premium payments be debited from the \_\_\_\_\_ shown below.

Card Type: \_\_\_\_\_ Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Printed Name *(As it appears on file with the financial institution)*

Electronically Signed By: \_\_\_\_\_  
AUTHORIZED SIGNATURE

Voice Signature on File: \_\_\_\_\_ Reference #: \_\_\_\_\_  
AUTHORIZED SIGNATURE

PRE-AUTHORIZED PAYMENT AUTHORIZATION

Application for Individual Life Insurance  
[RD Express Term Life Insurance]

NAME OF PROPOSED INSURED:

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION	<p>I declare that each answer and statements given to the questions contained in this application is complete and true to the best of my knowledge and belief. I understand and agree that the Fidelity Life Association, A Legal Reserve Life Insurance Company (Fidelity Life) will rely on these answers, and the answers and statements I may give in any other form, taken as a part of this application, as representations and not warranties and that no such statement shall void the policy unless it is contained in a written application and a copy of such application shall be endorsed upon or attached to the policy when issued. I also understand that the Fidelity Life reserves the right to accept or deny this application after taking into account whatever information may be available to it, including availability as to coverage by its reinsurers.</p> <p>I understand that the statements and answers in the application are the basis for any policy issued by Fidelity Life, and that no information will be considered to have been given to the company unless it is stated in the application;</p> <p>I understand that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.</p> <p>The coverage will be effective on its date of issue if the: (a) health; (b) avocations; (c) occupation; and (d) any other condition relating to the Proposed Insured are as described in the application. The effective date will be shown on page 3 of the Policy, provided one is issued. I understand that Fidelity Life will have no liability until a policy is issued on this application and delivered to and accepted by the owner and the first premium is paid in full while the insured is alive.</p> <p>I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (MIB), consumer reporting agency or employer to give to Fidelity Life any information they might have regarding the diagnosis, treatment, prescription and prognosis of any physical or mental condition, my driving record, avocations, credit history, insurance history, occupation, character and hobbies, as applicable. To facilitate the rapid transmission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Fidelity Life to collect and transmit such information.</p> <p>I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization shall be used to evaluate my application for insurance. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization. I also understand that I have the right to revoke this authorization at any time.</p> <p>All or part of such information may be disclosed to a physician of my choosing, my insurance agent, the Medical Information Bureau (MIB), to other persons or organizations performing business or legal services in connection with this application, including reinsuring companies and as may be required by law.</p> <p><b>Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of criminal offense and subject to penalties under state law.</b></p> <p>Signed at: _____ Date: _____</p> <p><u>Electronically Signed By:</u> _____ Signature of Proposed Insured</p> <p><u>Voice Signature on File:</u> _____ <u>Reference #:</u> _____ Signature of Proposed Insured</p>
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AGENT	<p>To the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of any proposed insured? (If yes, complete appropriate state replacement forms) ..... <input type="checkbox"/> Yes. <input type="checkbox"/> No.</p> <p>Does any Proposed Insured have existing Life Insurance or Annuity contracts in force? ..... <input type="checkbox"/> Yes. <input type="checkbox"/> No.</p> <p>Printed Name of Agent: _____</p> <p>Agent ID: _____ General Agent ID: _____ State License Number: _____</p> <p>Email Address of Agent: _____ Telephone Number of Agent: _____</p> <p><u>Electronically Signed By:</u> _____ Signature of Licensed Agent:</p>
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SERFF Tracking Number: PSEN-127089035 State: Arkansas  
 Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company State Tracking Number: 48321  
 Company Tracking Number: FLA F1048E ELECTRONIC APPLICATION  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: F1048E Electronic Application  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Satisfied - Item:</b> Flesch Certification  <b>Comments:</b>  <b>Attachments:</b>            FLA_F1048E_Readability Certification.pdf            AR_Certification to Regulations 19 &amp; 49.pdf</p>		
<p><b>Satisfied - Item:</b> F1048E Statement of Variability  <b>Comments:</b>  <b>Attachment:</b>            FLA_F1048E_Statement of Variability_110322.pdf</p>		
<p><b>Satisfied - Item:</b> Third Party Authorization Letter  <b>Comments:</b>  <b>Attachment:</b>            SignedLetterOfAuthorization_FLA_110106.pdf</p>		



## ARKANSAS CERTIFICATION

I, Ciaran Brady, Vice President – Operations, for Fidelity Life Association, do hereby attest and certify to the following:

- The Company has further reviewed its issuance procedures and is compliance with Regulation 49, Life and Health Insurance Guaranty Association Notices.
- This submission meets the provisions of Regulation 19, Unfair Sex Discrimination in the Sale of Insurance, as well as all applicable requirements of the Arkansas Insurance Department.

FIDELITY LIFE ASSOCIATION

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Ciaran Brady, Vice President - Operations

March 22, 2011

Date

## Statement of Variability

**Company:** Fidelity Life Association, A Legal Reserve Life Insurance Company

**Contract Forms:** F1048E Electronic Individual Life Application

<b>Page #</b>	<b>[Variable Item]</b>	<b>Statement of Variability</b>
All	Company Address	Changed if company home office location changes
All	All applicant blanks and checkboxes to be completed by applicant or agent.	All the policyowner specific contract data will be based upon each individual's information.
All	The product name (marketing name)	The company will be offering its term life products with this application. This information will print in the title of each page. The company would like to reserve the right to use this application with future products as they are developed and approved.



Fidelity Life Association  
1211 West 22<sup>nd</sup> Street, Suite 209  
Oak Brook, IL 60523  
Tel: 630.522.0392 Fax: 866.375.8175

January 6<sup>th</sup>, 2011

To Whom It May Concern:

Please allow this letter to serve as authorization for Problem Solving Enterprises, Inc to make rate, rule and form filings on behalf of Fidelity Life Association, a Legal Reserve Life Insurance Company. Problem Solving Enterprises serves as actuarial and compliance consultants for Fidelity Life Association.

Any questions may be directed to me at 630-371-1888.

Sincerely,

Ciaran Brady  
Vice President of Operations