

SERFF Tracking Number: AAAL-127150116 State: Arkansas
Filing Company: AAA Life Insurance Company State Tracking Number: 48706
Company Tracking Number: LF0411PEXM
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Paramedical Form
Project Name/Number: /

Filing at a Glance

Company: AAA Life Insurance Company

Product Name: Paramedical Form

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AAAL-127150116 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 48706

Co Tr Num: LF0411PEXM

State Status: Approved-Closed

Authors: Barbara Hassell, Judy
Lucas, Victoria Windham

Reviewer(s): Linda Bird

Disposition Date: 05/11/2011

Date Submitted: 05/06/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

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: 05/11/2011

State Status Changed: 05/11/2011

Created By: Judy Lucas

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Judy Lucas

Filing Description:

May 6, 2011

Arkansas Insurance Department

Re: AAA Life Insurance Company

NAIC #71854; FEIN: 52-0891929

Form Number and Description:

SERFF Tracking Number: AAAL-127150116 State: Arkansas
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LF0411PEXM Supplemental Information Paramedical Form

Dear Reviewer:

We are submitting the above form for your review and approval. It is being submitted in final printed format; however, we reserve the right to change fonts, layouts, or company logo/address. We certify that the font size will never be less than the minimum 10-point type size. Once approved, this form will be used on an as needed basis with our approved paramedical exam vendor. No part of this filing contains any unusual or possibly controversial items from our normal Company or industry standards.

The form submitted will be used as supplemental underwriting information if the Agent completed part 1 and part 2 of the Application. The Applications that this will be used with are forms LF80201APP, LF80202APP, LF80200 TIA. These forms were approved by your Department under SERFF tracking number FRCS-126987253, approved on 1/20/2011. It will also be used with Application Form LF80202APPr filed in your state on our behalf by First Consulting & Administration under SERFF tracking number FRCS-127131144.

In addition, this form will be used in the Application process for the individual universal life policies approved by the Department on 2/15/2011 (SERFF Tracking number: FRCS-126980406) and the Individual Term Filing approved by the Department on 3/23/2011 (SERFF Tracking number: FRCS-127074810). It may also be used with individual life products filed and approved with your department in the future.

This form will be completed by our paramedical exam facility.

This will not replace anything currently approved in your state.

All appropriate transmittal forms are submitted with this filing, as well as all appropriate filing fees.

If you have any questions, feel free to contact me at the (734) 779-2646 or by email at Jalucas@aaalife.com.

Respectfully Submitted,

Judy Lucas
Compliance Specialist III
AAA Life Insurance Company

SERFF Tracking Number: AAAL-127150116 State: Arkansas
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Company and Contact

Filing Contact Information

Judy Lucas, Compliance Specialist III
 17900 N. Laurel Park Dr.
 Livonia, MI 48152

JALucas@aaalife.com
 734-779-2646 [Phone]
 734-805-6282 [FAX]

Filing Company Information

AAA Life Insurance Company
 17900 N. Laurel Park Drive
 Livonia, MI 48152-3985
 (800) 624-1662 ext. 2942[Phone]

CoCode: 71854
 Group Code: -99
 Group Name:
 FEIN Number: 52-0891929

State of Domicile: Michigan
 Company Type:
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 1 filing
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AAA Life Insurance Company	\$50.00	05/06/2011	47347749

SERFF Tracking Number: AAAL-127150116

State: Arkansas

Filing Company: AAA Life Insurance Company

State Tracking Number: 48706

Company Tracking Number: LF0411PEXM

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: Paramedical Form

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/11/2011	05/11/2011

SERFF Tracking Number: AAAL-127150116

State: Arkansas

Filing Company: AAA Life Insurance Company

State Tracking Number: 48706

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Disposition

Disposition Date: 05/11/2011

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	Cover Letter		Yes
Form	Supplemental Information - Paramedical Form		Yes

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Form Schedule

Lead Form Number: LF0411PEXM

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LF0411PEXM	Other	Supplemental Information - Paramedical Form	Initial			LF0411PEXM - Paramed Form - non-compact.pdf



Supplemental Information Paramedical Exam

[App ID:]

17900 N. Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

PROPOSED INSURED INFORMATION

Full Legal Name	Social Security Number _____ - ____ - _____	Date of Birth (MM/DD/YYYY) / /	Drivers License Number
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The following questions must be answered by each adult Proposed Insured or by the Parent or Legal Guardian(s) for any Proposed Insured less than 18 years old.

Primary Care Physician Name	Physician Address	Physician Phone Number
Date Physician Last Consulted	Reason Physician Last Consulted	Results from Physician Visit

Have you ever been diagnosed, treated, or advised to seek treatment by a member of the medical profession for:	Fully explain all 'Yes' answers. Include diagnoses, dates, duration, and names/addresses of all attending physicians and medical facilities.
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1. Heart disorder, including chest pain, circulatory disorder, high blood pressure, or elevated lipids (cholesterol or triglycerides)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Stroke, Transient Ischemic Attack (TIA or mini-stroke), or seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Diabetes, thyroid disorder, pancreatic disorder, liver disorder, including, but not limited to, hepatitis or kidney disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Lung or chronic respiratory disorder, including, but not limited to, sleep apnea or asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Cancer or tumor, cyst, or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Rheumatoid Arthritis, Lupus, Multiple Sclerosis, or other autoimmune or connective tissue disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV (Human Immunodeficiency Virus) infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Any blood disorder or blood clotting disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever:		
9. Had a parent or sibling diagnosed or treated by a member of the medical profession for heart disease, cancer, or diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Used any illicit drugs not prescribed by a physician, or have been advised to, or received treatment or counseling for drug or alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you in the past 10 years been diagnosed, treated, or advised to seek treatment by a member of the medical profession for:

11. Mental or emotional disorders, including, but not limited to, anxiety, depression, bipolar, schizophrenia, dementia, eating disorders, or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Any central nervous system disorder including, but not limited to, Amyotrophic Lateral Sclerosis (ALS), Parkinson's, Alzheimer's, Huntington's disease, or Cerebral Palsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Digestive system, intestinal or stomach disorder, ulcer, or colitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Chronic pain or fibromyalgia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Supplemental Information Paramedical Exam

[App ID:]

17900 N. Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

Have you in the <u>past 5 years</u> been treated by a member of the medical profession and:	Fully explain all 'Yes' answers. Include diagnoses, dates, duration, and names/addresses of all attending physicians and medical facilities.
15. Applied for or received income benefits for injury, sickness, or disability, or are you currently disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Been advised to have surgery, testing, or hospital care not already mentioned?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Taken prescribed medications or are you currently taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Information	
18. In the <u>past 5 years</u> have you used nicotine in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have you lost more than 20 pounds in the <u>past 12 months</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Are you now under observation or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I declare that all answers in this application and any attached questionnaires are, to the best of my knowledge and belief, true and complete. The answers given are the basis for any policy issued by the Company, and will be made part of the policy.

In order to determine insurability, I authorize any licensed medical practitioner, hospital, clinic, or other medical facility, insurance company, pharmacy benefit manager, MIB Inc., other organization, institution, or person having any records of the Proposed Insured's medical or prescription history, to give such information to the Company, it's reinsurers, or any agency employed by the Company to collect and transmit such information. I understand that medical records are protected by certain federal regulations. The Company will not use or disclose medical information for any purpose other than stated above, except as may be required by law. This authorization is valid for 24 months from the date signed. A copy of this authorization will be as valid as the original. I have the right to revoke this authorization in writing to the Company; however if I do, the Company may decline my application.

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

Signed at (City and State)	Date
Signature of Proposed Insured	Signature of Owner <i>(If Other Than Proposed Insured)</i>
Signature of Parent or Legal Guardian <i>(If Proposed Insured is a Minor)</i>	

SIGNATURE OF INTERPRETER *(if applicable)*

I, the undersigned, do hereby state that I am 18 years of age or older, and that I am not the beneficiary or owner of any AAA Life Insurance policy being applied for on the life of the above named Proposed Insured.

By signing this form as the interpreter I have met the following expectations:

- I have translated and asked all application questions of the Proposed Insured.
- I have provided all responses exactly as stated by the Proposed Insured.
- The Proposed Insured understood all questions when asked.
- The information provided is true and accurate as provided by the Proposed Insured.
- I understand that the contents of the application are confidential and that questions and answers will not be disclosed to another applicant or to any other person unless required by a court of law.

Interpreter Name (PLEASE PRINT)	Date
Signature of Interpreter	Date

Height (in shoes)	Weight	Weight is Scale Weight:	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
ft. in.	lbs.	<input type="checkbox"/> with shoes <input type="checkbox"/> without shoes	in.	in.	in.

21. Exercise all applicants under age 60, unless contra-indicated. Blood Pressure (Record ALL readings)

	Initial	5 minutes later	10 minutes later
Systolic			
Diastolic			

22. Pulse

	Initial	5 minutes later	10 minutes later
Rate			
Irregularities per minute			

23. Heart - Is there any: Details of 'Yes' answers (identify item)

Displaced PMI Yes No Dyspnea Yes No
 Murmur(s) Yes No Edema Yes No Bruit Yes No

	Murmur 1	Murmur 2
Location	<input type="text"/>	<input type="text"/>
Constant	<input type="checkbox"/>	<input type="checkbox"/>
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
Localized	<input type="checkbox"/>	<input type="checkbox"/>
Systolic	<input type="checkbox"/>	<input type="checkbox"/>
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>

After exercise:
 Increased Unchanged Decreased Any difference in murmur with position change

Indicate:
 Apex by: X
 Murmur area by: ⊙
 Point of greatest intensity by: ○
 Transmission by: ⇨

24. Is there, on examination, any abnormality of the following: *(Circle applicable items and give details)*

a. Eyes, ears, nose, mouth, or pharynx? (if vision or hearing markedly impaired, indicate degree and correction)	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Skin (including scars), lymph nodes, veins, or peripheral pulses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Abdomen (include scars)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Genitalia (males only)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Musculoskeletal system (include spine, joints, amputation, and deformities)?	<input type="checkbox"/> Yes <input type="checkbox"/> No



MEDICAL EXAMINER'S REPORT

[App ID:]

17900 N. Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

		Details of 'Yes' answers (identify item)	
25. Are you aware of additional medical history: Signs, symptoms, or laboratory findings? (A confidential report may be sent to the Medical Director)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
26. Have you any reason to believe that the Proposed Insured uses or has used alcoholic beverages or drugs to excess?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you forwarding a specimen to the laboratory? (if 'No', provide reason)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Signed at (City and State)	Date	Signature of Medical Examiner	
Mail this report to: AAA LIFE INSURANCE COMPANY 17900 N. Laurel Park Dr. Livonia, Michigan 48152			
DO NOT DETACH		DO NOT DETACH	
CHECK REQUISITION AAA Life Insurance Company			
NAME AND ADDRESS OF MEDICAL EXAMINER (PAYEE)		MEDICAL EXAMINER'S SOCIAL SECURITY NUMBER	
		____ - ____ - _____	
		NAME OF PROPOSED INSURED	
		FOR HOME OFFICE USE ONLY	
		POLICY NUMBER	
		APPROVED BY	
		ACCOUNTING DEPARTMENT	

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Product Name: Paramedical Form
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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Readability Certification - LF0411PEXM.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: This will be used with the following approved forms LF80201APP, LF80202APP, LF80200 approved under FRCS-126987253 approved 1/28/2011. and LF80202APP approved under FRCS-127131144 approved 5/4/2011		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter Comments: Attachment: Arkansas Cover Letter.pdf		

READABILITY CERTIFICATION

COMPANY NAME: AAA Life Insurance Company

I hereby certify that the forms listed below have achieved the following score as calculated by the Flesch Reading Ease Test.

Form Number	Description	Score
LF0411PEXM	Supplemental Information – Paramedical Exam	50.2



Company Officer: Robert J Dotson

Title: Vice President and General Counsel

May 4, 2011

Date



AAA Life Insurance Company

17900 N. Laurel Park Dr.

Livonia, MI 48152-3985

800-624-1662, ext. 2646 or 734-779-2946

Fax: 734-805-6282

E-mail: jalucas@aaalife.com

May 6, 2011

Arkansas Insurance Department

Re: AAA Life Insurance Company
NAIC #71854; FEIN: 52-0891929

Form Number and Description:

LF0411PEXM Supplemental Information Paramedical Form

Dear Reviewer:

We are submitting the above form for your review and approval. It is being submitted in final printed format; however, we reserve the right to change fonts, layouts, or company logo/address. We certify that the font size will never be less than the minimum 10-point type size. Once approved, this form will be used on an as needed basis with our approved paramedical exam vendor. No part of this filing contains any unusual or possibly controversial items from our normal Company or industry standards.

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This form will be completed by our paramedical exam facility.

This will not replace anything currently approved in your state.

All appropriate transmittal forms are submitted with this filing, as well as all appropriate filing fees.

If you have any questions, feel free to contact me at the (734) 779-2646 or by email at Jalucas@aaalife.com.

Respectfully Submitted,

A handwritten signature in cursive script that reads 'Judy Lucas'.

Compliance Specialist III

AAA Life Insurance Company