

SERFF Tracking Number: PHYS-127166282 State: Arkansas
Filing Company: Physicians Life Insurance Company State Tracking Number: 48752
Company Tracking Number:
TOI: A02I Individual Annuities- Deferred Non- Sub-TOI: A02I.003 Single Premium
Variable
Product Name: Supplemental Annuity Application
Project Name/Number: /

Filing at a Glance

Company: Physicians Life Insurance Company

Product Name: Supplemental Annuity Application SERFF Tr Num: PHYS-127166282 State: Arkansas

TOI: A02I Individual Annuities- Deferred Non- Variable SERFF Status: Closed-Approved- Closed State Tr Num: 48752

Sub-TOI: A02I.003 Single Premium

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Sonja Morton

Disposition Date: 05/17/2011

Date Submitted: 05/12/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 05/09/2011

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: 05/17/2011

State Status Changed: 05/17/2011

Deemer Date:

Created By: Sonja Morton

Submitted By: Sonja Morton

Corresponding Filing Tracking Number:

Filing Description:

RE: Physicians Life Insurance Company – NAIC No. 72125; FEIN 47-0529583

Individual Deferred Annuity

L-NB-0018-AA – Supplemental Application

The above captioned form is submitted for approval. This form is new and does not replace any currently approved forms. To the best of my knowledge this form complies with all state laws and regulations.

The L-NB-0018-AA, Supplemental Application, will be used with the AP117, Single Premium Deferred Annuity, which

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Product Name: *Supplemental Annuity Application*
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was approved by your Department on December 7, 2009.

This form was approved by our state of domicile, Nebraska, on May 9, 2011.

We reserve the right to alter the format of the forms submitted without re-filing due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval.

Your early review and approval of this filing is greatly appreciated. If there is anything I can do to facilitate the review and approval, please contact me via SERFF, or at the e-mail address or phone number listed below.

Sincerely,

Sonja Morton
Product Approval & Compliance Coordinator
Government and Industry
Voice: 402-633-1662
Fax: (402) 633-1096
E-mail: sonja.morton@physiciansmutual.com

Company and Contact

Filing Contact Information

Sonja Morton, Policy Approval & Compliance Coordinator
sonja.morton@physiciansmutual.com
2600 Dodge Street
Omaha, NE 68131
402-633-1662 [Phone]
402-633-1096 [FAX]

Filing Company Information

Physicians Life Insurance Company
2600 Dodge Street
Omaha, NE 68131
(402) 633-1188 ext. [Phone]

CoCode: 72125
Group Code: 367
Group Name:
FEIN Number: 47-0529583
State of Domicile: Nebraska
Company Type:
State ID Number:

Filing Fees

SERFF Tracking Number: *PHYS-127166282* State: *Arkansas*
Filing Company: *Physicians Life Insurance Company* State Tracking Number: *48752*
Company Tracking Number:
TOI: *A021 Individual Annuities- Deferred Non- Variable* Sub-TOI: *A021.003 Single Premium*
Product Name: *Supplemental Annuity Application*
Project Name/Number: */*

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: The filing fee is \$50.00 per form. We are filing one form, so the filing fee is \$50.00.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Life Insurance Company	\$50.00	05/12/2011	47516915

SERFF Tracking Number: *PHYS-127166282* State: *Arkansas*
Filing Company: *Physicians Life Insurance Company* State Tracking Number: *48752*
Company Tracking Number:
TOI: *A021 Individual Annuities- Deferred Non- Variable* Sub-TOI: *A021.003 Single Premium*
Product Name: *Supplemental Annuity Application*
Project Name/Number: */*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	05/17/2011	05/17/2011

SERFF Tracking Number: *PHYS-127166282* State: *Arkansas*
 Filing Company: *Physicians Life Insurance Company* State Tracking Number: *48752*
 Company Tracking Number:
 TOI: *A021 Individual Annuities- Deferred Non- Variable* Sub-TOI: *A021.003 Single Premium*
 Product Name: *Supplemental Annuity Application*
 Project Name/Number: */*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Supplemental Application		Yes

Physicians Life Insurance Company®

2600 Dodge, Omaha, Nebraska 68131

1-877-500-7542

Home Office Use Only

Medicare Supplement Policy Number _____

SUPPLEMENTAL APPLICATION FOR PURPOSES OF PARTIAL WITHDRAWALS FREE OF SURRENDER CHARGES

Annuity Owner/Applicant			Annuity Joint Owner/Applicant		
Full Name			Full Name		
Address			Address		
City	State	Zip	City	State	Zip
Date of Birth	/ /		Date of Birth	/ /	
(MM/DD/YY)			(MM/DD/YY)		
<input type="checkbox"/>	Social Security Number	/ /	<input type="checkbox"/>	Social Security Number	/ /
<input type="checkbox"/>	Taxpayer Identification Number	/	<input type="checkbox"/>	Taxpayer Identification Number	/

Medicare Supplement Information

Check One:

I am the insured on the Medicare Supplement policy.

My spouse is the insured on the Medicare Supplement policy.

Full Name of Medicare Supplement insured or applicant: _____

Medicare Supplement Plan (Check one): High Deductible Plan F Innovative Plan F Plan N

Application Date (or Issue Date if issued) / / Medicare Supplement policy number (if issued) _____
(MM/DD/YY)

Partial Withdrawal Authorization

Check One:

I **DO** want Partial Withdrawals free of Surrender Charges taken from my annuity for qualifying Medicare Supplement out-of-pocket expenses.

Send partial withdrawals of qualifying out-of-pocket expenses to:

Check One:

Send my Partial Withdrawals free of Surrender Charges directly to the health care provider(s).

Send my Partial Withdrawals free of Surrender Charges directly to me, the annuity Owner.

I **DO NOT** want Partial Withdrawals free of Surrender Charges taken from my annuity. I will notify the Medicare Supplement insured of this request. (Not available at time of sale)

Note: Your Partial Withdrawal request will be effective on the date your request is processed at the Home Office. You may cancel partial withdrawals free of surrender charges at any time after the annuity is issued and you can reconnect to the same or another eligible Medicare Supplement policy. You may also change who receives the partial withdrawals at any time after the annuity is issued. Each eligible Medicare out-of-pocket expense is paid automatically based on when the claim for the connected policy is received and processed. Claims received when the policy is no longer connected will not be paid from the VISTA Funder™, even if incurred while the two were connected.

Signature

To the best of my knowledge and belief, the statements and answers contained in this application are true and complete and the above Social Security and/or Taxpayer Identification numbers are correct. I understand I may cancel or change the authorization by notifying the Home Office and completing this form.

 X
Owner's Signature

 X
Joint Owner's Signature

Date

Date

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Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Readability Certification.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

Attachment:

L-NB-0018-AA-Supplemental Application.pdf

PHYSICIANS LIFE INSURANCE COMPANY

OMAHA, NEBRASKA

Certification of Flesch

The form has the following Flesch Readability Score:

<u>Form</u>	<u>Flesch Score</u>
L-NB-0018-AA	42.8

The entire form was analyzed. The following was excluded in the text: name and address of the insurer; name, number and title of the form; captions and sub-captions; medical terminology; defined terms.



Shawn Pollock
Vice President
Government and Industry

05-12-11
Date

Physicians Life Insurance Company®

2600 Dodge, Omaha, Nebraska 68131

1-877-500-7542

Home Office Use Only

Medicare Supplement Policy Number _____

SUPPLEMENTAL APPLICATION FOR PURPOSES OF PARTIAL WITHDRAWALS FREE OF SURRENDER CHARGES

Annuity Owner/Applicant			Annuity Joint Owner/Applicant		
Full Name			Full Name		
Address			Address		
City	State	Zip	City	State	Zip
Date of Birth	/ /		Date of Birth	/ /	
(MM/DD/YY)			(MM/DD/YY)		
<input type="checkbox"/> Social Security Number	/ /		<input type="checkbox"/> Social Security Number	/ /	
<input type="checkbox"/> Taxpayer Identification Number	/		<input type="checkbox"/> Taxpayer Identification Number	/	

Medicare Supplement Information

Check One:

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Signature

To the best of my knowledge and belief, the statements and answers contained in this application are true and complete and the above Social Security and/or Taxpayer Identification numbers are correct. I understand I may cancel or change the authorization by notifying the Home Office and completing this form.

X

Owner's Signature

X

Joint Owner's Signature

Date

Date