

SERFF Tracking Number: PSEN-127147776 State: Arkansas
 Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company State Tracking Number: 48666
 Company Tracking Number: FLA F1048E(04/11)
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
 Product Name: FLA F1048E(04/11) Electronic Application
 Project Name/Number: /

Filing at a Glance

Company: Fidelity Life Association, A Legal Reserve Life Insurance Company
 Product Name: FLA F1048E(04/11) Electronic Application SERFF Tr Num: PSEN-127147776 State: Arkansas
 TOI: L04I Individual Life - Term SERFF Status: Closed-Approved-Closed State Tr Num: 48666
 Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium Co Tr Num: FLA F1048E(04/11) State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Linda Bird
 Authors: Barbara Ritzke, Deb Howver Disposition Date: 05/09/2011
 Date Submitted: 05/03/2011 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: 05/09/2011
	State Status Changed: 05/09/2011
Deemer Date:	Created By: Deb Howver
Submitted By: Deb Howver	Corresponding Filing Tracking Number:
Filing Description:	

On behalf of Fidelity Life Association, a Legal Reserve Life Insurance Company, form F1048E (04/11), 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 a revision of form F1048E previously approved in your state on 03/29/11 via SERFF tracking number PSEN-127089035 and state tracking number 48321.

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The only two changes that have been made to previously approved F1048E are the addition of term period options in the 'Coverage' section and a language correction to question #36. The language was:
 "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?"
 The language has been corrected to read:
 "Have you been diagnosed by a member of the medical profession as having a life expectancy of 24 months or less?"

Company and Contact

Filing Contact Information

Barbara Ritzke, Barb@myactuary.com
 35W841 Burr Oak Lane 847-322-5862 [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 Insurance Company CoCode: 63290 State of Domicile: Illinois
 1211 West 22nd Street Suite 209 Oak Brook, IL 60523
 (630) 533-0392 ext. [Phone]
 Group Code: Company Type:
 Group Name: State ID Number:
 FEIN Number: 36-1068685

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	05/03/2011	47228859

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/09/2011	05/09/2011

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Disposition

Disposition Date: 05/09/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Product Name: FLA F1048E(04/11) Electronic Application
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		Yes
Supporting Document	Third Party Authorization Letter		No
Supporting Document	Statement of Variability		No
Form	Electronic Life Application		No

SERFF Tracking Number: PSEN-127147776 State: Arkansas
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Form Schedule

Lead Form Number: F1048E(04/11)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	F1048E(04/11)	Application/Enrollment Form	Electronic Life Application	Initial		51.900	FLA_F1048E(04_11) Electronic Life Application_110429_Final.pdf

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

NEW ISSUE REINSTATEMENT of Policy # _____

PROPOSED INSURED	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: _____

COVERAGE	Face Amount: \$ _____
	Term Period: <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <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	

OTHER COVERAGE	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.

POLICY OWNER	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: _____

SECONDARY ADDRESSEE	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:

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

BENEFICIARY	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	

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

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 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:

DEPENDENT CHILD RIDER	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.			

ADDITIONAL INFORMATION	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>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.</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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 Product Name: FLA F1048E(04/11) Electronic Application
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments:</p> <p>Attachments: FLA_F1048E(04_11)_Readabilty Certification.pdf AR_Certification to Regulations 19 & 49.pdf</p>		
<p>Satisfied - Item: Third Party Authorization Letter</p> <p>Comments:</p> <p>Attachment: SignedLetterOfAuthorization_FLA_110106.pdf</p>		
<p>Satisfied - Item: Statement of Variability</p> <p>Comments:</p> <p>Attachment: FLA_F1048E(04_11)_Statement of Variability_110429.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



Digitally signed by Ciaran Brady
DN: cn=Ciaran Brady, o=Fidelity Life
Association, ou=Vice President -
Operations,
email=Ciaran.Brady@fidelitylife.com,
c=US
Date: 2011.05.03 15:54:34 -05'00'

Ciaran Brady, Vice President - Operations

May 3, 2011

Date



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

January 6th, 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,

A handwritten signature in black ink, appearing to read 'C. Brady'.

Ciaran Brady
cn=Ciaran Brady, o=Fidelity Life Association,
ou=Vice President of Operations,
email=Ciaran.Brady@FidelityLife.com, c=US
2011.01.06 15:23:29 -06'00'

Ciaran Brady
Vice President of Operations

Statement of Variability

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

Contract Forms: F1048E(04/11) Electronic Individual Life Application

Page #	[Variable Item]	Statement of Variability
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.