

SERFF Tracking Number: AAMC-127187143 State: Arkansas
Filing Company: Occidental Life Insurance Company of North Carolina State Tracking Number: 48942
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Supplement to Application - 9917
Project Name/Number: /

Filing at a Glance

Company: Occidental Life Insurance Company of North Carolina

Product Name: Supplement to Application - 9917 SERFF Tr Num: AAMC-127187143 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 48942

Sub-TOI: L08.000 Life - Other

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Author: Traci Baty

Reviewer(s): Linda Bird

Date Submitted: 05/31/2011

Disposition Date: 06/08/2011

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: Filed in Texas, our State of Domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/08/2011

State Status Changed: 06/08/2011

Deemer Date:

Created By: Traci Baty

Submitted By: Traci Baty

Corresponding Filing Tracking Number:

Filing Description:

Cover Letter under Supporting Documentation.

Company and Contact

Filing Contact Information

Clara Keel, Product Filing Manager and Assistant Secretary

ckeel@aatx.com

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425 Austin Avenue 254-297-2794 [Phone]
 Waco, TX 76701 254-297-2138 [FAX]

Filing Company Information

Occidental Life Insurance Company of North Carolina CoCode: 67148 State of Domicile: Texas
 425 Austin Avenue Group Code: 1327 Company Type: LAH
 Waco, TX 76701 Group Name: State ID Number:
 (254) 297-2777 ext. [Phone] FEIN Number: 56-0343440

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Occidental Life Insurance Company of North Carolina	\$50.00	05/31/2011	48199647

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/08/2011	06/08/2011

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Disposition

Disposition Date: 06/08/2011

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	Supplement to Application		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form No. OL9917	Other	Supplement to Application	Initial		51.500	OL9917.pdf

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

P.O. Box 2595, Waco, TX 76702-2595

SUPPLEMENT TO APPLICATION

(Application Supplement in Continuation of and Forming a Part of my Application for Insurance)

Proposed Insured Name (Print): _____

PART III – HEALTH QUESTIONS

“Treated” or “Treatment” as used in the health questions that follow is defined as the diagnosis, the prescribing of any medication or course of action, undergoing or being advised to undergo any diagnostic testing or any stay in a health care facility”.

- 1. Have you smoked cigarettes in the past 24 months? YES NO
- 2. In the past 12 months, have you taken 3 or more medications at the same time to control high blood pressure? YES NO
- 3. Have you ever been Treated, advised to receive Treatment, including maintenance medications, for cancer (other than basal cell carcinoma), malignant melanoma or leukemia?... YES NO
- 4. In the past 3 years, have you been Treated or advised to receive Treatment for major depression, schizophrenia, or bi-polar disorder? YES NO
- 5. In the past 10 years, have you been Treated or advised to receive Treatment (including maintenance medications) for heart attack, heart disease or disorder, angina, stroke, diabetes, congestive heart failure, transient ischemic attack (TIA) or seizures? YES NO
- 6. In the past 10 years, have you been Treated or advised to receive Treatment (including maintenance medications) for liver disease, kidney disease or kidney failure, or Chronic Obstructive Pulmonary Disease (COPD)? YES NO
- 7. List Current Prescription Medications: _____

I hereby agree that this supplement shall be an amendment to and form a part of my application for insurance, and be a part of any contract of insurance issued on the basis of such application.

Signed at _____
CITY STATE

Application Date _____
MONTH DAY YEAR

SIGNATURE OF PROPOSED INSURED

SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

WITNESS-LICENSED AGENT SIGNATURE

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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR OL9917 Readability Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Form No. OL9466-AR(Rev.7/09), approved by your department on July 28, 2009.

Attachment:

AR OL9466(Rev.7-09) Life Insurance Application.pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter

Comments:

Cover Letter attached.

Attachment:

AR OL9917 Cover Letter.pdf

ARKANSAS

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

CERTIFICATION

This is to certify that the attached Supplement to Application, Form Number OL9917, has achieved a Flesch Reading Ease Score of 51.5 and complies with the requirements of Arkansas Statue 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Simplification Act.



Signature

Clara Keel, FLMI
Product Filing Manager and Assistant Secretary

May 25, 2011

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

P.O. BOX 2595, WACO, TX 76702-2595 • (254) 297-2775

LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case No: _____

Proposed Insured _____ <small>(First) (Middle) (Last)</small>			Telephone interview completed <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address (No. & Street) _____			_____ <input type="checkbox"/> am <input type="checkbox"/> pm		
City _____		State _____	Zip Code _____		E-mail Address _____
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Age	State of Birth	Social Security Number / /	Height ft in
					Weight lbs
Owner: Name _____		Relationship _____		SS# _____ / _____ / _____	
Address _____		City/State/Zip _____			
Primary Beneficiary _____		Relationship _____	Contingent Beneficiary _____		Relationship _____
Plan: <input type="checkbox"/> Immediate Death Benefit <input type="checkbox"/> Graded Death Benefit (Percentage of Face Amount)					
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Face Amount of Insurance \$ _____					
Rider: <input type="checkbox"/> Grandchild/Great Grandchild Coverage (Indicate Number of Children Applying) _____				Automatic Premium	
<input type="checkbox"/> Child Rider _____ Units <input type="checkbox"/> ADB Amt \$ _____				Loan Elected? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mode: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Draft 1st Prem on Req. Date		CWA: <input type="checkbox"/> E-Check Immediate 1st Prem	Mail Policy To: <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Owner		
<input type="checkbox"/> Other Modal Prem \$ _____		<input type="checkbox"/> Collected \$ _____	Requested Policy Date: / /		
A. Do you have existing life insurance or an annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No			Company _____		
B. Will you replace an existing life insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No			Policy # _____	Amount of Coverage \$ _____	
Physician Name: _____		City/State: _____		Phone: _____	

HEALTH INFORMATION

1. Are you currently hospitalized, confined to a bed or nursing facility, confined to a wheelchair due to chronic illness or disease, or using oxygen equipment to assist in breathing, or receiving Hospice Care? Yes No
2. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having metastatic cancer, Alzheimer's, dementia, mental incapacity, or have you been diagnosed, treated (including dialysis) or taken medication for renal insufficiency, kidney failure, liver failure, or respiratory failure? Yes No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
4. Have you been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, TIA, heart disease, heart attack, coronary artery bypass, angioplasty, circulatory disease, or peripheral vascular disease? Yes No
5. Have you taken insulin shots prior to age 50 or been treated for insulin shock or diabetic coma? Yes No
6. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, Huntington's disease, had an amputation caused by disease, or more than one occurrence of cancer (excluding basal or squamous cell skin cancer) in your lifetime? Yes No
7. Within the past 12 months have you:
 - a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? Yes No
 - b. had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant or had or been medically advised to have surgery for brain or heart disorders (including, but not limited to catheterization, a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? Yes No
 - c. been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? Yes No
 - d. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? Yes No
 - e. used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug use, or been convicted of any felony or driving under the influence of alcohol or drugs? Yes No

If any answer to questions 1 through 7 is answered "Yes" the Proposed Insured is not eligible for any coverage.

8. Within the past 24 months have you been medically diagnosed or treated, or hospitalized for:
 - a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ... Yes No
 - b. or taken medication for internal cancer, leukemia, melanoma, emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, liver disease? Yes No
 - c. paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? Yes No

If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.

If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.

Form No. OL9466-AR(Rev.7/09)

NOTICE

Printed in compliance with Public Law 91-508

Thank you for considering Occidental Life Insurance Company of North Carolina for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Occidental Life Insurance Company of North Carolina, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Occidental Life Insurance Company of North Carolina, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):

Proposed Insured Name	Sex	Birthdate	Relationship	Proposed Insured Name	Sex	Birthdate	Relationship

PROPOSED CHILDREN'S HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT.

Children listed as an exception are excluded from the appropriate Child Rider Coverage. Exceptions are: _____

AGREEMENT—I agree with Occidental Life Insurance Company of North Carolina (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the Medical Information Bureau or other organization that has knowledge or records of me and my health to give such information to: (a) Occidental Life Insurance Company of North Carolina; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the Medical Information Bureau, are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Occidental Life Insurance Company of North Carolina to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the Medical Information Bureau; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at _____
CITY STATE

Date of Application _____
MONTH DAY YEAR

SIGNATURE OF PROPOSED INSURED

SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

AGENT'S REPORT

Does the proposed insured have any existing life insurance or annuity contract? Yes No
 Is the proposed insurance intended to replace or change any existing life insurance or annuity?..... Yes No

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.

I certify that the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable. AGENT'S REMARKS: _____

AGENT'S PRINTED NAME DATE
 Agent _____ No: _____ %
SIGNATURE

AGENT'S PRINTED NAME DATE
 Agent _____ No: _____ %
SIGNATURE

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured _____ Account Holder _____
 Financial Institution _____ Address _____
 Transit/ABA Number _____ Account Number _____ Checking Savings Requested Draft Day (1st-28th) _____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of Occidental Life Insurance Company of North Carolina, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS)

DATE

Form No. 0L9466-AR(Rev.7/09)

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
 P.O. BOX 2595, WACO, TX 76702-2595

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
 DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of _____ the sum of \$ _____ as first payment on this application.

Date _____ Agent _____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED \$30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.



**OCCIDENTAL LIFE INSURANCE
COMPANY OF NORTH CAROLINA**

P.O. Box 2595 • Waco, Texas 76702-2595 • 254-297-2775

May 31, 2011

NAIC No. 67148

Mr. Joe Musgrove
Policy and Other Form Filings
State of Arkansas
Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-1904
Attention: Compliance - Life and Health

Re: Form No. OL9917 – Supplement to Application

Dear Mr. Musgrove:

The above referenced Supplement to Application is being submitted for your consideration and approval. This application supplement is new and will not replace any application approved by your department.

Supplement to Application, Form No. OL9917, will be used as a supplement to Application Form No. OL9466-AR(Rev.7/09), approved by your department on July 28, 2009. This Supplement to Application will be used to apply for a preferred plan of whole life insurance. The Flesch readability score for the supplemental application combined with the application is 51.5.

The above referenced submission meets the provisions of Arkansas Rule and Regulation 19 (Unfair Sex Discrimination in the Sale of Insurance) as well as all applicable requirements of the department.

If I may be of assistance in your review, please contact me at 1-800-736-7311, extension 3216, or ckeel@aatx.com.

Sincerely,

A handwritten signature in blue ink that reads "Clara Keel".

Clara Keel, FLMI
Product Filing Manager & Assistant Secretary

CJK:tab
Enc.