

SERFF Tracking Number: UCTA-127201295 State: Arkansas
 Filing Company: Order of United Commercial Travelers of America State Tracking Number: 48992
 Company Tracking Number: FXP APP
 TOI: L07I Individual Life - Whole Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Whole Life
 Project Name/Number: /

Filing at a Glance

Company: Order of United Commercial Travelers of America

Product Name: Whole Life SERFF Tr Num: UCTA-127201295 State: Arkansas
 TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved- Closed State Tr Num: 48992
 Sub-TOI: L07I.101 Fixed/Indeterminate Co Tr Num: FXP APP State Status: Approved-Closed
 Premium - Single Life
 Filing Type: Form Reviewer(s): Linda Bird
 Authors: Denise Sharif, Jane Visocan, Lyndsay Fields Disposition Date: 06/10/2011
 Date Submitted: 06/06/2011 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: 06/10/2011
 State Status Changed: 06/10/2011
 Deemer Date: Created By: Denise Sharif
 Submitted By: Denise Sharif Corresponding Filing Tracking Number:
 Filing Description:
 See attached cover letter for filing description.

Company and Contact

Filing Contact Information

Denise Sharif, Compliance Supervisor dsharif@uct.org

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 Product Name: Whole Life

Project Name/Number: /
 1801 Watermark Dr. 614-487-9680 [Phone] 103 [Ext]
 Suite 100 614-487-9675 [FAX]
 Columbus, OH 43215

Filing Company Information

Order of United Commercial Travelers of America CoCode: 56383 State of Domicile: Ohio
 1801 Watermark Dr. Group Code: Company Type:
 Suite 100 Group Name: State ID Number:
 Columbus, OH 43215 FEIN Number: 31-4273120
 (614) 487-9680 ext. 103[Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: \$50 for Application and \$50 for Reinstatement Application
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Order of United Commercial Travelers of America	\$100.00	06/06/2011	48397826

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/10/2011	06/10/2011

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Life
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Disposition

Disposition Date: 06/10/2011

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 - Acturial Memo		No
Supporting Document	Cover letter		Yes
Form	Whole Life Application		Yes
Form	Reinstatement 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
	FXP_APP_0611	Application/ Enrollment Form	Whole Life Application	Initial		0.000	FXP_APP_0611.pdf
	FXP_COH_0611	Application/ Enrollment Form	Reinstatement Application	Initial		0.000	FXP_COH_0611.pdf



Application for Final Expense Life Insurance

Requested Effective Date of Policy:
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1. PROPOSED INSURED AND BENEFICIARY INFORMATION

Applicant Name				Residence Address		
Last:	First:	MI:	Street:			
Description of Occupation:				City:		
Name of Employer:				State, Zip Code:		
Address:				Email:		
Telephone: ()				Telephone: ()		
Age:	Date of Birth: (M/D/Y)	Birth State:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	Social Security No.:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced						

Primary Beneficiary

Name (Last, First, MI) or Non-Natural Entity Name:	Relationship to Proposed Insured:
Percentage of Death Benefit:	Social Security No.:

Primary Beneficiary Contingent Beneficiary

Name (Last, First, MI) or Non-Natural Entity Name:	Relationship to Proposed Insured:
Percentage of Death Benefit:	Social Security No.:

ADD ADDITIONAL SHEET FOR MORE BENEFICIARIES

Are you a member of The Order of United Commercial Travelers of America? Yes No

If "Yes," Members No: _____ If "No," complete M-81 Form.

2. OWNER (If other than Proposed Insured)

Last Name:	First Name:	MI:	Date of Birth:	Social Security No.:
Street:	City:	State:	Zip Code:	Relationship to Proposed Insured:

3. PROPOSED INSURANCE PLAN

Type Plan	Face Amount:	Premium:	Premium Mode:	
Final Expense Plan	\$ _____	\$ _____	<input type="checkbox"/> Annual	<input type="checkbox"/> Semi-Annual
Annual Policy Fee:	\$ 36.00		<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly EFT (Electronic Funds Transfer)

Sum Paid with Application: \$ _____ Total Modal Premium: \$ _____
 (Receipt valid only if amount paid with application is entered here)

Will the premium be paid by the Proposed Insured or the Owner? Yes No If "No," please complete the Payor's information below:

Payor's Name	Payor's Address (Number, Street, City, State, Zip Code)
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4. MEDICAL QUESTIONS FOR PROPOSED INSURED

If any question in this section is answered "Yes," the Proposed Insured is not eligible for coverage.

1. Do you currently need assistance from or supervision by another individual for dressing, eating, bathing, toileting, walking or transferring to or from a bed or chair, or are you currently confined to a hospital, psychiatric or nursing facility, or receiving home health or receiving or been advised to receive hospice care? Yes No
2. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? Yes No
3. Have you ever received or been advised to receive an organ or tissue transplant? Yes No
4. Have you ever been diagnosed with Alzheimer's Disease, Dementia, Amyotrophic Lateral Sclerosis (ALS) or a Terminal Illness (any illness diagnosed that would reasonably be expected to cause death within 12 months)? Yes No
5. Within the past thirty-six months have you been diagnosed with or had treatment for Cancer (including Leukemia, Lymphoma or Melanoma)? Yes No
6. Within the past twenty-four months have you used oxygen equipment to assist in breathing or had dialysis? Yes No
7. Within the past twelve months have you been advised to have a diagnostic test, surgery, home health care, or hospitalization which has not yet been started, completed or for which results are not known? Yes No
8. Within the past twenty-four months have you been confined to a hospital or a nursing facility (for 3 or more consecutive days) or has hospital/nursing home confinement or surgery been recommended to you? Yes No
9. Within the past twenty-four months have you had or have you received treatment (including prescription drugs) for any of the following conditions:
 - (a) Chronic Obstructive Pulmonary Disease, Emphysema, Congestive Heart Failure? Yes No
 - (b) Alzheimer's Disease, Dementia, Parkinson's Disease, Systemic Lupus Erythematosus (SLE), Huntington's Disease, or other neurological disorder? Yes No
 - (c) Insulin Dependent Diabetes, Insulin Shock, Diabetic Coma, Kidney Insufficiency or failure, other chronic Kidney Disease, Cirrhosis of the Liver, Hepatitis B or C, or other Liver Disorder? Yes No
 - (d) Heart Attack, Stroke, Cardiomyopathy, Heart Arrhythmia, Transient Ischemic Attack (TIA), Aneurysm, or Brain Tumor? Yes No
 - (e) Alcohol, Drug, or Substance Abuse or addiction (including prescription drugs)? Yes No
10. Within the past twenty-four months have you undergone any procedure to improve circulation or had an amputation due to disease? Yes No
11. Have you used any form of tobacco in the past twenty-four months? Yes No
12. Have you been declined for life insurance within the past twelve months? Yes No

5. REPLACEMENT INFORMATION

1. Does the Proposed Insured have any existing life insurance or annuities currently in force or pending with this or any other company? Yes No
2. Will this policy, if issued, replace or modify insurance or annuities with this or any other company? Yes No

If "Yes," provide the following information:

Name of Company: _____ Policy No.: _____

Reason for replacement: _____

6. AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Signed at (City & State):	Date:	Applicant's Signature:
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7. AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other life insurance or annuity policies you have sold to the Applicant that is still in force.

2. List any other life insurance or annuity policies you have sold to the Applicant in the past five (5) years that is no longer in force.

3. Do you have any knowledge or reason to believe that the Applicant is intending to replace an existing insurance? Yes No

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Signature:	Agent's Printed Name:	
Date (M/D/Y):	Agent No.:	Agent's E-mail Address:

MIB AUTHORIZATION & ACKNOWLEDGEMENT THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization **EXCEPT** to reinsurance companies, the Medical Information Bureau Inc. (MIB), or other persons or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medically-related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution, or person, that has my records or knowledge of my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

I also understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, or a request for change in policy benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

Applicant Name:	Signature of Applicant:	
Social Security No.:	Date of Birth:	Date:

AUTHORITY TO HONOR PREMIUM CHECKS

AUTHORIZATION	IN FAVOR OF:	The Order of United Commercial Travelers of America 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619		AUTHORIZATION
	Name of Bank Customer: _____	Type of Account: <input type="checkbox"/> Checking		
	Insured's Name: _____	<input type="checkbox"/> Savings		
	Routing Number: _____	Account Number: _____		
	To (Name of Bank): _____			
Address of Bank: _____				
<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority 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 or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America 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 forfeiture of insurance.</p>				
Date: _____		Signature of Bank Customer: _____		

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above: In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted

NOTICE TO APPLICANT

In making this application for insurance to The Order of United Commercial Travelers of America, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. 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.

Information regarding your insurability will be treated as confidential. The Order of United Commercial Travelers of America, or its reinsurer, may; however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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, Braintree, Massachusetts 02184-8734.

The Order of United Commercial Travelers of America, or its reinsurer, may also release information from its file to other insurance companies to whom you 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.

Leave with Applicant



Certificate of Health

Application for Final Expense Life Insurance Reinstatement

INSURED'S INFORMATION						
Applicant Name				Residence Address		
Last:	First:	MI:	Street:			
Description of Occupation:				City:		
Name of Employer:				State, Zip Code:		
Address:				Email:		
Telephone: ()				Telephone: ()		
Age:	Date of Birth: (M/D/Y)	Birth Prov.:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	Social Security No.:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced						

MEDICAL QUESTIONS
1. Do you currently need assistance from or supervision by another individual for dressing, eating, bathing, toileting, walking or transferring to or from a bed or chair, or are you currently confined to a hospital, psychiatric or nursing facility, or receiving home health or receiving or been advised to receive hospice care? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever received or been advised to receive an organ or tissue transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been diagnosed with Alzheimer's Disease, Dementia, Amyotrophic Lateral Sclerosis (ALS) or a Terminal Illness (any illness diagnosed that would reasonably be expected to cause death within 12 months)? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the past thirty-six months have you been diagnosed with or had treatment for Cancer (including Leukemia, Lymphoma or Melanoma)? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past twenty-four months have you used oxygen equipment to assist in breathing or had dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past twelve months have you been advised to have a diagnostic test, surgery, home health care, or hospitalization which has not yet been started, completed or for which results are not known? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past twenty-four months have you been confined to a hospital or a nursing facility (for 3 or more consecutive days) or has hospital/nursing home confinement or surgery been recommended to you? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the past twenty-four months have you had or have you received treatment (including prescription drugs) for any of the following conditions:
(a) Chronic Obstructive Pulmonary Disease, Emphysema, Congestive Heart Failure? <input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Alzheimer's Disease, Dementia, Parkinson's Disease, Systemic Lupus Erythematosus (SLE), Huntington's Disease, or other neurological disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Insulin Dependent Diabetes, Insulin Shock, Diabetic Coma, Kidney Insufficiency or failure, other chronic Kidney Disease, Cirrhosis of the Liver, Hepatitis B or C, or other Liver Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Heart Attack, Stroke, Cardiomyopathy, Heart Arrhythmia, Transient Ischemic Attack (TIA), Aneurysm, or Brain Tumor? <input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Alcohol, Drug, or Substance Abuse or addiction (including prescription drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past twenty-four months have you undergone any procedure to improve circulation or had an amputation due to disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you used any form of tobacco in the past twenty-four months? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you been declined for life insurance within the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Signed at (City & State):	Date:	Applicant's Signature:
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MIB AUTHORIZATION & ACKNOWLEDGEMENT THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization **EXCEPT** to reinsurance companies, the Medical Information Bureau Inc. (MIB), or other persons or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medically-related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution, or person, that has my records or knowledge of my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

I also understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, or a request for change in policy benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

Applicant Name:	Signature of Applicant:	
Social Security No.:	Date of Birth:	Date:

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Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: Flesch Certification is attached. Attachment: ReadCert 6-3-11.pdf</p>		

	Item Status:	Status Date:
<p>Satisfied - Item: Application Comments: Application is being submitted for approval and is attached to the form schedule page.</p>		

	Item Status:	Status Date:
<p>Bypassed - Item: Life & Annuity - Acturial Memo Bypass Reason: Not applicable. Comments:</p>		

	Item Status:	Status Date:
<p>Satisfied - Item: Cover letter Comments: See attached. Attachment: AR Cover letter.pdf</p>		

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

The Order of United Commercial Travelers of America
1801 Watermark Dr., Suite 100
Columbus, OH 43215

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Title of Form	Form Number	Flesch Score	
		Stand-Alone	Combined with Policy Form
Application for Whole Life Insurance	FXP APP 0611	36.2	50.6
Application for Reinstatement of Life Insurance – Certificate of Health	FXP COH 0611	37.5	53.5

In determining the Flesch Scores shown above, the following “text” was excluded:

1. The name and address of the company;
2. The name, number and title of the form;
3. The table of contents or index;
4. Captions and sub-captions;
5. Specification pages, schedules and tables;
6. Any provisions required by federal law or regulation; and
7. Any medical terminology.

The type size of the text is at least 10-point.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in the state.



Signature of Insurance Company Officer

June 6, 2011

Department of Insurance
State of Arkansas
1200 West 3rd Street
Little Rock, Arkansas 72201-1904

**RE: The Order of United Commercial Travelers of America
NAIC number: 56383
FEIN number: 31-4273120**

SUBMISSION

**Whole Life Application – Form Number FXP APP 0611
Certificate of Health – Form Number FXP COH 0611**

FOR USE WITH:

Whole Life Insurance Policy – Form WL-92 – Approved August 9, 1995

We are requesting the Department's review and approval of this filing.

Form number FXP APP 0611 is an application for life insurance. It is replacing Form Number FXP-98-A-AR which was previously approved on March 4, 1998.

The Application is being revised to add the fraud warning, update authorization language and to expand the medical questions to help improve the underwriting process. The Certificate of Health form is the application for reinstatement of the life insurance.

The application will be used by licensed agents to sell the above captioned Whole Life Insurance Policy approved in your state.

We appreciate your time and consideration with regard to this filing.

Sincerely,

Denise Sharif
Compliance Supervisor
(800) 848-0123, Ext. 103
Email: dsharif@uct.org