

SERFF Tracking Number:	AAAL-127339283	State:	Arkansas
Filing Company:	AAA Life Insurance Company	State Tracking Number:	49426
Company Tracking Number:	LF-20901APPRC		
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	Reinstatement Application		
Project Name/Number:	/		

Filing at a Glance

Company: AAA Life Insurance Company
 Product Name: Reinstatement Application
 TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other
 Filing Type: Form

SERFF Tr Num: AAAL-127339283 State: Arkansas
 SERFF Status: Closed-Approved-
 Closed State Tr Num: 49426

Co Tr Num: LF-20901APPRC State Status: Approved-Closed
 Reviewer(s): Linda Bird
 Disposition Date: 08/04/2011

Authors: Judy Lucas, Tamara
 Thompson
 Date Submitted: 07/29/2011
 Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval
 State Filing Description:

Implementation Date:

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: Authorized
 Date Approved in Domicile: 07/22/2011
 Domicile Status Comments:
 Market Type: Individual
 Individual Market Type:
 Filing Status Changed: 08/04/2011
 State Status Changed: 08/04/2011
 Created By: Judy Lucas
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Judy Lucas
 Filing Description:
 See Cover Letter

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

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Product Name:	Reinstatement Application		
Project Name/Number:	/		
AAA Life Insurance Company	CoCode: 71854	State of Domicile:	Michigan
17900 N. Laurel Park Drive	Group Code:	Company Type:	
Livonia, MI 48152-3985	Group Name:	State ID Number:	
(800) 624-1662 ext. 2942[Phone]	FEIN Number: 52-0891929		

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AAA Life Insurance Company	\$50.00	07/29/2011	50196668

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/04/2011	08/04/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	08/03/2011	08/03/2011	Judy Lucas	08/03/2011	08/03/2011

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Disposition

Disposition Date: 08/04/2011

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	Reinstatement Application		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/03/2011
Submitted Date 08/03/2011
Respond By Date 09/05/2011

Dear Judy Lucas,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Cover letter was not attached to the submission.

Please feel free to contact me if you have questions.

Sincerely,
Linda Bird

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Product Name: Reinstatement Application
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/03/2011
Submitted Date 08/03/2011

Dear Linda Bird,

Comments:

I apologize for the oversight

Response 1

Comments: A cover letter is now attached.

Related Objection 1

Comment:

Cover letter was not attached to the submission.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Cover Letter

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your continued review.

Judy Lucas

Sincerely,

Judy Lucas, Tamara Thompson

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Form Schedule

Lead Form Number: LF-20901APPRC

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LF-20901APP RC	Application/ Reinstatement Enrollment Application Form	Initial			LF-20901APPRC - Reinstatement Application.pdf



**INDIVIDUAL LIFE INSURANCE
APPLICATION FOR REINSTATEMENT OR CHANGE IN COVERAGE**

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

Section A. Customer Information - Please complete entire section

Policy Number		AAA Member Number	
Name of Insured		Insured SSN (Last 4 digits) ____ _	
Street Address	City	State	ZIP
Insured Date of Birth	Driver's License No. or Government ID No.		
Daytime Phone	E-mail Address		
Annual Income	Occupation	Name of Owner (if different than Insured)	

Section B. Reinstatement (Underwriting Required)

Reinstatement | I hereby apply for reinstatement in accordance with all the Policy's terms and conditions.
COMPLETE SECTION D - UNDERWRITING INFORMATION

Section C. Policy Changes

Policy Change - (Underwriting Required) | *Please work with your Agent to make any policy changes. If you do not have an Agent, please call 1-800-624-1662 and we will put you in touch with a new Agent.*

SELECT CHANGE REQUEST AND THEN COMPLETE SECTION D - UNDERWRITING INFORMATION

NOTE: Changes to a Universal Life Policy may affect its performance

Increase Base Face Amount from \$ _____ to \$ _____ *(Universal Life Policies Only)*
 Will you be replacing any coverage with this increase? Yes No
 If "Yes", name of insurer and policy number: _____

Premium Class Change from Nicotine to Non-Nicotine or reduction/removal of substandard rating

Add Riders: Note: Not all riders are available with all products

Add **Primary Insured Rider** for \$ _____ Add **Accidental Death Rider** for \$ _____

Add **Additional Insured Rider** for \$ _____

Additional Insured Rider Information				SSN	Relationship to Primary Insured	Amount of Life Insurance In Force	Date of Last Issue
Full Name	Gender	Date of Birth	Age				

Policy Change - (NO Underwriting Required) | *Please work with your Agent to make any policy changes. If you do not have an Agent, please call 1-800-624-1662 and we will put you in touch with a new Agent.*

SELECT CHANGE REQUEST AND THEN SKIP TO SECTION E (No need to complete Section D)

NOTE: Changes to a Universal Life Policy may affect its performance

Change Death Benefit Option (Choose Only One) : A-Level to B-Increasing C-Premium Recovery to A-Level *
 * Accumulator - Universal Life only B-Increasing to A-Level C-Premium Recovery to B-Increasing *

Add Child Term Rider for \$ _____

Name of Child (Attach additional sheets if necessary)	Gender	Age	Date of Birth	SSN	Relationship to Primary Insured

Decrease Base Face Amount from \$ _____ to \$ _____

Exercise GPO (Guaranteed Purchase Option) for \$ _____

Cancel Riders:

- | | | | | | |
|---------------------------------|------------------------------|---------------------------------|---------------------------------|---------------------------------|---|
| Cancel <input type="checkbox"/> | Child Term Rider | Cancel <input type="checkbox"/> | Accidental Death Rider | Cancel <input type="checkbox"/> | Guaranteed Purchase Option Rider |
| Cancel <input type="checkbox"/> | Primary Insured Rider | Cancel <input type="checkbox"/> | Intermediate Period | Cancel <input type="checkbox"/> | Disability Waiver of Premium Rider |
| Cancel <input type="checkbox"/> | Additional Insured Rider | | Endowment Benefit Rider | Cancel <input type="checkbox"/> | Spouse Rider |
| Cancel <input type="checkbox"/> | Waiver of Monthly Deductions | Cancel <input type="checkbox"/> | Payor Death or Disability Rider | Cancel <input type="checkbox"/> | Return of Premium Rider (11/8/2009 issue date or earlier) |

Section D. Underwriting Information - Please complete entire section if you are applying for Reinstatement or a Policy Change requiring underwriting

Important: The Insured must answer ALL the questions below. Provide details to any "Yes" answers in the space provided. Attach additional sheets if necessary.

1. Height: _____ft. _____in. Weight: _____lbs. Weight Loss in past Year: _____lbs.
2. In the past 60 months, 36 months, 24 months, have you used tobacco in any form or nicotine, including substitutes such as patches or gum? Date last used: _____ Yes No
3. HAVE YOU PARTICIPATED, OR DO YOU ANTICIPATE IN THE NEXT TWO YEARS, PARTICIPATION IN ANY FORM OF: sky diving, underwater scuba diving, parachuting, parasailing, racing of any vehicle, rock and/or mountain climbing, boxing, kayak competition, cave exploration, ice boating, ice climbing, hot air ballooning, or helicopter skiing. Yes No
4. Do you have a personal physician? Yes (if yes, write name, address & phone below) No
- Physician Name: _____ Phone No.:(_____) _____
- Street Address: _____ City, State, Zip: _____
- Date of Last Visit: _____ Reason for Visit: _____

Since the date of the original application:	Insured	Additional Insured
5. Have you or additional insured covered under this Policy been treated for, or informed by a medical professional as having:		
a.) Seizure, brain, neurological, mental or nervous disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or other disorder of the lungs or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.) Intestinal bleeding, chronic colitis, hepatitis, or other disorder of the esophagus, stomach, intestines, liver, or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.) Diabetes, anemia, or any disorder of the glandular system or blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.) Disease of the kidney or bladder, or sugar, blood or protein in urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.) Arthritis or any disorder of muscles or bones including spine or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.) Cancer or tumor (any location)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the Insured or Additional Insured:		
a.) In addition to the information above, had examination, testing, treatment, or consultation with a doctor or been hospitalized during the past five years (except those tests related to HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.) Sought, received, or been advised to seek treatment or counseling for alcohol and/or drug drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.) Used narcotics, hallucinogens, barbiturates, heroin, marijuana, cocaine, or any other drug not prescribed by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.) Been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.) Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed (except those tests related to HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.) In the last year had any conditions or disorders not listed above, for which you were treated or diagnosed by a medical professional?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.) In the past 5 years, been convicted of driving under the influence of alcohol or reckless driving, had your license denied, suspended or revoked, or been ticketed for a moving violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.) Pled guilty or been convicted of a felony or misdemeanor or do you have a charge currently pending against you, other than a traffic violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.) Have you been treated by a member of the medical professional and applied for or received income benefits for injury, sickness, or disability, or have you been diagnosed as being currently disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide details to "Yes" answers on the next page: (Attach separate sheet if necessary)

Full Name of Insured or Additional Insured	Ques. No.	Date of Onset & Duration	Diagnosis & Treatment	Name, Address & Phone No. of Attending Physician & Hospital	Date Last Seen

Section E. Premium Payments - Please complete to authorize the draft of all premiums due upon approval.
NOTE: You will be notified of any changes to premium based upon the underwriting of this Policy, if applicable, before funds are drafted from your checking/savings account or credit card.

Payment Frequency: Annually Semi-Annually Quarterly Monthly*
 (EFT & Credit Card Only)

*An Additional Fee May Apply

Payment Method: Automatic Premium Payment (EFT or Credit Card) - *Please complete form 10034*
 Other Instructions / Requests: _____

Section F. Signatures - Please read, sign and date

Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines or penalties.

Applicable to residents of:

Arkansas: Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Oregon: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud and may be subject to

I declare that all statements and answers in this application for reinstatement or change in coverage are, to the best of my knowledge and belief, true, complete and correctly recorded. A copy of the application will be attached to the Policy which is being changed or reinstated. I understand this application will be used to determine my insurability with regard to the requested change or reinstatement.

I understand that no change in coverage or reinstatement will become effective unless and until this application is approved by the Company at its Home Office, and the full amount of premium due is received while the insured is living. I further understand that this Policy's Incontestability Provision will apply from the date this policy is changed or reinstated with regard to statements made on this application.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), pharmacy, benefit manager, or other organization, institution or person that has any records or knowledge of the Proposed Insured's medical or prescription history to give any such information to the Company, its representatives or reinsurers. I understand that my medical records may be protected by certain federal regulations, especially as they apply to any drug or alcohol abuse data. I understand that I may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original. I understand that I or my authorized representative have the right to a copy of this authorization.

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

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TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: Reinstatement Application

Project Name/Number: /

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Readability Certification - noncompact.pdf

Item Status:

Status

Date:

Satisfied - Item: Application

Comments:

See Cover Letter for details of SERFF tracking numbers and approval dates.

Item Status:

Status

Date:

Satisfied - Item: Cover Letter

Comments:

Attachment:

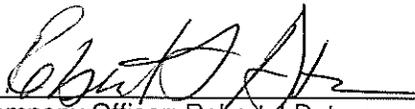
Cover Letter - AR.pdf

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
LF-20901APPRC	Reinstatement Application	50.2



Company Officer: Robert J. Dotson

Title: Vice President and General Counsel

July 29, 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

July 29, 2011

Arkansas Insurance Department

Re: AAA Life Insurance Company, NAIC #71854
Form Number: LF-20901APPRC - Reinstatement Application (Individual)

To Whom It May Concern:

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 as required.. Once approved, this form will be used on an as needed basis upon an applicant's desire for reinstatement or change to their existing policy. No part of this filing contains any unusual or possibly controversial items from our normal Company or industry standards.

The Application that this will be used with are forms LF80201APP, LF80202APP, LF80200. These forms were approved by you under SERFF tracking number FRCS-125066808, approved on 1/19/2011. It will also be used with the revised part II Application, LF80202APP approved on 5/3/2011 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 your state (SERFF Tracking number: FRCS-126980406 & FRCS-127017493) and the Individual Term Filing approved with your state (SERFF Tracking number: FRCS-127074810). It may also be used with individual life products filed and approved with the department in the future. It will also be used with all individual life policies approved for use in your state.

This will not replace anything currently approved in your state.

All appropriate certification forms are submitted with this filing.

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