

SERFF Tracking Number: CAKN-127626754 State: Arkansas
Filing Company: Catholic Financial Life State Tracking Number: 49798
Company Tracking Number: CNO-130
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Simplified Application
Project Name/Number: SIM APP/CNO-130-133

Filing at a Glance

Company: Catholic Financial Life
Product Name: Simplified Application
TOI: L08 Life - Other

SERFF Tr Num: CAKN-127626754 State: Arkansas
SERFF Status: Closed-Approved- State Tr Num: 49798
Closed

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

Co Tr Num: CNO-130 State Status: Approved-Closed
Reviewer(s): Linda Bird
Author: Donna Peterson Disposition Date: 09/16/2011
Date Submitted: 09/15/2011 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: SIM APP
Project Number: CNO-130-133
Requested Filing Mode:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Wisconsin, our
state of domicile is part of the Interstate
Compact. This application was filed with the
Compact on September 7, 2011.

Explanation for Combination/Other:
Submission Type:
Overall Rate Impact:

Market Type: Individual
Individual Market Type:
Filing Status Changed: 09/16/2011
State Status Changed: 09/16/2011

Deemer Date:
Submitted By: Donna Peterson
Filing Description:

Created By: Donna Peterson
Corresponding Filing Tracking Number:

We are filing a new application that will be used for small face amount life policies. This paper application will be used with our whole life plans. In Section 6 if all questions in Part A and Part B are answered NO the product is issued. There is no underwriting.

If questions in Part B are answered yes, the application goes to our tele-underwriter who will use our Supplementary Application, form 2010 LF APP2 for additional information, This form was approved by AR 6/16/2010. Your assigned state tracking number was 45939 and the SERFF tracking number was FRCS-126669812. A copy is enclosed for

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 reference on the Supporting Documentation Tab.

Company and Contact

Filing Contact Information

Donna Peterson, donna.peterson@catholicfinanciallife.org
 1100 W Wells Street 414-278-6509 [Phone]
 Milwaukee, WI 53233

Filing Company Information

Catholic Financial Life CoCode: 56030 State of Domicile: Wisconsin
 1100 West Wells Street Group Code: Company Type: Fraternal
 Milwaukee, WI 53233 Group Name: State ID Number: 2796
 (414) 273-6266 ext. 6509[Phone] FEIN Number: 39-0201015

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Catholic Financial Life	\$50.00	09/15/2011	51637019

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/16/2011	09/16/2011

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Disposition

Disposition Date: 09/16/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>CAKN-127626754</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Catholic Financial Life</i>	<i>State Tracking Number:</i>	<i>49798</i>
<i>Company Tracking Number:</i>	<i>CNO-130</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Simplified Application</i>		
<i>Project Name/Number:</i>	<i>SIM APP/CNO-130-133</i>		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application		Yes
Supporting Document	Flesch Certification		Yes
Form	Application for Individual Insurance and Membership		Yes

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Form Schedule

Lead Form Number: 2011 SIM APP

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	2011 SIM APP	Application/ Enrollment Form	Application for Individual Insurance and Membership	Initial		50.100	2011 SIM APP.pdf

Application for Individual Insurance and Membership

1. PROPOSED INSURED

Name: _____ M F
First Middle Initial Last

SS/ITIN No _____ DOB _____ Age _____ State of Birth _____

Is the proposed insured a US Citizen? Yes No

If No, does the proposed insured have permanent resident (green card) status? Yes _____ No

Does the proposed insured have a valid driver's license? Yes No Card Number

If Yes, list state of issue and number _____

Address _____
Street City State Zip

Occupation _____ Employer _____ Income _____

Phone # (____) _____ - _____ Email Address _____

a) Is Proposed Insured Catholic? Yes No If Yes, indicate parish: _____

b) If "No", how does the proposed insured otherwise qualify for Membership? Married to a Catholic Child/Grandchild of a Catholic

Employed by a Catholic Organization: Name of Catholic Organization: _____

2. OWNER (Must complete section if owner is not the Insured)

Name: _____ M F SS/ITIN No _____
First Middle Initial Last

Address _____
Street City State Zip

Phone # (____) _____ - _____ Relationship to proposed insured _____

3. BENEFICIARY (attach a sheet with additional Beneficiaries if necessary)

Primary	Name (first, initial, last)	Relationship	Birth date	SS/ITIN No
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Contingent	Name (first, initial, last)	Relationship	Birth date	SS/ITIN No
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. PLAN OF INSURANCE

20 Pay Life Whole Life Single Premium Whole Life
 Face Amount: \$ _____ (minimum \$10,000 and maximum \$25,000)
 Premium Mode: Annual Semi-Annual Monthly EFT
 Dividend Option: Cash Paid Up Life Additions Interest Reduced Premium
 Automatic Premium Loan provision elected: Yes No

5. REPLACEMENT SUITABILITY

1. Does the Proposed Insured have any existing coverage and/or pending applications for individual life insurance or annuities with this or any other company? (other than group) Yes No
 2. Does the Proposed Insured intend to replace, discontinue or change any such coverage? Yes No
If YES to 1 or 2 provide the following information, and complete and return any required replacement forms
 Certificate No: _____ Amount _____ Company _____

6. MEDICAL HISTORY

Proposed Insured's Current Height _____ Current Weight _____
 Within the past 12 months has the Proposed Insured used Tobacco or Nicotine in any form? Yes No
Part A – If any question is answered "Yes" in Part A, the Proposed Insured is not eligible for coverage.
 1. Is the Proposed Insured currently bedridden at home, confined in a licensed facility, or diagnosed with a terminal illness? Yes No
 2. Does the Proposed Insured require the use of a wheelchair, or currently use oxygen due to a chronic illness? Yes No
 3. Has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No

4. Has the Proposed Insured ever had, been told they have, been treated for, or taken medication for:
- a. Cerebral palsy, Down's syndrome, spina bifida, cystic fibrosis, mental retardation, or muscular dystrophy? Yes No
 - b. Systemic Lupus, Alzheimer's disease, Parkinson's disease, organic brain syndrome, dementia, or Amyotrophic Lateral Sclerosis? Yes No
 - c. Cirrhosis of the liver, chronic hepatitis, or other liver disorder, kidney failure or other chronic kidney disease? Yes No

Part B – Provide details in the Remarks section for all questions that are answered “Yes” in Part B.

1. Has the Proposed Insured ever had insurance or reinstatement denied, postponed, limited or offered on a substandard basis? Yes No
2. Has the Proposed Insured been diagnosed with or advised to have treatment for chronic obstructive pulmonary disease, chronic bronchitis, or emphysema? Yes No
3. Has the Proposed Insured ever been diagnosed, treated, or been given medical advice by a member of the medical profession for:
 - a. Any disorder or disease of the brain or nervous system such as stroke, paralysis, or transient ischemic attack (TIA)? Yes No
 - b. Any disorder or disease of the heart, blood vessels or circulatory system such as heart attack, coronary artery disease (CAD), congestive heart failure (CHF), angina, chest pain, irregular heartbeat, aneurysm, cardiomyopathy, or uncontrolled hypertension, or procedures such as angioplasty, stent placement, valve replacement, or pacemaker? Yes No
 - c. Any psychiatric or mental health disorder or disease such as depression, schizophrenia, bipolar disorder? Yes No
 - d. Any internal cancer, or other cancers such as melanoma, leukemia, or sickle cell anemia? Yes No
 - e. Any digestive disorder such as Crohn's disease, ulcerative colitis, gastrointestinal bleeding, or unexplained weight loss? Yes No
4. Has the Proposed Insured been advised to have surgery or biopsy that has not been done? Yes No
5. In the past 2 years has the Proposed Insured received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs? Yes No
6. Has the Proposed Insured been diagnosed with diabetes? Yes No
 - a. Has the Proposed insured been diagnosed or treated for uncontrolled diabetes, diabetic coma, or insulin shock? Yes No

Remarks - For each “Yes” response in Part B above list question number and give full details such as doctor name and address, diagnosis, tests, treatments and dates (if more space is required then attach an additional sheet):

AGREEMENT:

- 1) I declare that I have read the application and all answers and statements pertaining to me in this application are complete and true to the best of my knowledge and belief.
- 2) I agree that the statements and answers in the application are the basis for contract issue. No information about them will be considered to have been given to the Society unless it is stated in the application. I understand that that no insurance will be effective unless: a contract is issued and delivered to me; the first premium paid; and my health status does not change between the application and issue dates.
- 3) I received the Notice of Insurance Information Practices. Catholic Financial Life may release information to the Medical Information Bureau (MIB) in accordance with this notice.
- 4) I understand that the agent does not have the Society's authorization to accept risk, pass on insurability or make, void, waive or change any conditions or provisions of the application, contract or receipt. No agent or person other than the President or Secretary has the authority to change or modify this contract or waive any of its provisions.
- 5) I hereby authorize any licensed physician, medical practitioner, any medical or related facility, insurance or reinsurance company, the MIB, employer, individual, entity, or consumer reporting agency, to give to Catholic Financial Life, its reinsurers or its legal representatives, any and all medical and non-medical information (such as credit reports and employer reports) available on me.
- 6) The release of information may include all medical historical records and any records dated up to two years beyond the date of this authorization. The scope of these records may include, but not be limited to: diagnoses, treatment and prognosis of any physical or mental condition, psychiatric history or treatment and drug or alcohol abuse history or treatment.
- 7) I understand that Catholic Financial Life requires this information to determine eligibility for life insurance coverage. I also authorize the above sources, except the MIB, to provide the requested information to any consumer reporting agency, or to any legal agent employed by the Society.
- 8) No obtained information will be released to any person or entity except to reinsuring companies, or other persons or organizations performing business or legal services with my application. The Society may release this information when lawfully required, or as I further authorize.
- 9) This authorization is valid for two years from the date shown below, unless revoked earlier. This consent may be revoked at any time upon written request, executed by the undersigned and directed in writing to the insurer's mailing address. Such revocation will have no effect on actions already taken by the Society or its authorized agents. I have the right to refuse to sign this authorization. However, Catholic Financial Life may refuse coverage if this authorization is not signed. I agree that copies of this authorization may be used in place of the original.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at _____ on _____

City State Month Day Year

Signature of Insured _____

Signature of Parent/Guardian for Minor _____

Signature of Advisor _____

Agent Number _____

Signature of Owner (if other than insured) _____

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Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Application

Comments:

Attached part II application used by tele-underwriters was approved by AR on 6/16/2010 AR filing 45939.

Attachment:

non-compct part II.pdf

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Flesch SIM app.pdf



PART II SUPPLEMENTARY

Application for Membership and Insurance to:
 Catholic Financial Life
 1100 West Wells Street
 Milwaukee, Wisconsin 53233
 (800) 927-2547

Full Legal Name _____

Date of Birth _____

Social Security Number _____

Policy Number _____

Interviewer _____

Date of Interview _____

PROPOSED INSURED MUST COMPLETE ALL QUESTIONS. ALL "YES" ANSWERS MUST BE EXPLAINED AND REFERENCED IN REMARKS.		
	Yes	No
Has or does the person proposed for this insurance coverage:		
1) Ever engaged in or expect to engage within the next two years any of the following:		
a. Aviation activities as a pilot or crew member?	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin or Scuba Diving; organized motor vehicle or motor boat racing; mountain climbing; professional rodeo competition; skydiving; parachuting, hang-gliding?	<input type="checkbox"/>	<input type="checkbox"/>
2) Are you or do you intend to become a member of the Armed Forces (including Reserves or National Guard)?	<input type="checkbox"/>	<input type="checkbox"/>
3) a. Drink alcoholic beverages? If yes, how much per week? _____ (one drink = 12 oz. beer, 4 oz. wine, or 1 oz. hard liquor) Amount _____	<input type="checkbox"/>	<input type="checkbox"/>
b. Now or ever used heroin, cocaine, marijuana, or illegal, restricted or controlled substance, except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
c. Ever had or been advised by a physician, practitioner, or court of law to have treatment for alcohol, drug, or substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>
4) a. Had insurance or reinstatement refused, postponed, limited, offered, or quoted on a rated or substandard basis?	<input type="checkbox"/>	<input type="checkbox"/>
b. Will this insurance replace or change any existing life insurance or annuity contract?	<input type="checkbox"/>	<input type="checkbox"/>
c. Made within the past 5 years a claim for or received benefits compensation, or pension for any injury, sickness, disability, or impaired condition?	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 5 years been unable to work, attend school, or perform normal activities of like age and gender, or been confined at home.	<input type="checkbox"/>	<input type="checkbox"/>
5) Ever been cited for driving while intoxicated (DWI), or driving under the influence (DUI)?	<input type="checkbox"/>	<input type="checkbox"/>
a. Ever been cited for any other driving violation in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
6) Ever been convicted in a court of law for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
7) a. Have you traveled outside the United States within the past 2 years or intend to travel outside the United States within the next 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you lived outside of the United States within the past 2 years or intend to live outside the United States within the next 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
8) 8) Do you now use or have you ever used tobacco or nicotine in any form? If yes, indicate the type of tobacco used: <input type="checkbox"/> cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigar <input type="checkbox"/> chewing tobacco <input type="checkbox"/> other If applicable, the date you stopped: _____	<input type="checkbox"/>	<input type="checkbox"/>
9) a. Were your parents, brothers or sisters diagnosed and treated for mental illness, diabetes, heart, kidney or liver disease, high blood pressure, stroke or cancer? If yes, name person(s). b. Give name, cause and age at death of father, mother, brother(s), sister(s) if deceased: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
10) Full name and complete address of personal physician; the date, reason last seen and diagnosis: _____ _____		
11) Have you declared bankruptcy in the last 7 years or had any suits, judgments or liens against you? If yes, discharged date: _____	<input type="checkbox"/>	<input type="checkbox"/>

COMPLETION OF QUESTIONS 12-19 IS REQUIRED IN ALL CASES. ANY "YES" ANSWERS MUST BE FULLY EXPLAINED AND REFERENCED IN REMARKS.

AIDS TEST RESULTS OBTAINED AT AN ANONYMOUS COUNSELING AND TESTING SITE DESIGNATED BY THE STATE EPIDEMIOLOGIST OR AT A SIMILAR FACILITY IN ANOTHER JURISDICTION OR HOME TESTING ARE CONFIDENTIAL AND NEED NOT BE DISCLOSED. NONE OF THESE APPLICATION QUESTIONS SHOULD BE INTERPRETED AS ASKING ABOUT AIDS, UNLESS THE QUESTION SPECIFICALLY MENTIONS AIDS.

Has or does the person proposed for insurance coverage:	Yes	No
12) Ever been diagnosed or treated by a member of the medical profession for a disorder, disease or persistent discomfort of the following systems:		
a. Respiratory (lungs, bronchi, trachea, etc.) such as, but not limited to, TB, asthma, emphysema, bronchitis, shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
b. Circulatory (heart, blood, arteries, veins, etc.) such as, but not limited to, high blood pressure, heart attack, chest pains, murmur?	<input type="checkbox"/>	<input type="checkbox"/>
c. Digestive (Throat, esophagus, stomach, intestine, liver, gall bladder, etc.) such as, but not limited to, ulcer, colitis, cirrhosis, hemorrhoids, bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
d. Nervous (brain, nerves, etc.) such as, but not limited to, paralysis, stroke, fainting, dizziness, epilepsy, convulsions, recurring headaches?	<input type="checkbox"/>	<input type="checkbox"/>
e. Musculo-skeletal (muscles, bones, joints, spine, etc.) such as, but not limited to, neck/back problems, fracture, arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genito-urinary (kidney, bladder, reproductive organs, etc.) such as, but not limited to, kidney stones, infection, bleeding, male or female disorders?	<input type="checkbox"/>	<input type="checkbox"/>
g. Glandular (thyroid, pancreas, adrenal, lymph glands, etc.) such as, but not limited to, abnormal growth or function, including diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
13) Been diagnosed or treated by a member of the medical profession for:		
a. impaired sight, or eye disorder	<input type="checkbox"/>	<input type="checkbox"/>
b. impaired hearing, or ear disorder	<input type="checkbox"/>	<input type="checkbox"/>
c. hernia	<input type="checkbox"/>	<input type="checkbox"/>
d. skin disease	<input type="checkbox"/>	<input type="checkbox"/>
e. any sexually transmitted disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
14) Been diagnosed or treated by a member of the medical profession for any mental, nervous, psychological, or emotional condition or disorder, such as, but not limited to, anxiety, depression, or nervous breakdown?	<input type="checkbox"/>	<input type="checkbox"/>
15) Have you ever been diagnosed or treated for cancer, tumor, cyst, or growth?	<input type="checkbox"/>	<input type="checkbox"/>
16) Gained or lost more than 10 pounds in the past year? Amount: _____ Cause: _____	<input type="checkbox"/>	<input type="checkbox"/>
17) Within the past 5 years: (Refer to disclaimer concerning AIDS test results at top of page)		
a. Have you been treated, examined or advised by a member of the medical profession?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had a physical examination? If yes, list the reason for and results below.	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Been on, or now on, prescribed diet or medication? List description of medication or diet, date prescribed and name and address of prescriber in remarks	<input type="checkbox"/>	<input type="checkbox"/>
e. Currently take any herbs, vitamins, mineral supplements or other non-prescription remedies? List description of non-prescribed medications in remarks.	<input type="checkbox"/>	<input type="checkbox"/>
18) Been diagnosed or treated by a member of the medical profession the past 10 years for complications of pregnancy (such as C-section) or now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
19) a. Been treated or diagnosed by a member of the medical profession as having any disorder of the blood or immune system, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Ever been treated by a member of the medical profession as having the AIDS (TTLV-III) Virus or tested positive to FDA licensed blood tests?	<input type="checkbox"/>	<input type="checkbox"/>



READABILITY CERTIFICATION

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of the Policy Language Simplification Act.

Form Number	Score
ICC11 SIM APP	50.1

A handwritten signature in blue ink, appearing to read "Daniel H. Strasburg", is written over a horizontal line.

Daniel H. Strasburg, FSA, MAAA
Vice President and Chief Actuary

August 31, 2011