

SERFF Tracking Number:	CTZN-127609544	State:	Arkansas
Filing Company:	Security Plan Life Insurance Company	State Tracking Number:	49693
Company Tracking Number:	201109		
TOI:	L071 Individual Life - Whole	Sub-TOI:	L071.101 Fixed/Indeterminate Premium - Single Life
Product Name:	SPLIC Applications		
Project Name/Number:	Applications/201109-02		

Filing at a Glance

Company: Security Plan Life Insurance Company

Product Name: SPLIC Applications

SERFF Tr Num: CTZN-127609544 State: Arkansas

TOI: L071 Individual Life - Whole

SERFF Status: Closed-Approved-
Closed State Tr Num: 49693

Sub-TOI: L071.101 Fixed/Indeterminate
Premium - Single Life

Co Tr Num: 201109

State Status: Approved-Closed

Filing Type: Form

Author: Amy Inman

Reviewer(s): Linda Bird

Date Submitted: 08/31/2011

Disposition Date: 09/07/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Applications

Status of Filing in Domicile: Pending

Project Number: 201109-02

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: The filing in the
domicile state (Louisiana) was submitted on
8/31/11.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 09/07/2011

State Status Changed: 09/07/2011

Deemer Date:

Created By: Amy Inman

Submitted By: Amy Inman

Corresponding Filing Tracking Number:
201109-02

Filing Description:

Application form F00151E (R201109 is meant to replace currently approved application form F00151E (201011) for individual whole life policies. Application form F00251E (R201109) is meant to replace currently approved application form F00251E (201011) for family whole life policies. Application form F00351E (R201109) is meant to replace currently approved application form F00351E (201011) for graded whole life policies. Three changes to these currently approved application forms were made that are mostly clean-up clerical changes. First, a clerical reference to "Book Number" has

SERFF Tracking Number: CTZN-127609544 State: Arkansas
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been changed to reflect five blanks instead of one long blank. Second, the question "is automatic premium loan desired?" has been added since this option is available in the policies but was not reflected in the previous application. Third, in the signature line for the Proposed Insured a reference to the minimum age for an insured has been deleted so that these application forms can be used in multiple states that have different minimum age requirements.

Company and Contact

Filing Contact Information

Amy Inman, Associate Counsel amy.inman@sbcglobal.net
 400 E. Anderson Lane 512-837-7100 [Phone]
 Austin, TX 78752 512-836-9334 [FAX]

Filing Company Information

Security Plan Life Insurance Company CoCode: 60076 State of Domicile: Louisiana
 400 E. Anderson Lane Group Code: 612 Company Type: LAH
 Austin, TX 78752 Group Name: State ID Number:
 (512) 837-7100 ext. [Phone] FEIN Number: 72-1308780

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: \$50 per each application form (3).
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Plan Life Insurance Company	\$150.00	08/31/2011	51151331

SERFF Tracking Number: CTZN-127609544 State: Arkansas
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Product Name: SPLIC Applications
Project Name/Number: Applications/201109-02

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/07/2011	09/07/2011

SERFF Tracking Number: CTZN-127609544 *State:* Arkansas
Filing Company: Security Plan Life Insurance Company *State Tracking Number:* 49693
Company Tracking Number: 201109
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: SPLIC Applications
Project Name/Number: Applications/201109-02

Disposition

Disposition Date: 09/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CTZN-127609544 State: Arkansas
 Filing Company: Security Plan Life Insurance Company State Tracking Number: 49693
 Company Tracking Number: 201109
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: SPLIC Applications
 Project Name/Number: Applications/201109-02

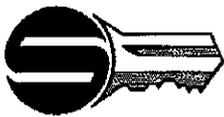
Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Application		Yes
Form	Family Application		Yes
Form	Graded Application		Yes

SERFF Tracking Number: CTZN-127609544 State: Arkansas
 Filing Company: Security Plan Life Insurance Company State Tracking Number: 49693
 Company Tracking Number: 201109
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: SPLIC Applications
 Project Name/Number: Applications/201109-02

Form Schedule

Lead Form Number: F00151E (R201109)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	F00151E (R201109)	Application/ Enrollment Form	Initial			F00151E (R201109) SPLIC Application.pdf
	F00251E (R201109)	Application/ Family Enrollment Form	Initial			F00251E (R201109) SPLIC Family Application.pdf
	F00351E (R201109)	Application/ Graded Enrollment Form	Initial			F00351E (R201109) SPLIC Graded Application.pdf



**APPLICATION FOR INSURANCE TO:
SECURITY PLAN LIFE INSURANCE COMPANY
205 Railroad Avenue • Donaldsonville, LA 70346**

DISTRICT _____ BOOK NUMBER _____ PAYOR GROUP NUMBER _____ APPLICATION #51N _____

1. PLAN NUMBER	DESCRIPTION OF POLICY	MONTHLY PREMIUM	AMOUNT OF INSURANCE
2. NAME OF PROPOSED INSURED (Please print full name)			TELEPHONE NUMBER
Last	First	Middle Initial	()
3. SOCIAL SECURITY NUMBER		MARITAL STATUS	OCCUPATION
4. <u>PHYSICAL</u> ADDRESS (Street)		City	State Zip Code
5. <u>MAILING</u> ADDRESS(Street)		City	State Zip Code
6. DATE AND PLACE TO COLLECT PREMIUMS			7. IS AUTOMATIC PREMIUM LOAN DESIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO
8. EMPLOYER - LIST NAME, ADDRESS AND TELEPHONE NUMBER			HOW LONG EMPLOYED Yrs. Mos.
9. DATE OF BIRTH		AGE	SEX
MONTH	DAY	YEAR	LAST
		NEXT	MALE FEMALE
		HEIGHT	WEIGHT
		Ft. In.	lbs.
10. METHOD OF COLLECTION			
<input type="checkbox"/> AGENT COLLECT <input type="checkbox"/> MAIL PAY <input type="checkbox"/> OFFICE PAY <input type="checkbox"/> ELECTRONIC DRAFT <input type="checkbox"/> SINGLE PREMIUM			
11. NAME, ADDRESS AND TELEPHONE NUMBER OF PREMIUM PAYOR (if different from Proposed Insured)			
Last	First	Middle Initial	Address Telephone Number
12. NAME OF OWNER (if different from Proposed Insured)		AGE	RELATIONSHIP
Last	First	Middle Initial	
13. NAME OF CONTINGENT OWNER		AGE	RELATIONSHIP
Last	First	Middle Initial	
14. NAME OF PRIMARY BENEFICIARY		AGE	RELATIONSHIP
Last	First	Middle Initial	
15. NAME OF CONTINGENT BENEFICIARY		AGE	RELATIONSHIP
Last	First	Middle Initial	

ALL QUESTIONS MUST BE COMPLETED (EVEN IF A MEDICAL EXAM IS REQUIRED). EXPLANATIONS FOR "YES" RESPONSES SHOULD BE RECORDED IN THE "REMARKS" SECTION OF THIS APPLICATION.

- | | |
|--|--|
| 16. Is this policy replacing any existing insurance? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 17. Have you ever applied for insurance that was declined, rated or postponed? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 18. Are you pregnant? If yes, list number of months _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 19. Have you ever been arrested for or convicted of any violation other than a traffic violation? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 20. Have you seen a doctor in the past 3 years? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 21. Have you been hospitalized during the last 5 years? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 22. Have you ever been diagnosed with or treated for diabetes, cancer, tumors or any other illness? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 23. Have you ever been diagnosed with or treated for heart trouble, blood disorders, or high blood pressure? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

FOR HOME OFFICE USE ONLY

POLICY NUMBER: _____ ISSUE DATE: _____ AMOUNT OF INSURANCE: _____

ENDORSEMENTS: _____

24. Have you ever had trouble breathing or been diagnosed with or treated for any disease such as asthma, emphysema, tuberculosis or other lung problems? YES NO
25. Have you ever been diagnosed with or treated for kidney disorder, bladder trouble, gall bladder trouble, stomach ulcer, liver disease, or bleeding from stomach, intestines, or rectum? YES NO
26. Have you ever been diagnosed with or treated for nervous trouble, nervous breakdown, epileptic attacks, or other convulsions or mental disorders? YES NO
27. Have you ever been diagnosed with or treated for venereal disease, or ever had trouble with the male or female sexual or reproductive organs? YES NO
28. In the past have you had or been told you had Acquired Immune Deficiency Syndrome, ("AIDS"), or AIDS Related Complex ("ARC") or ever tested positive on an AIDS-related blood test? YES NO
29. Have you ever had or been advised by a physician or practitioner to have treatment for alcohol or drug use? YES NO
30. Have you ever used or are you currently using cocaine, marijuana or other drugs (except as prescribed by a physician)? YES NO
31. Do you have any abnormality(s) or deformity(s) not covered above? YES NO
32. Have you ever received disability benefits of any kind? YES NO
33. Who is your family doctor? Name: _____
Address: _____

REMARKS

(Provide complete details to any "YES" answer and include dates, medications, results, etc.)

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.

I affirm that all the statements on both sides of this application are true and complete to the best of my knowledge and belief and that they shall be the basis for and a part of the policy.

I understand and agree that the Company is not bound to issue a policy and has no liability unless a policy is issued and the first premium paid (date of receipt at the Company's office shall be considered the date of payment) while the Proposed Insured's health and other conditions affecting insurability remain as described herein.

HIPAA PRIVACY AUTHORIZATION

THIS AUTHORIZATION COMPLIES WITH HIPAA PRIVACY RULE: By executing this Authorization, I authorize all health care providers that have been involved in the care, diagnosis or treatment (including but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose medical records of the Proposed Insured (including but not limited to, patient histories, progress notes, test results, x-rays, and other diagnostic information) to SECURITY PLAN LIFE INSURANCE COMPANY for the purpose of determining eligibility for payment of a claim or issuance of a policy.

I understand and agree that the hospital or doctor indicated may disclose the medical records on the Proposed Insured and the information contained in those records to SECURITY PLAN LIFE INSURANCE COMPANY for the purpose stated above.

I also understand that when the medical records are disclosed pursuant to this Authorization, the medical records on the Proposed Insured 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 health care provider or hospital or doctor indicated above has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to Security Plan Life Insurance Company, Post Office Box 609, Donaldsonville, LA 70346.

This Authorization will expire six months after the date the Authorization is signed.

SIGNED AT (City and State) _____ SIGNATURE _____
Proposed Insured

DATE _____ SIGNATURE _____
Applicant/Policyowner (if different from Proposed Insured)

I certify that I have personally seen the Proposed Insured, witnessed the Proposed Insured or Applicant/Policyowner sign this application, asked all health questions above and have truly and accurately recorded the information supplied.

Signature of Agent/Producer

*Amount Collected with THIS Application _____

Paid by: _____ Cash _____ Check _____



**APPLICATION FOR INSURANCE TO:
SECURITY PLAN LIFE INSURANCE COMPANY
205 Railroad Avenue • Donaldsonville, LA 70346**

DISTRICT _____ BOOK NUMBER _____ PAYOR GROUP NUMBER _____ APPLICATION #51N _____

- 2 Parent Family Plan - Plan 363 - Male
 2 Parent Family Plan - Plan 364 - Female

- 1 Parent Family Plan - Plan 365 - Male
 1 Parent Family Plan - Plan 366 - Female

1. PLAN NUMBER	DESCRIPTION OF POLICY	MONTHLY PREMIUM	AMOUNT OF INSURANCE	
2. NAME OF PROPOSED INSURED (Please print full name)			TELEPHONE NUMBER	
Last	First	Middle Initial	()	
3. SOCIAL SECURITY NUMBER		MARITAL STATUS		OCCUPATION
4. <u>PHYSICAL</u> ADDRESS (Street)		City		State Zip Code
5. <u>MAILING</u> ADDRESS(Street)		City		State Zip Code
6. DATE AND PLACE TO COLLECT PREMIUMS			7. IS AUTOMATIC PREMIUM LOAN DESIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
8. EMPLOYER - LIST NAME, ADDRESS AND TELEPHONE NUMBER				HOW LONG EMPLOYED
				Yrs. Mos.
9. DATE OF BIRTH		AGE		SEX
MONTH	DAY	YEAR	LAST	NEXT
				MALE FEMALE
				HEIGHT
				Ft. In. lbs.
10. METHOD OF COLLECTION				
<input type="checkbox"/> AGENT COLLECT <input type="checkbox"/> MAIL PAY <input type="checkbox"/> OFFICE PAY <input type="checkbox"/> ELECTRONIC DRAFT				
11. NAME, ADDRESS AND TELEPHONE NUMBER OF PREMIUM PAYOR (if different from Proposed Insured)				
Last	First	Middle Initial	Address	Telephone Number
12. NAME OF OWNER (if different from Proposed Insured)			AGE	RELATIONSHIP
Last	First	Middle Initial		
13. NAME OF CONTINGENT OWNER			AGE	RELATIONSHIP
Last	First	Middle Initial		

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POLICY NUMBER: _____ ISSUE DATE: _____ AMOUNT OF INSURANCE: _____

ENDORSEMENTS:

14. PRIMARY BENEFICIARY FOR THE FOLLOWING:

Last	First	Middle Initial	AGE	RELATIONSHIP
INSURED: _____			_____	_____
INSURED SPOUSE: _____			_____	_____
INSURED CHILDREN: _____			_____	_____

15. CONTINGENT BENEFICIARY FOR THE FOLLOWING:

Last	First	Middle Initial	AGE	RELATIONSHIP
INSURED: _____			_____	_____
INSURED SPOUSE: _____			_____	_____
INSURED CHILDREN: _____			_____	_____

16. List name of spouse and names of unmarried children UNDER the age of 18 proposed for insurance.

FULL NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP	DATE OF BIRTH			AGE Last Birthday	HEIGHT		WEIGHT lbs.
			Mo.	Day	Year		Ft.	In.	

17. I hereby amend this application to EXCLUDE from coverage the family members listed below.

FULL NAME	RELATIONSHIP	DATE OF BIRTH			AGE	REASON(S) EXCLUDED FROM PLAN
		Mo.	Day	Year		

Signed this _____ day of _____, _____ Signature of Proposed Insured _____

ALL QUESTIONS MUST BE COMPLETED (EVEN IF A MEDICAL EXAM IS REQUIRED). EXPLANATIONS FOR "YES" RESPONSES SHOULD BE RECORDED IN THE "REMARKS" SECTION OF THIS APPLICATION.

- 18. Is this policy replacing any existing insurance? YES NO
- 19. Have you or any family members ever applied for insurance that was declined, rated or postponed? YES NO
- 20. Are you or any family members herein now pregnant? YES NO
 If yes, list number of months and name of expectant mother _____
- 21. Have you or any family members ever been arrested for or convicted of any violation other than a traffic violation? YES NO
- 22. Have you or any family members seen a doctor in the past 3 years? YES NO
- 23. Have you or any family members been hospitalized during the last 5 years? YES NO
- 24. Have you or any family members ever been diagnosed with or treated for diabetes, cancer, tumors or any other illness? YES NO
- 25. Have you or any family members ever been diagnosed with or treated for heart trouble, blood disorders, or high blood pressure? YES NO
- 26. Have you or any family members ever had trouble breathing or been diagnosed with or treated for any disease such as asthma, emphysema, tuberculosis or other lung problems? YES NO
- 27. Have you or any family members ever been diagnosed with or treated for kidney disorder, bladder trouble, gall bladder trouble, stomach ulcer, liver disease, or bleeding from stomach, intestines or rectum? YES NO
- 28. Have you or any family members ever been diagnosed with or treated for nervous trouble, nervous breakdown, epileptic attacks, or other convulsions or mental disorders? YES NO
- 29. Have you or any family members ever been diagnosed with or treated for venereal disease, or ever had trouble with the male or female sexual or reproductive organs? YES NO
- 30. In the past have you or any family members had or been told you had Acquired Immune Deficiency Syndrome, ("AIDS") or AIDS Related Complex ("ARC") or ever tested positive on an AIDS-related blood test? YES NO
- 31. Have you or any family members ever had or been advised by a physician or practitioner to have treatment for alcohol or drug use? YES NO
- 32. Have you or any family members ever used or are you currently using cocaine, marijuana or other drugs (except as prescribed by a physician)? YES NO
- 33. Do you or any family members have any abnormality(s) or deformity(s) not covered above? YES NO
- 34. Have you or any family members ever received disability benefits of any kind? YES NO

35. List below the name(s) of the family doctor for the Proposed Insured, spouse (if applicable) and all family members:

**NAME OF PROPOSED INSURED,
SPOUSE OR CHILD**

**DOCTOR(S)
NAME AND ADDRESS**

REMARKS
 (Provide complete details to any "YES" answer and include dates, medications, results, etc.)

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.

I affirm that all the statements on each page of this application are true and complete to the best of my knowledge and belief and that they shall be the basis for and a part of the policy.

I understand and agree that the Company is not bound to issue a policy and has no liability unless a policy is issued and the first premium paid (date of receipt at the Company's office shall be considered the date of payment) while the Proposed Insured's health and other conditions affecting insurability remain as described herein.

HIPAA PRIVACY AUTHORIZATION

THIS AUTHORIZATION COMPLIES WITH HIPAA PRIVACY RULE: By executing this Authorization, I authorize all health care providers that have been involved in the care, diagnosis or treatment (including but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose medical records of the Proposed Insured (including but not limited to, patient histories, progress notes, test results, x-rays, and other diagnostic information) to SECURITY PLAN LIFE INSURANCE COMPANY for the purpose of determining eligibility for payment of a claim or issuance of a policy.

I understand and agree that the hospital or doctor indicated may disclose the medical records on all of the Proposed Insureds and the information contained in those records to SECURITY PLAN LIFE INSURANCE COMPANY for the purpose stated above.

I also understand that when the medical records are disclosed pursuant to this Authorization, the medical records on all of the Proposed Insureds 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 health care provider or hospital or doctor indicated above has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to Security Plan Life Insurance Company, Post Office Box 609, Donaldsonville, LA 70346.

This Authorization will expire six months after the date the Authorization is signed.

SIGNED AT (City and State) _____ SIGNATURE _____
Proposed Insured

DATE _____ SIGNATURE _____
Applicant/Policyowner (if different from Proposed Insured)

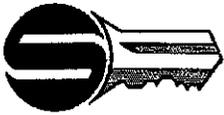
I certify that I have personally seen the Proposed Insured, witnessed the Proposed Insured or Applicant/Policyowner sign this application, asked all health questions above and have truly and accurately recorded the information supplied.

Signature of Agent/Producer

*Amount Collected with THIS Application _____

Paid by: _____ Cash _____ Check

***If more than one application is written, list all amounts collected separately.**



**APPLICATION FOR INSURANCE TO:
SECURITY PLAN LIFE INSURANCE COMPANY
205 Railroad Avenue • Donaldsonville, LA 70346**

DISTRICT _____ BOOK NUMBER _____ PAYOR GROUP NUMBER _____ APPLICATION #51N _____

20 Payment Graded Death Benefit

Whole Life Graded Death Benefit

1. PLAN NUMBER	DESCRIPTION OF POLICY	MONTHLY PREMIUM	AMOUNT OF INSURANCE
2. NAME OF PROPOSED INSURED (Please print full name) Last First Middle Initial			TELEPHONE NUMBER ()
3. SOCIAL SECURITY NUMBER		MARITAL STATUS	OCCUPATION
4. <u>PHYSICAL</u> ADDRESS (Street)		City	State Zip Code
5. <u>MAILING</u> ADDRESS (Street)		City	State Zip Code
6. DATE AND PLACE TO COLLECT PREMIUMS		7. IS AUTOMATIC PREMIUM LOAN DESIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
8. EMPLOYER - LIST NAME, ADDRESS AND TELEPHONE NUMBER			HOW LONG EMPLOYED Yrs. Mos.
9. DATE OF BIRTH MONTH DAY YEAR		AGE LAST NEXT	SEX MALE FEMALE
		HEIGHT Ft. In.	WEIGHT lbs.
10. METHOD OF COLLECTION <input type="checkbox"/> AGENT COLLECT <input type="checkbox"/> MAIL PAY <input type="checkbox"/> OFFICE PAY <input type="checkbox"/> ELECTRONIC DRAFT			
11. NAME, ADDRESS AND TELEPHONE NUMBER OF PREMIUM PAYOR (if different from Proposed Insured) Last First Middle Initial Address Telephone Number			
12. NAME OF OWNER (if different from Proposed Insured) Last First Middle Initial		AGE	RELATIONSHIP
13. NAME OF CONTINGENT OWNER Last First Middle Initial		AGE	RELATIONSHIP
14. NAME OF PRIMARY BENEFICIARY Last First Middle Initial		AGE	RELATIONSHIP
15. NAME OF CONTINGENT BENEFICIARY Last First Middle Initial		AGE	RELATIONSHIP

COMMENTS: _____

FOR HOME OFFICE USE ONLY		
POLICY NUMBER: _____	ISSUE DATE: _____	AMOUNT OF INSURANCE: _____
ENDORSEMENTS: _____ _____ _____		

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.

I affirm that all the statements on both sides of this application are true and complete to the best of my knowledge and belief and that they shall be the basis for and a part of the policy.

I understand and agree that the Company is not bound to issue a policy and has no liability unless a policy is issued, and the first premium is paid (date of receipt at the Company's office shall be considered the date of payment) and the Proposed Insured is still living.

HIPAA PRIVACY AUTHORIZATION

THIS AUTHORIZATION COMPLIES WITH HIPAA PRIVACY RULE: By executing this Authorization, I authorize all health care providers that have been involved in the care, diagnosis or treatment (including but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose medical records of the Proposed Insured (including but not limited to, patient histories, progress notes, test results, x-rays, and other diagnostic information) to SECURITY PLAN LIFE INSURANCE COMPANY for the purpose of determining eligibility for payment of a claim or issuance of a policy.

I understand and agree that the hospital or doctor indicated may disclose the medical records on the Proposed Insured and the information contained in those records to SECURITY PLAN LIFE INSURANCE COMPANY for the purpose stated above.

I also understand that when the medical records are disclosed pursuant to this Authorization, the medical records on the Proposed Insured 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 health care provider or hospital or doctor indicated above has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to Security Plan Life Insurance Company, Post Office Box 609, Donaldsonville, LA 70346.

This Authorization will expire six months after the date the Authorization is signed.

I FULLY UNDERSTAND THAT THIS POLICY HAS A LIMITED NATURAL DEATH BENEFIT FOR THE FIRST 2 POLICY YEARS.

SIGNED AT (City and State) _____ SIGNATURE _____
Proposed Insured

WITNESS _____

DATE _____ SIGNATURE _____
Applicant/Policyowner (if different from Proposed Insured)

I certify that I have personally seen the Proposed Insured and witnessed the Proposed Insured or Applicant/Policyowner sign this application, and have truly and accurately recorded the information supplied.

Signature of Agent/Producer

*Amount Collected with THIS Application _____

Paid by: _____ Cash _____ Check _____

***If more than one application is written, list all amounts collected separately.**

SERFF Tracking Number: CTZN-127609544 State: Arkansas
 Filing Company: Security Plan Life Insurance Company State Tracking Number: 49693
 Company Tracking Number: 201109
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: SPLIC Applications
 Project Name/Number: Applications/201109-02

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification		
Bypass Reason: Not applicable because the forms being submitted are applications.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: The forms being submitted are application forms and are, therefore, attached under the Form Schedule.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: Not applicable because the forms being submitted are application forms.		
Comments:		