

SERFF Tracking Number: UNFG-127632600 State: Arkansas
Filing Company: United Life Insurance Company State Tracking Number: 49840
Company Tracking Number: LIU-839 (11-11)
TOI: L071 Individual Life - Whole Sub-TOI: L071.111 Single Premium - Single Life
Product Name: SPWL SU Application
Project Name/Number: /

Filing at a Glance

Company: United Life Insurance Company

Product Name: SPWL SU Application

TOI: L071 Individual Life - Whole

SERFF Tr Num: UNFG-127632600 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49840

Sub-TOI: L071.111 Single Premium - Single Life Co Tr Num: LIU-839 (11-11)

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Joanne Young

Disposition Date: 09/26/2011

Date Submitted: 09/21/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: 01/01/2012

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: 09/26/2011

State Status Changed: 09/26/2011

Deemer Date:

Created By: Joanne Young

Submitted By: Joanne Young

Corresponding Filing Tracking Number:

Filing Description:

LIU-839 (11-11) SPWL Simplified Underwriting Application

We are filing this form for review and approval. This is a new life application that will be used for our Single Premium Whole Life policy. This new application will have simplified underwriting.

There is one bracketed item on the application which is the maximum issue age. The range for that item is [60-90]. We will initially use 85 for the maximum issue age.

Our products are individually marketed by our contracted agents. This filing, to the best of our knowledge, contains no unusual or possibly controversial items from normal company or industry standards.

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Thank you for your consideration.

Company and Contact

Filing Contact Information

Joanne Young, Analyst jyoung@unitedfiregroup.com
 118 2nd Ave SE 319-286-2620 [Phone]
 PO Box 73909 319-286-2570 [FAX]
 Cedar Rapids, IA 52407-3909

Filing Company Information

United Life Insurance Company CoCode: 69973 State of Domicile: Iowa
 118 2nd Ave SE Group Code: 248 Company Type: Life
 PO Box 73909 Group Name: United Fire Group State ID Number:
 Cedar Rapids, IA 52407-3909 FEIN Number: 42-6061188
 (319) 399-5700 ext. [Phone]

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Life Insurance Company	\$50.00	09/21/2011	51953680

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/26/2011	09/26/2011

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Disposition

Disposition Date: 09/26/2011

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		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Single Premium Whole Life Simplified		Yes
	Underwriting Application		

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Form Schedule

Lead Form Number: LIU-839 (11-11)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LIU-839 (11-11)	Application/ Single Premium Enrollment Form Whole Life Simplified Underwriting Application	Initial		0.000	LIU-839 (11-11).pdf



UNITED LIFE INSURANCE COMPANY
 118 Second Avenue SE P.O. Box 73909 – Cedar Rapids, Iowa 52407
 800-637-6318 FAX 888-726-9736

SINGLE PREMIUM WHOLE LIFE SIMPLIFIED UNDERWRITING APPLICATION
Death Benefit Based on Simplified Underwriting May Not Exceed \$100,000 with the Company

PROPOSED INSURED

Name (Last, First, Middle) _____ U.S. Citizen Yes No
 Street Address _____ City _____ State _____ Zip _____
 Soc. Sec. # _____ Male Female Date of Birth _____ Age _____ not to exceed [85]
 Driver's License # _____ Email _____
 Occupation _____ Employer _____
 Work Phone _____ Home Phone _____ Cell Phone _____
 Other Life Insurance in force? No Yes With United Life \$ _____ With other companies \$ _____

RATE CLASS (choose one)

Select (No cigarettes for 12 months, other tobacco acceptable) Standard (Cigarette smoker)

Owner (if different than insured) _____ Date of Birth _____ Phone # _____
 Street Address _____ City _____ State _____ Zip _____
 Relationship to the insured _____ Individual Corp LLC Partnership Other
 Tax ID/SS # _____ U.S. Citizen Yes No Email _____

Contingent Owner (Required if proposed insured is a minor) _____

Payor Name (if different than owner) _____ Tax ID/SS Number _____
 Billing Address _____ City _____ State _____ Zip _____ U.S. Citizen Yes No
 Email _____

FACE AMOUNT \$ _____ *

PLAN

Single Premium Whole Life

Guaranteed Ins. Option \$ _____ Number of Options (1-5) _____ Final Total Benefit \$ _____ *
 QCADB Rider (Qualified Care Accelerated Death Benefit) Amount \$ _____
 (Cannot exceed death benefit. QCADB minimum \$50,000.)

*Death Benefit based on simplified underwriting may not exceed \$100,000 with the Company.

PREMIUM

Planned 1st Yr. or **Annual Premium \$** _____ Cash with app \$ _____
 1035(a) Exchange? Yes No COD

Bank Withdrawal (EFT) Draft Date _____
 Mo Please draft initial premium upon receipt of this application

Mail Bill to payor: Single Prem. Paymt Semi-Annual

“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 or may be guilty of a crime and may be subject to fines and confinement in prison.”

When we use the words “you” or “your” in this application, we mean Proposed Insured.

MEDICAL

- | | | |
|---|--------------------------|--------------------------|
| 1. Current height _____ Current weight _____ | Yes | No |
| 2. Within the past five years, have you been treated for or diagnosed with: | | |
| a. Heart disease, heart attack, arrhythmia, stroke or transient ischemic attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Respiratory disease, kidney disease, diabetes or connective tissue disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cancer of any type? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. An organ transplant, liver disorder, a neuro/muscular disorder or blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Alcoholism, drug addiction, depression, anxiety, mental disorder or Alzheimer’s disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sexually transmitted disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Back, bone or joint pain, arthritis, muscular disease or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you taken any prescription medication in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |

Provide the name, address and phone number of your personal physician along with the date and reason last seen.

Dr. Name _____ Phone _____

Address _____

Date and reason last seen: _____

Explain any “YES” answers. Provide details, dates, diagnosis, reason for prescriptions, etc.

SUITABILITY

- | | | |
|---|--------------------------|--------------------------|
| 1. Is the proposed insured or the owner planning to enter into any arrangement to pay the premiums due under this policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the proposed insured or owner intend to sell or transfer any interest in any policy issued as a result of this application? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain any “YES” answers. Provide details, dates, etc.

- | | | |
|--|--------------------------|--------------------------|
| 3. Do you have existing insurance or annuity contracts with this or any other company? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is this insurance intended to replace existing insurance or annuity with this or any other company? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to either question, complete the replacement form as required by state law and submit it with this application.

BENEFICIARY DESIGNATION (will be Revocable and Per Stirpes if not indicated.)

PER STIRPES—if a named beneficiary dies before the insured, proceeds will be paid to the surviving direct descendants of that beneficiary.

PER CAPITA—if named beneficiary dies before the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

Primary Revocable or Irrevocable
 Per Stirpes or Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

2. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

3. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

4. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

5. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

Contingent Revocable or Irrevocable
 Per Stirpes or Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

2. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

3. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

4. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

5. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

ASSIGNMENT Is this policy assigned? Yes No

If yes, must attach a completed assignment form in order for assignment to be effective for this policy.

IRS Taxpayer Certification

Under penalties of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

Medical Authorization

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, employer, or the MIB Inc., formerly known as the Medical Information Bureau, Inc., to give United Life Insurance Company all information from the past 10 years that it holds, that pertains to medical consultations, treatments, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. United Life Insurance Company or its reinsurers may release information to the MIB, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This authorization shall be valid for 24 months following the date of my signature, or in Minnesota, until any contract of insurance issued as a result of this application ends, whichever come first. In Arizona, the authorization to disclose HIV related information shall be in force for 180 days. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at 118 Second Avenue SE, Cedar Rapids, Iowa 52407. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

I acknowledge that I have received a copy of this Authorization and I agree that a photocopy of this Authorization shall be as valid as the original.

Acknowledgement

I (we) have read this application in its entirety. I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.

City and State where signed _____ **Date** _____

X _____
SIGNATURE OF PROPOSED INSURED
(or parent if Proposed Insured is a minor)

X _____ **X** _____
SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED

I, the **AGENT**, certify that I have used only insurer-approved or provided sales material. I also certify that I have left a copy of all sales material, replacement forms and disclosures with the applicant.

Are there existing life insurance or annuity contracts on the life of the insured? Yes No

Is this policy intended to replace existing insurance or annuity with this or any other company? Yes No

SIGNATURE OF AGENT AGENT'S PRINTED NAME

_____% _____%
AGENCY NAME AGENCY NUMBER AGENCY NAME AGENCY NUMBER

Date _____



United Life Insurance Company

P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

CONDITIONAL RECEIPT

AGENT: VALID ONLY WHEN ONE MONTH PREMIUM HAS BEEN COLLECTED

Unless every condition specified in Paragraph "First" below is fulfilled exactly, no insurance will become effective prior to Policy Delivery. No agent of the Company may alter or waive any conditions.

Received from _____ this _____ day of _____, 20____

the sum of \$_____ in connection with this application for life insurance to United Life Insurance Company. The application bears the same date as this receipt. (Checks must be payable to United Life Insurance Company.)

All premium checks must be made payable to the insurance company. Do not make the check payable to the agent or leave the payee blank.

Type of Policy applied for: _____ (Generic Name)

FIRST. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery.

- (a) the amount of premium taken with the application must be at least equal to the amount of one full monthly premium for the amount of insurance which may become effective prior to policy delivery; and
- (b) all outstanding requirements must be completed within 60 days from the date of the application; and
- (c) the Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards for the plan and for the amount applied for without modification and at the rate of premium paid; and
- (d) with respect to any life and disability insurance applied for the Proposed Insureds must be in good health on the Effective Date.

Then the insurance as applied for in an amount not exceeding \$99,999 will become effective as of the latest of: (a) the date of the application, or (b) the date of completion of all medical examinations, tests, and electrocardiograms required by the Company or (c) the Date of Issue, if any, requested on the application.

SECOND. Limits Provision:

The maximum amount of insurance which may become effective prior to policy delivery shall not exceed a total of \$99,999 for this and any other applications pending with this Company.

THIRD. Return of Premiums Paid.

If one or more of the conditions in paragraph "FIRST" have not been fulfilled exactly, there shall be no liability on the part of the Company except to return Premiums paid.

(Signature of Agent)



United Life Insurance Company
P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

NOTICES TO APPLICANTS
AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

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

United Life Insurance Company or its reinsurers may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at www.mib.com.

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Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR Cert.pdf

Item Status:

Status

Date:

Bypassed - Item: Application

Bypass Reason: N/A

Comments:

Item Status:

Status

Date:

Bypassed - Item: Life & Annuity - Acturial Memo

Bypass Reason: N/A

Comments:

CERTIFICATE OF COMPLIANCE

UNITED LIFE INSURANCE COMPANY

Form number: LIU-582 (11-11) Disability Waiver of Charges Rider

Flesch Readability Score: 48.5

I hereby certify to the best of my knowledge and belief that this filing is in compliance with Arkansas Regulations 19 and 49 and Bulletin 11-88.

Certified by:



Jean Newlin Schnake, Secretary
United Life Insurance Company

9/21/11

Date