

SERFF Tracking Number: USHG-128005738 State: Arkansas
Filing Company: Freedom Life Insurance Company of America State Tracking Number:
Company Tracking Number: APP-2012-NOARB-AR-FLIC
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: APP-2012-NOARB-AR-FLIC
Project Name/Number: APP-2012-NOARB-AR-FLIC/

Filing at a Glance

Company: Freedom Life Insurance Company of America

Product Name: APP-2012-NOARB-AR-FLIC SERFF Tr Num: USHG-128005738 State: Arkansas
TOI: H21 Health - Other SERFF Status: Closed-Approved State Tr Num:
Sub-TOI: H21.000 Health - Other Co Tr Num: APP-2012-NOARB-AR-State Status: Approved-Closed
FLIC

Filing Type: Form

Reviewer(s): Donna Lambert

Authors: Shelley Kuhleman, Lisa Granada
Disposition Date: 01/23/2012

Date Submitted: 01/19/2012 Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 02/23/2012

State Filing Description:

General Information

Project Name: APP-2012-NOARB-AR-FLIC

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: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Association

Overall Rate Impact:

Filing Status Changed: 01/23/2012

State Status Changed: 01/23/2012

Deemer Date:

Created By: Shelley Kuhleman

Submitted By: Shelley Kuhleman

Corresponding Filing Tracking Number: APP-2012-NOARB-AR-FLIC

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

See attached cover letter for more information.

Company and Contact

Filing Contact Information

Lisa Granada, Project Assistant
3100 Burnett Plaza

granadol@ushealthgroup.com
817-878-3408 [Phone]

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801 Cherry Street, Unit 33 817-878-3310 [FAX]
 Fort Worth, TX 76102

Filing Company Information

Freedom Life Insurance Company of America CoCode: 62324 State of Domicile: Texas
 3100 Burnett Plaza Group Code: 839 Company Type: Accident, Life and Health
 801 Cherry Street, Unit 33 Group Name: State ID Number:
 Fort Worth, TX 76102 FEIN Number: 61-1096685
 (817) 878-3328 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: \$100.00 per filing
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Freedom Life Insurance Company of America	\$100.00	01/19/2012	55616242

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/23/2012	01/23/2012

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Disposition

Disposition Date: 01/23/2012

Implementation Date: 02/23/2012

Status: Approved

HHS Status: Not Reported

State Review: Not Reviewed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	Cover Letter	Approved	Yes
Form	Application	Approved	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/23/2012	APP-2012- NOARB- AR-FLIC	Application/ Enrollment Form	Application	Initial			APP-2012- NOARB-AR- FLIC.pdf

Primary Applicant Information

APP

A. Primary Applicant Information

Name _____ Height: _____ Weight: _____
 First MI Last Gender Male Female

Social Security #: _____ Date of Birth: _____ Birth Place: _____

Employer: _____ Occupation/Duties: _____

Any form of tobacco or tobacco cessation product in past 12 months? Yes No

Resident Address

Address: _____ Home Phone: () _____

City: _____ Business Phone: () _____

State: _____ Zip Code: _____ Cell Phone: () _____

Email: _____ Best time to call: _____

Family Information

B. Spouse Information

Name: _____ Height: _____ Weight: _____
 First MI Last Gender Male Female

Social Security #: _____ Date of Birth: _____ Birth Place: _____

Employer: _____ Occupation/Duties: _____

Any form of tobacco or tobacco cessation product in past 12 months? Yes No

Dependent Information	
<p>C. Name: _____ First MI Last <input type="radio"/> M or <input type="radio"/> F DOB _____ Ht. _____ Wt. _____</p>	<p>F. Name _____ First MI Last <input type="radio"/> M or <input type="radio"/> F DOB _____ Ht. _____ Wt. _____</p>
<p>D. Name _____ <input type="radio"/> M or <input type="radio"/> F DOB _____ Ht. _____ Wt. _____</p>	<p>G. Name _____ <input type="radio"/> M or <input type="radio"/> F DOB _____ Ht. _____ Wt. _____</p>
<p>E. Name _____ <input type="radio"/> M or <input type="radio"/> F DOB _____ Ht. _____ Wt. _____</p>	<p>H. Name _____ <input type="radio"/> M or <input type="radio"/> F DOB _____ Ht. _____ Wt. _____</p>

Agent Information

Agent Name: _____ Agent Number: _____
 (Please Print)

Coverage Selection

APP

PPO Network			
Premium Rate Guarantee Period :	<input type="radio"/> 12 Months	<input type="radio"/> 24 months	<input type="radio"/> 36 months
Method of Payment:	<input type="radio"/> Bank Draft	<input type="radio"/> Direct Billing	<input type="radio"/> Credit Card (Initial Payment Only)
Mode of Payment:	<input type="radio"/> Monthly	<input type="radio"/> Quarterly	<input type="radio"/> Semi-Annual
			<input type="radio"/> Annual

REQUESTED EFFECTIVE DATE: This effective date request does not guarantee that the application will be approved before the requested date, and thus may not be honored.

<input type="radio"/> Specific Date / /	<input type="radio"/> On the next _____ (except 29 th , 30 th , or 31 st) of the month after underwriting decision.	<input type="radio"/> Date of Application Approval
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<input type="radio"/> SecureAdvantage SICKNESS HBP Rate Up <input type="radio"/> A <input type="radio"/> B H/W Rate Up <input type="radio"/> A <input type="radio"/> B	Calendar Year Deductible Options: <input type="radio"/> \$3,000 <input type="radio"/> \$6,000 <input type="radio"/> \$9,000 <input type="radio"/> \$12,000 <input type="radio"/> \$15,000 Coinsurance Options: (must select same for SecureAdvantage Sickness and SecureAdvantage Accident) <input type="radio"/> PPO 80%-20% <input type="radio"/> PPO 70%-30% <input type="radio"/> PPO 60%-40% Maximums (must select same for SecureAdvantage Sickness and SecureAdvantage Accident) <input type="radio"/> Unlimited Lifetime Certificate Maximum/Unlimited Lifetime Transplant Maximum Per Insured <input type="radio"/> \$5,000,000 Lifetime Certificate Maximum/\$5,000,000 Lifetime Transplant Maximum Per Insured <input type="radio"/> \$5,000,000 Lifetime Certificate Maximum/\$500,000 Lifetime Transplant Maximum/\$250,000 Calendar Year Maximum Per Insured <input type="radio"/> \$5,000,000 Lifetime Certificate Maximum/\$500,000 Lifetime Transplant Maximum/\$100,000 Calendar Year Maximum Per Insured
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<input type="radio"/> SecureAdvantage ACCIDENT List alphabetic indicator (A,B,C., etc.) for all applicants applying for coverage	Calendar Year Deductible Options: <input type="radio"/> \$1,500 <input type="radio"/> \$2,250 <input type="radio"/> \$3,000 <input type="radio"/> \$4,500 <input type="radio"/> \$6,000 <input type="radio"/> \$6,750 <input type="radio"/> \$7,500 <input type="radio"/> \$9,000 <input type="radio"/> \$10,500 <input type="radio"/> \$11,250 <input type="radio"/> \$12,000 <input type="radio"/> \$13,500 <input type="radio"/> \$15,000 Coinsurance Options: (must select same for SecureAdvantage Sickness and SecureAdvantage Accident) <input type="radio"/> PPO 80%-20% <input type="radio"/> PPO 70%-30% <input type="radio"/> PPO 60%-40% Maximums (must select same for SecureAdvantage Sickness and SecureAdvantage Accident) <input type="radio"/> Unlimited Lifetime Certificate Maximum/Unlimited Lifetime Transplant Maximum per Insured <input type="radio"/> \$5,000,000 Lifetime Certificate Maximum/\$5,000,000 Lifetime Transplant Maximum per Insured <input type="radio"/> \$5,000,000 Lifetime Certificate Maximum/\$500,000 Lifetime Transplant Maximum/\$250,000 Calendar Year Maximum Per Insured <input type="radio"/> \$5,000,000 Lifetime Certificate Maximum/\$500,000 Lifetime Transplant Maximum/\$100,000 Calendar Year Maximum Per Insured
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<input type="radio"/> SecureAdvantage WELLNESS List alphabetic indicator (A,B,C., etc.) for all applicants applying for coverage	Doctor Office Visit & Wellness Plan Level Options: <input type="radio"/> Bronze <input type="radio"/> Silver <input type="radio"/> Gold Prescription Drug Coverage Options: <input type="radio"/> Level 1 <input type="radio"/> Level II <input type="radio"/> Level III
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Total Premium \$ _____

OTHER COVERAGE PLANS

<input type="radio"/> Accident Protector – Accident Coverage <input type="radio"/> Primary <input type="radio"/> Spouse <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> \$100 Deductible <input type="radio"/> \$250 Deductible <input type="radio"/> \$500 Deductible <input type="radio"/> \$2,500 Accident Coverage <input type="radio"/> \$5,000 Accident Coverage <input type="radio"/> \$10,000 Accident Coverage <input type="radio"/> \$7,500 Accident Coverage <input type="radio"/> \$12,500 Accident Coverage <input type="radio"/> \$15,000 Accident Coverage <div style="text-align: right;">Total: \$</div>
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<input type="radio"/> MedGuard –Critical Illness <input type="radio"/> Primary Insured – Money Purchase Plan Premium: \$ <input type="radio"/> Spouse – Money Purchase Plan Premium: \$ <input type="radio"/> Child Benefit <input type="radio"/> \$5,000 <input type="radio"/> \$10,000 <input type="radio"/> \$15,000 Premium: \$ Total \$
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<input type="radio"/> Dental Expense List applicant alphabetic indicator (A, B,C etc.) for all applicants applying for dental coverage.	Premium: \$
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ASSOCIATION INFORMATION	Initiation Fee
Name of Association:	\$
	Membership Dues
	\$

<input type="radio"/> Life Protector Primary Insured Death Benefit \$ _____ Spouse Death Benefit: \$ _____ <input type="radio"/> Primary Insured - Money Purchase Plan <input type="radio"/> \$20 <input type="radio"/> \$30 <input type="radio"/> \$40 <input type="radio"/> \$50 <input type="radio"/> Spouse – Money Purchase Plan <input type="radio"/> \$20 <input type="radio"/> \$30 <input type="radio"/> \$40 <input type="radio"/> \$50 Premium: \$
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TOTAL COLLECTED	\$
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BENEFICIARY DESIGNATION	
Your Beneficiary: _____	Spouse's Beneficiary: _____

Current and Prior Coverage

APP

Other Coverage – Please answer the following questions

1. Does any applicant(s) currently have, or has any applicant made application for any type of health insurance? Yes No

If Yes complete below.

Company Name: _____	Phone # _____	Type of Coverage _____	Date Effective _____
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2. Are all applicant(s) covered under prior coverage? If No, list below those not covered: Yes No

3. Is the coverage you are applying for intended to replace your existing coverage? Yes No

If yes, please be advised that you should not cancel your current coverage until you receive and review your certificate, if issued.

4. Has any applicant ever been declined, had coverage excluded, been charged extra premium, or been postponed for any kind of personal insurance, or in the past 18 months filed a claim for disability, or are you or any member listed receiving benefits from Social Security or Workers' Compensation? Yes No
 If yes, provide details _____

Medical History

1. Please list all drugs prescribed or taken in the past 12 months.

Applicant _____	RX/Med _____	Reason _____	Doctor _____
Applicant _____	RX/Med _____	Reason _____	Doctor _____
Applicant _____	RX/Med _____	Reason _____	Doctor _____
Applicant _____	RX/Med _____	Reason _____	Doctor _____

2. Has any applicant been diagnosed with, treated or taken medications for, consulted with, had symptoms of, or been advised to seek treatment for any disease or disorder of the:
- a) Lungs or Respiratory system including but not limited to Asthma, Allergies, Pneumonia, Chronic Bronchitis, Emphysema or Sleep Apnea? Yes No
 - b) Heart or Circulatory system including but not limited to High Blood Pressure, Coronary Artery Disease, Heart Attack, Stroke, Heart Murmur, Congestive Heart Failure, Mitral Valve Prolapse, or Irregular Heartbeat? Yes No
 - c) Blood or Blood forming organs including but not limited to Anemia, Hemophilia, or Blood Clots? Yes No
 - d) Stomach, Esophagus, Intestines, Rectum, or Digestive system including by not limited to Ulcers, Colitis, Gastritis, Crohn's disease, Hernia, Hemorrhoids, or Gallbladder disease? Yes No
 - e) Liver including but not limited to Hepatitis, or Cirrhosis? Yes No
 - f) Kidneys or Urinary System including but not limited to Kidney Stones, Urinary Tract Infections, Cystitis, or Urinary Incontinence? Yes No
 - g) Pancreas including but not limited to Pancreatitis, Diabetes, or Sugar/Glucose Intolerance? Yes No
 - h) Thyroid, Pituitary, Adrenal or Endocrine glands including but not limited to Hyperthyroidism, Graves' Disease, or Goiter? Yes No
 - i) Neuromuscular system including but not limited to Parkinson's Disease, Muscular Dystrophy, or Lou Gehrig's Disease ALS? Yes No
 - j) Muscles, Joints, or Connective Tissues including but not limited to Rheumatism, Arthritis, Rheumatoid Arthritis, Gout, Fibromyalgia, Temporomandibular Joint disorder, (TMJ), Carpal Tunnel Syndrome, Lupus or Lyme disease? Yes No
 - k) Back, Neck or Spine including but not limited to Sprain or Strain, Herniated or Slipped Disc, Chiropractic Adjustments or Spinal Manipulations? Yes No
 - l) Brain or Central Nervous System including but not limited to Convulsions, Epilepsy, Seizures, Recurrent Headaches, Migraine(s), Dementia, Multiple Sclerosis, or Paralysis? Yes No
 - m) Skin including but not limited to Psoriasis or Eczema? Yes No
 - n) Eyes, Ears, Nose or Throat including but not limited to Glaucoma, Cataracts, Blindness, Tubes in Ears, Deafness or Hearing loss, Cochlear Implants, or Chronic Tonsillitis? Yes No
 - o) **Male Applicant(s)** – Breast, Prostate, or Male Reproductive System including but not limited to an abnormal PSA test or impotence? Yes No
 - p) **Female Applicant(s)** - Breast or Female Reproductive System including but not limited to Endometriosis, Pelvic Pain, Menstruation Disorder, Abnormal Pap Test, Cyst or Fibroid Tumors? Yes No
 - q) **Female Applicant(s)** Has any applicant ever had a Cesarean Section, miscarriage, abortion, or premature delivery? Yes No

- 3. Is any applicant listed currently pregnant, or expecting a child with anyone, whether or not listed on this application, or in the process of adoption? ○ Yes ○ No
- 4. **Has any Applicant ever:**
 - a. received consultation, testing, or counseling for infertility, impotence, in-vitro fertilization, artificial insemination, or surrogacy? ○ Yes ○ No
 - b. been treated for Sexually Transmitted Disease, hormone imbalance or oral contraceptive reaction of any kind? ○ Yes ○ No
 - c. tested positive for the presence of the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? ○ Yes ○ No
 - d. had or is any applicant considering any cosmetic or reconstructive surgery, or has any applicant ever had or been diagnosed or treated for a congenital birth defect or bodily deformity, or had or considering an organ transplant? ○ Yes ○ No
 - e. had or does any applicant have a monitoring device, implants, amputation(s), prosthetic, or internal fixations (i.e. pins, plates, screws, shunt, pacemaker), or been advised to use a walking aid, wheelchair, or any other device or equipment? ○ Yes ○ No
 - f. had Leukemia, Hodgkin's Disease, Lymphoma or any other form of Cancer? ○ Yes ○ No
 - g. had a tumor, cyst or any form of growth? ○ Yes ○ No
 - h. had mental, emotional or nervous disease or disorder including but not limited to Depression, Anxiety, Bulimia, Anorexia, Bipolar Disorder, Mental Retardation, Learning/Behavior Disorder, or Attention Deficit Disorder? ○ Yes ○ No
 - i. been advised or treated for alcohol or drug abuse, used illegal drugs, been a member of any alcohol or drug support group, or been given counseling or directive to seek treatment for use or abuse of alcohol or drugs? ○ Yes ○ No
- 5. In the past five years, has any applicant gone to any health care professional for diagnosis, advice, treatment, checkup or consultation, been recommended treatment, or been confined to a hospital, clinic, or other medical facility for any condition, disease or disorder not listed above? ○ Yes ○ No
- 6. Has any applicant been cited for a DWI or DUI or had their driver's license suspended or revoked in the past 5 years, or currently on probation or been convicted of a felony in the past 10 years? ○ Yes ○ No
- 7. Are all applicants U.S. Citizen(s) or do all applicants have Permanent Residence status (Green Card)? ○ Yes ○ No
- 8. Do any applicants participate in any hazardous avocation or sport including but not limited to vehicle racing, skydiving, pilot or student pilot, scuba diving, rock or mountain climbing, or rodeo? ○ Yes ○ No
- 9. Has any applicant traveled outside the U.S. for more than 30 days in past two years, or does any applicant plan to travel outside the U.S. for more than 30 days in the next two years? ○ Yes ○ No
- 10. Has any person proposed for coverage had an immediate family member diagnosed with heart disease, heart attack, stroke, kidney disorder, diabetes, cancer, leukemia, or Hodgkin's Disease? (An immediate family member is a father, mother, brother or sister.) ○ Yes ○ No

Please provide details to any "Yes" answers to questions 1 through 10 above in the section below.

Applicant: _____	Question _____	Condition _____	
Treatment Dates _____		Doctor/Hospital Name/Address/Phone _____	
Applicant: _____	Question _____	Condition _____	
Treatment Dates _____		Doctor/Hospital Name/Address/Phone _____	
Applicant: _____	Question _____	Condition _____	
Treatment Dates _____		Doctor/Hospital Name/Address/Phone _____	
Applicant: _____	Question _____	Condition _____	
Treatment Dates _____		Doctor/Hospital Name/Address/Phone _____	

Home Office Corrections:

Fraud Notices:

California Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Ohio Residents: 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.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For all States other than those mentioned above: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Consumer Report Notice:

This is to inform you as part of our procedure for processing your application an investigative report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with 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 the investigation.

Applicant's Acknowledgments and Authorizations

APP

The undersigned individual(s) ("Applicant") understand, certify to, agree with and affirm each of the following statements, as being true and correct:

- [1.] Applicant submits my/our application(s) to Freedom Life Insurance Company of America ("Company") for plan(s) of coverage identified on such application(s) ("Application"), and understand that the Company will evaluate the health history information provided for all family members listed on the Application as part of its underwriting process.
- [2.] The insurance agent named on the Application ("Agent") (i) reviewed the [SecureAdvantage][Marketing Name] coverage brochure with Applicant, (ii) provided a copy of this coverage brochure to Applicant, and (iii) asked every question contained on the Application.
- [3.] The answers recorded to the health questions on the Application were provided to the Agent by the Applicant.
- [4.] The Company will verify the information contained on the Application in a recorded telephone call. This recorded verification call is a routine process for individuals applying for coverage with the Company, and the recording will be made a part of Applicant's file with the Company. I/we also understand that the Application will not be considered if this recorded verification with the Company is not completed.
- [5.] The Company will attempt to place a call using the telephone number(s) listed on the first page of the Application for the purposes of completing this verification call. If no one is available when the Company attempts this verification call, the Primary Applicant or the undersigned spouse of the Primary Applicant should call the Company at 1-800-387-9027 for the purposes of scheduling a time when the call can be completed.
- [6.] If approved by the Company, each applicable plan of insurance coverage selected by Applicant on the Application that is approved by the Company will be issued in reliance by the Company upon (i) the answers of Applicant to the health insurance questions on the Application, (ii) all other information provided by Applicant and contained in the Application package, and (iii) the content the verification telephone call.
- [7.] The answers of Applicant to the health information questions on the Application and all other information provided by Applicant and contained in the Application package is full, complete, true and correct in its entirety on the date of the Application to the best of Applicant's knowledge and honest belief, except as hereinafter specifically modified by Applicant in (i) the verification call, or (ii) other written amendment and modification of the Application prepared by the Applicant and submitted to the Company for underwriting consideration prior to the issuance of any coverage by the Company that was selected by Applicant on the Application.
- [8.] The answers of Applicant to the health insurance questions on the Application and all other information provided by Applicant and contained in the Application package shall form part of the basis for and be part of each insurance plan of coverage selected on the Application that is issued to me/us by the Company.
- [9.] The plan(s) of coverage applied for on the Application shall not be effective until either the applicable policy of insurance or the applicable certificate of insurance coverage under an association group master policy has been actually issued by the Company, with first premium paid by Applicant while the health of all persons named in the Application remains as stated therein.
- [10.] Applicant received a copy of the Company's notice related to certain federal legislation entitled the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, the Women's Health and Cancer Rights Act of 1998 ("WHCR"), the Financial Services Modernization Act of 1999 and also known as the Gramm-Leach-Bliley Act ("GLB") and the Patient Protection and Affordable Care Act of 2010 ("PPACA") in connection with the Application and Applicant has reviewed the HIPAA, WHCR, GLB and PPACA sections of such notice in connection with the Application.
- [11.] [Applicant received and reviewed the SecureAdvantage brochure, which summarizes the optional SecureAdvantage sickness plan, the optional SecureAdvantage accident plan, and the optional SecureAdvantage wellness plan.]
- [12.] Applicant received and reviewed the plan brochure for all other plans of coverage selected by the Applicant on the Application.
- [13.] The Agent is not an officer of the Company and has no authority from the Company to change, waive, alter or amend (i) the language or provisions of any insurance policy or certificate of coverage under any insurance policy, (ii) the Application for insurance coverage, or (iii) any underwriting requirement of the Company.
- [14.] The Agent does not have any authority from the Company to make any representations or binding commitments on behalf of the Company about the conditions under which the Company will issue coverage or the effective date of any coverage to be issued by the Company.
- [15.] If coverage is offered and issued by the Company, the effective date of such coverage shall be subject to the Company's receipt of the timely payment of the required premium owed by the Applicant on each applicable plan, and the applicable amount of any other fees.
- [16.] Should payment of such required premium and any other applicable fees not be timely made to the Company, or if such payment is returned by Applicant's bank for insufficiency of funds or in any other way not honored by my/our bank, the applicable policy of insurance or the applicable certificate of insurance coverage under an association group master policy is withdrawn, void and of no effect.
- [17.] [The SecureAdvantage Sickness plan provides benefits for covered sicknesses only, unlike a major medical plan that also provides benefits for the treatment of covered accidental bodily injuries, as well as benefits for certain wellness tests and procedures.]
- [18.] [The SecureAdvantage Accident plan provides benefits for covered accidental bodily injuries only, unlike a major medical plan that also provides benefits for the treatment of covered sicknesses, as well as benefits for certain wellness tests and procedures.]
- [19.] [The SecureAdvantage Wellness plan is a fixed indemnity insurance coverage that pays (i) pre-determined and fixed dollar amounts for covered wellness tests, procedures, and childhood immunizations, (ii) pre-determined and fixed dollar amounts for doctor office visits for covered sickness or bodily injuries and (iii) pre-determined and fixed dollar amounts for covered outpatient prescription medications, regardless of the amount charged by the medical provider or pharmacy, which is unlike major medical coverage that, among other things, also provides benefits for the treatment of covered sicknesses and covered accidental bodily injuries resulting in hospital confinements, treatments in hospital emergency rooms, treatments at outpatient surgical facilities.]
- [20.] [The SecureValue and SecureValuePlus plans are a fixed indemnity insurance coverage that pays pre-determined and fixed dollar

amounts for medical services regardless of the amount charged by the medical provider or pharmacy.]

- [21.] [The [SecureAdvantage Wellness][Marketing Name] plan pays the applicable first dollar fixed benefit amounts (without requiring the insured to first satisfy a calendar year deductible which is typically required by major medical policies) for treatment of covered sicknesses, [and] bodily injuries [and wellness services;] and if the fixed dollar amount is more than the amount charged by the medical provider or pharmacy, the insured keeps the difference, but if the fixed dollar amount is less than the amount charged by the medical provider or pharmacy, the insured is responsible for the difference.]
- [22.] [Each of the three optional SecureAdvantage plans of coverage (sickness, accident and wellness)][Marketing Name] is an excepted benefit plan that exempt from the mandates of PPACA.
- [23.] Applicant hereby authorizes each licensed physician, medical practitioner, hospital, clinic, outpatient diagnostic testing center or laboratory, outpatient surgery center or other medically related facility, which has access to or is the custodian of any medical, diagnostic, surgical, or treatment records or knowledge of the current and past medical conditions and treatments of me, and of any member of my/our family listed on the Application to give copies of all such medical information to the Company and any of its applicable reinsurers. To facilitate rapid submission of such medical information for underwriting and or subsequent claims payment purposes, Applicant also authorizes all said sources and custodians to give all such medical records or knowledge to any agency employed by the Company to collect and transmit such medical information.
- [24.] Applicant authorizes the Company to use such medical information to make determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to all individual family members listed on the Application. A photographic or electronic copy of this authorization shall be as valid as the original. This authorization shall be valid for two years from the date signed.
- [25.] Applicant hereby authorizes and consents to (i) the Company's report of personal health information contained on my/our Application or otherwise disclosed in the telephone verification call described in sections 4 and 5 above to the MIB Group, Inc. ("MIB"), (ii) MIB's search of its records for any personal health information of any applicant previously reported to MIB by another insurance carrier, (iii) the Company's receipt from MIB of the personal health information of any individual family member listed on the Application that was previously reported to MIB by another insurance carrier for the purposes of evaluation and fraud detection by the Company of such individual's health condition in connection with the Company's underwriting of the Application.
- [26.] The Company provides remuneration or fees to MIB in exchange for the MIB's services provided to the Company and any data exchanged between the Company and MIB.
- [27.] Upon a request from the Applicant, MIB will arrange disclosure of any personal health information it may have on any family member listed on the Application. Depending upon the nature of the personal health information and the age and relationship of the applicable individual family member to the Primary Applicant, MIB may require a HIPPA authorization from such applicable family member. If the accuracy of any information in MIB's files is questioned, the Applicant may contact MIB and seek a correction of such information 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, Suite 400, Braintree, MA 02184-8734. MIB's telephone number for information questions is (866) 692-6901. For hearing impaired applicants, MIB has arranged a separate phone number, (866) 346-3642.
- [28.] Applicant hereby authorizes and consents to any insurance company, or other organization, institution or person that has records or knowledge of me, or any family member listed the Application to provide personal health information of each family member and other applicable non-health confidential information.
- [29.] Acknowledge that any fraudulent statement or material misrepresentation on the Application and/or amendments may result in claim denial or contract rescission.
- [30.] [Acknowledge that there is a waiting period in both the [SecureAdvantage sickness plan and the SecureAdvantage wellness plan]][Marketing Name] before expenses incurred for the treatment of Pre-existing Conditions of any applicant will be eligible for a benefit payment under either plan (as described in the applicable sections of the [SecureAdvantage][Marketing Name] brochure.)
- [31.] Any person who knowingly presents a false or fraudulent claim for payment for 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.

Applicant Attestation: I/we hereby certify and affirm my/our review and understanding of each of the statements above, all of which are true and correct. If my/our electronic signature(s) cannot be provided, then a verbal electronic signature(s) will be obtained during a recorded telephone interview before coverage will be considered.

Dated at _____
(City) (State) (Month) (Day) (Year)

✕ _____
Signature of Primary Applicant

✕ _____
Signature of Spouse of Primary Applicant, if Applicable

I certify that I have truly and accurately recorded on each application form the information supplied by the applicant and that I am not aware of any other information that might have an adverse effect on the insurability of any person here proposed for insurance.

I certify that I have reviewed the Application, and that each has been completed in full for submission to Freedom Life Insurance Company of America.

Agent's Signature _____ Agent # _____ Date: _____

SERFF Tracking Number: USHG-128005738 State: Arkansas
 Filing Company: Freedom Life Insurance Company of America State Tracking Number:
 Company Tracking Number: APP-2012-NOARB-AR-FLIC
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: APP-2012-NOARB-AR-FLIC
 Project Name/Number: APP-2012-NOARB-AR-FLIC/

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved	01/23/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	01/23/2012
Bypass Reason:	See Form Schedule attachment.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	01/23/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	01/23/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	01/23/2012
Bypass Reason:	N/A		
Comments:			

SERFF Tracking Number: USHG-128005738 State: Arkansas
Filing Company: Freedom Life Insurance Company of America State Tracking Number:
Company Tracking Number: APP-2012-NOARB-AR-FLIC
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: APP-2012-NOARB-AR-FLIC
Project Name/Number: APP-2012-NOARB-AR-FLIC/

Item Status:

Status

Date:

Satisfied - Item: Cover Letter

Approved

01/23/2012

Comments:

See attached cover letter.

Attachment:

Cover LTR FLIC.pdf

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza ♦ 801 Cherry Street, Unit 33, ♦ Fort Worth, Texas 76102 ♦1-800-387-9027

January 19, 2012

The Honorable Jay Bradford
Life and Health Division
Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: **Freedom Life Insurance Company of America**
NAIC 62324 FEIN #61-1096685
New Submission

Forms

APP-2012-NOARB-AR-FLIC Application

Dear Commissioner Bradford:

Enclosed is the referenced form filed for your review and approval. This form is new and is not intended to replace any forms previously approved or filed with your Department.

This form comprises an enrollment application to be used during the marketing of any products previously approved, or that shall be approved in the future, by your Department. Please notice that the coverage selection pages of the application are bracketed to allow the insertion of product specific options as needed. We may also use this application electronically or via telephone.

We also reserve the right to amend the referenced form to correct any minor typographical errors we may have neglected to find prior to submitting for approval, and to amend the language in order to clarify the intent within the confines of the law.

Thank you very much for your assistance with this filing. Should you have any questions, please contact me via email at kuhlemans@ushealthgroup.com, via telephone at (800) 387-9027, ext. 328, or via fax at (817) 878-3474.

Sincerely,

Shelley Kuhleman, AIRC
Assistant Vice President
Product Development