Filing at a Glance

Company:	Gerber Life Insurance Company
Product Name:	MIB Application Filing
State:	Arkansas
TOI:	L04G Group Life - Term
Sub-TOI:	L04G.500 Other
Filing Type:	Form
Date Submitted:	10/26/2012
SERFF Tr Num:	FRCS-128730942
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	5854
Implementation Date Requested:	On Approval
Author(s):	Exselsa Cartwright, Marilyn Odell
Reviewer(s):	Linda Bird (primary)
Disposition Date:	10/31/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Gerber Life Insurance Company*
TOI/Sub-TOI: *L04G Group Life - Term/L04G.500 Other*
Product Name: *MIB Application Filing*
Project Name/Number: *GERBER/184/184*

General Information

Project Name: GERBER/184
Project Number: 184
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 10/31/2012
State Status Changed: 10/31/2012
Created By: Exselsa Cartwright
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Only form SEA-990 is being submitted to the domicile state, on or about this same date.

Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Exselsa Cartwright

Filing Description:
We have been retained by Gerber Life Insurance Company to file the enclosed form(s) for approval in your state.

Our fee of $150 has been sent by EFT on this same date.

This filing contains a group term life late entrant application, enrollment form, and personal health enrollment application. These forms are completed by the employee as required during the enrollment process for group term life coverage.

Form LEA-03(AR) (09-12) will be used with Group Term Life Policy form GL-97. Form LEA-03(AR) (09-12) updates the MIB authorization and includes a general fraud warning which was not filed with the original form. (Previously, the fraud notice was only included in states where they were required.) Form LEA-03(AR) (09-12) will replace form LEA-03 (AR), approved in your state on 01/12/2004.

Form SEA-990-AR (09-12) will be used with Group Term Life Policy form GL-97. Form SEA-990-AR (09-12) updates the MIB authorization and includes a general fraud warning which did not appear in the original forms. (Previously, the fraud notice was only included in states where they were required.) Form SEA-990-AR (09-12) will replace form SEA-990-AR, approved in your state on 06/22/1999.

Form PHA-05-AR (09-12) will be used with Group Term Life Policy Form GL-05-P-AR. Form PHA-05-AR (09-12) was revised to update the MIB language, the HIPAA authorization and the old disclosure notice which included a statement of information practices and references to HIPAA, FCRA and MIB. A general fraud warning was added to the base form. (Previously, the fraud notice was only included in states where they were required.) Form PHA-05-AR (09-12) will replace form PHA-05-AR, approved in your state on 09/07/2006.

These forms are intended to be issued to employer groups. They will be marketed through licensed agents.

There are no unique or innovative features in this product.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

State:	*Arkansas*	**Filing Company:**	*Gerber Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.500 Other*		
Product Name:	*MIB Application Filing*		
Project Name/Number:	*GERBER/184/184*		

Company and Contact

Filing Contact Information

Exselsa Cartwright, Senior Compliance Specialist
1020 Central
Suite 201
Kansas City, MO 64105

exselsa.cartwright@firstconsulting.com
800-927-2730 [Phone] 2757 [Ext]
816-391-2755 [FAX]

Filing Company Information

(This filing was made by a third party - FC01)

Gerber Life Insurance Company	CoCode: 70939	State of Domicile: New York
1311 Mamaroneck Avenue	Group Code:	Company Type:
White Plains, NY 10605	Group Name:	State ID Number:
(914) 272-4025 ext. [Phone]	FEIN Number: 13-2611847	

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	$50 per form x 3 = $150
Per Company:	No

Company	Amount	Date Processed	Transaction #
Gerber Life Insurance Company	$150.00	10/26/2012	64338537

State: *Arkansas* **Filing Company:** *Gerber Life Insurance Company*
TOI/Sub-TOI: *L04G Group Life - Term/L04G.500 Other*
Product Name: *MIB Application Filing*
Project Name/Number: *GERBER/184/184*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/31/2012	10/31/2012

State: *Arkansas* **Filing Company:** *Gerber Life Insurance Company*
TOI/Sub-TOI: *L04G Group Life - Term/L04G.500 Other*
Product Name: *MIB Application Filing*
Project Name/Number: *GERBER/184/184*

Disposition

Disposition Date: 10/31/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Third Party Authorization		Yes
Supporting Document	Certification of Compliance		Yes
Form	Late Entrant Application		Yes
Form	Supplemental Group Term Life Insurance Employee Enrollment Application		Yes
Form	Personal Health Enrollment Application		Yes

State: *Arkansas* **Filing Company:** *Gerber Life Insurance Company*
TOI/Sub-TOI: *L04G Group Life - Term/L04G.500 Other*
Product Name: *MIB Application Filing*
Project Name/Number: *GERBER/184/184*

Form Schedule

Lead Form Number: LEA-03(AR) (09-12)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		Late Entrant Application	LEA-03(AR) (09-12)	AEF	Revised	Previous Filing Number:		53.000	LEA-03 (AR) (09-12).pdf
						Replaced Form Number:	LEA-03 (AR)		
2		Supplemental Group Term Life Insurance Employee Enrollment Application	SEA-990-AR (09-12)	AEF	Revised	Previous Filing Number:		52.700	SEA-990-AR (09-12).pdf
						Replaced Form Number:	SEA-990-AR		
3		Personal Health Enrollment Application	PHA-05-AR (09-12)	AEF	Revised	Previous Filing Number:	SERT-6SPL95833	50.100	PHA-05-AR (09-12).pdf
						Replaced Form Number:	PHA-05-AR		

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Statement of Physical Condition

- This form cannot be considered current unless received by Gerber Life Insurance Company within 30 days of completion.
- All questions must be answered completely by employee and form must be dated and signed.
- The information on this form will be considered current for no longer than 90 days from completion.
- When fully completed, return to your employer.

LATE ENTRANT APPLICATION

Gerber Life Insurance Company
White Plains, NY 10605

GENERAL INFORMATION Please Print

Employee Name	Social Security Number	Date of Employment	Occupation
Employee Address		Division	Policy Number
Employer Name and Address			

List below only those individuals applying for coverage	RELATIONSHIP (to Employee)	BIRTHDATE (Mo Dy Yr)	HEIGHT (FT. IN.)	WEIGHT (LBS.)

STATEMENT AND HISTORY OF PHYSICAL CONDITION

Have any of the above ever been diagnosed or treated by a physician for any of the conditions listed below?

A. High blood pressure, pain or pressure in chest, shortness of breath, irregular heart beats, heart murmur or other disease of the heart?..... □ **Yes** □ **No**

B. Stroke, paralysis, epilepsy, severe headaches or any disease of the brain or nervous system……. □ **Yes** □ **No**

C. Mental, emotional or other nervous disorder?..... □ **Yes** □ **No**

D. Pleurisy, asthma, allergies, tuberculosis, spitting of blood, chronic cough, or any disease of the throat, lungs or blood vessels..... □ **Yes** □ **No**

E. Chronic indigestion, gastric or duodenal ulcer, diabetes, jaundice, chronic diarrhea, gall stone or any disease of the liver?..... □ **Yes** □ **No**

F. Kidney stones, syphilis, any disease of the kidneys, bladder or prostate, or albumin or sugar in the urine?..... □**Yes** □ **No**

G. Enlarged glands, goiter, cancer or any tumor, gout, arthritis or rheumatism; any disease of the skin, bones or joints; any defect of hearing or eye sight? **.....** □ **Yes** □ **No**

H. AIDS(Acquired Immune Deficiency Syndrome),ARC(AIDS Related Complex), HIV(Human Immunodeficiency Virus), infection, pneumonia, swollen lymph nodes?.. □ **Yes** □ **No**

I. Any surgical operation performed or been advised to have surgery performed? ……..…□ **Yes** □ **No**

J. Ever been in a hospital or sanitarium for rest, treatment, observation or diagnosis? .....…..... □ **Yes** □ **No**

K. Within the past five years have you undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, blood or urine tests? **.....…... □ Yes No**

L. Any disease or disorder of the reproductive organs; breast disease or disorder, uterine or menstrual disorder?.....…..... □**Yes** □ **No**

M. Are you or any of your dependents now pregnant?.....…..... □ **Yes** □ **No**

N. Ever had or been treated for alcoholism or a drug habit?.....….. □ **Yes** □ **No**

O. Any medical advice, examination, consultation or treatment during the past 5 years not mentioned above?.....……..... □ **Yes** □ **No**

P. Any illness or injury not mentioned above?.....…..... □ **Yes** □ **No**

Give details to "YES" answers you indicated above in spaces provided below.

Check □ here if additional space is required and use a separate sheet.

Name of Person	Condition	Date Occurred	Duration	Current Status

Q. Is each of the above individuals applying for insurance in good health? (If NO, please explain)

R. Have you ever been refused insurance coverage by Gerber Life? Date refused	Or another insurance company? (If Yes, please explain)

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 REPRESENT, on behalf of myself and any person who shall have or claim any interest in said policy, that, to the best of my knowledge and belief, all of the above answers and information are complete and true, and I agree that they shall be taken as the basis of the issuance of insurance for me and for each of the eligible dependents listed above. I understand that Gerber Life Insurance Company may refuse to accept for this insurance any individual listed above who, in the opinion of the Gerber Life Insurance Company, is not insurable. I have read the notice explaining the use of the Medical Information Bureau (MIB). I authorize Gerber Life, its Medical Director or reinsurers to make a brief report of my personal health information, or the personal health information of any family member to be insured, to the MIB to determine eligibility for this insurance. A copy is available upon request.

Employee Signature X **Date** **City**

Statement of Physical Condition Important

- This form cannot be considered current unless received by this insurance Company within 30 days of completion.
- All questions must be answered completely by employee and form must be dated and signed.
- The information on this form will be considered current for no longer than 90 days from completion.
- When fully completed, return to your employer.

GERBER LIFE INSURANCE COMPANY

SUPPLEMENTAL GROUP TERM LIFE INSURANCE
EMPLOYEE ENROLLMENT APPLICATION

RETURN TO:

GENERAL INFORMATION Please Print

Employee Name	Social Security Number	Date of Employment	Occupation
Employee Address		Division	Policy Number
Employer Name and Address			

List below only those individuals applying for coverage	RELATIONSHIP (to Employee)	BIRTHDATE (Mo Day Yr)	HEIGHT (FT. IN.)	WEIGHT (LBS.)	AMOUNT OF LIFE INSURANCE
					$
					$
					$
					$
					$

STATEMENT AND HISTORY OF PHYSICAL CONDITION

Have any of the above ever been diagnosed or treated by a physician for any of the conditions listed below?

A. High blood pressure, pain or pressure in chest, shortness of breath, irregular heart beats, heart murmur or other disease of the heart?.....□ **Yes** □ **No**

B. Stroke, paralysis, epilepsy, severe headaches or any disease of the brain or nervous system……. □**Yes** □ **No**

C. Mental, emotional or other nervous disorder?.....□ **Yes** □ **No**

D. Pleurisy, asthma, allergies, tuberculosis, spitting of blood, chronic cough, or any disease of the throat, lungs or blood vessels.....□ **Yes** □ **No**

E. Chronic indigestion, gastric or duodenal ulcer, diabetes, jaundice, chronic diarrhea, gall stone or any disease of the liver?.....□ **Yes** □ **No**

F. Kidney stones, syphilis, any disease of the kidneys, bladder or prostate, or albumin or sugar in the urine?..... □ **Yes** □ **No**

G. Enlarged glands, goiter, cancer or any tumor, gout, arthritis or rheumatism; any disease of the skin, bones or joints; any defect of hearing or eye sight? .....□ **Yes** □ **No**

H. AIDS,ARC,HIV infection, pneumonia, swollen lymph nodes?..□ **Yes** □**No**

I. Any surgical operation performed or been advised to have surgery performed? ……..…□**Yes** □**No**

J. Ever been in a hospital or sanitarium for rest, treatment, observation or diagnosis? .....….....□ **Yes** □**No**

K. Within the past five years have you undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, blood or urine tests? .....…...□**Yes** □**No**

L. Any disease or disorder of the reproductive organs; breast disease or disorder, uterine or menstrual disorder?.....…..... □**Yes** □**No**

M. Are you or any of your dependents now pregnant?.....…....□**Yes** □**No**

N. Ever had or been treated for alcoholism or a drug habit?.....….□ **Yes** □**No**

O. Any medical advice, examination, consultation or treatment during the past 5 years not mentioned above?.....…….....□ **Yes** □ **No**

P. Any illness or injury not mentioned above?.....…....□ **Yes** □ **No**

Give details to "YES" answers you indicated above in spaces provided below.

Check □ here if additional space is required and use a separate sheet.

Name of Person	Condition	Date Occurred	Duration	Current Status

Q. Is each of the above individuals applying for insurance, in good health? (If NO, please explain)

R. Have you ever been refused insurance coverage by Gerber Life? Date refused	Or another insurance company? (If Yes, please explain)

S. Are you now and have you been actively at work ____ or more hours per week?

Designation of Beneficiary (The Dependent Life Benefits are Payable to the Employee Only)

☐ I Designate as my Beneficiary:	☐My Designation of Beneficiary is on a separate form.	
Name	Date of Birth	Relationship to Employee
Address		
If the Beneficiary dies before me, I designate as contingent beneficiary:		
Name	Date of Birth	Relationship to Employee
Address		
X If there is more than one beneficiary, or more than one contingent beneficiary, they will share the death benefits equally, or all will be paid to the survivor. X I RESERVE the right to change this designation at any time.		
Employee Signature	Date	

I REPRESENT, on behalf of myself and any person who shall have or claim any interest in said policy, that, to the best of my knowledge and belief, all of the above answers and information are complete and true, and I agree that they shall be taken as the basis of the issuance of insurance for me and for each of the eligible dependents listed above. I understand that the Insurance Company may refuse to accept for this insurance any individual listed above who, in the opinion of the Insurance Company, is not insurable. No insurance is in force until this application is accepted by Gerber Life. My employer may make deductions from my earnings in the amount of my premiums including premiums for dependent coverage.

I have read the notice explaining the use of the Medical Information Bureau (MIB). I authorize Gerber Life, its Medical Director or reinsurers to make a brief report of my personal health information, or the personal health information of any family member to be insured, to the MIB to determine eligibility for this insurance. A copy is available upon request.

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.

Employee Signature X **Date** **City**

Gerber Life Insurance Company
Personal Health Enrollment Application

Enrollees must complete this form if they have requested insurance coverage for themselves or any of their family members and are required to provide evidence of insurability.

Instructions

Employer's Responsibility:

1. Fill out the Employer Section completely. Please note an incomplete form will result in a delay in processing the enrollees(s) request for insurance. Refer to your Policy and employee records. These records are your property and are not on file with Gerber's Group Medical Underwriting Department.
2. In Section #1, "Who Requires an Application," indicate with a check mark why evidence of insurability is required – for employee and/or dependent(s).
3. In Section #2, "Coverage Summary," complete all coverage amounts for each Enrollee. **Basic Life coverage amounts are important and must be included for all Enrollees requesting additional Life coverage**. Consult your employee records to determine current coverage amounts. Please note that Gerber Life does not have access to employee records for amounts of coverage already in force. The term "Supplemental" refers to any additional amount of coverage provided above and beyond the Basic amount provided by your plan. The term "Voluntary" refers to any coverage where the enrollee is required to pay the entire cost of the plan. **Definitions of coverage requests**:
   - **Over Guaranteed Issue (GI) Limit:** Election of coverage exceeding the guaranteed issue amount (according to your contract) for which evidence of insurability is required.
   - **New Hire:** Newly hired employee electing coverage for the first time within the initial eligibility period (usually the first 31 days from date of hire).
   - **Opting up to Higher Level of Coverage**: Election of additional coverage with insurance currently in force.
   - **Late Entrant:** Employee who did not enroll during the initial eligibility period (date of hire or date of family status change) and/or does not currently have coverage in force. *(Note: Enrollee is responsible for payment of any additional information required for completion of the underwriting process e.g. exams, medical records, etc).*
   - **Change in Family Status**: Election of coverage usually made within 31 days of a qualified change in family status.
   - **Earnings Increase (for Employees ONLY):** Increase in coverage due solely to an increase in the amount of annual earnings. See your contract for specifics of when evidence of insurability is necessary for earnings increases.
4. After completing the Employer Section on page 2, forward the entire form to the employee.
5. No premiums may be deducted on additional amounts requiring evidence of insurability until a final decision regarding coverage is received from Gerber Life's Group Medical Underwriting Department.

Employee's Responsibility: **Upon Completion**

Send both the Employer and Employee Sections of this form to:
Group Medical Underwriting
Gerber Life Insurance Company
[1311 Mamaroneck Avenue
White Plains, NY 10605]

1. Make sure your Employer has already completed the Employer Section of this form in full.
2. Enter the name(s) of the Enrollee(s) under "Enrollees Required to Provide Evidence of Insurability." The Employer Section clarifies which Enrollees need to provide evidence of insurability and should be listed on this application. A box has been marked for each person who is required to fill out the application in the section entitled "Who Requires an Application" on the "Employer" page.
3. Answer all questions completely and accurately. Even details like height and weight are very important and must be accurate. **Leaving information blank can result in delays or may result in your file being closed.**
4. An Enrollee who did not enroll during their initial eligibility period or during annual enrollment and does not have coverage in force (shown in the Employer Section #1) will be responsible to pay for the cost of physical exams, medical records, or medical tests if they are required during the underwriting process.
5. YOU, THE EMPLOYEE, MUST SIGN AND DATE THIS FORM (even if you are not applying for coverage). Use your full legal signature. Your spouse must sign and date this form ONLY if using this form to apply for coverage. He or she must use a full legal signature.
6. **BOTH THE EMPLOYER AND EMPLOYEE SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY GROUP MEDICAL UNDERWRITING WITHIN 30 DAYS OF THE SIGNATURE DATE**.
7. Enrollee is required to notify Gerber Life Insurance Company in writing, of any changes in any enrollee's medical condition to the best of their knowledge, between the date the Enrollee signs this form and the date the coverage is approved.

THIS PAGE TO BE COMPLETED BY **EMPLOYER** USING BLACK OR BLUE INK ONLY.

Personal Health Application

Employer Name:		
Division/Subsidiary Name (If Applicable):		Policy Number:
Street Address:		
City:	State:	Zip:
Benefits Contact Person:	Telephone Number:	E-Mail:
Employee First Name:	MI:	Last Name:
Date of Hire:	Family Status Change Date:	Employee Social Security Number:
Base Annual Earnings (BAE): $	Earnings Increase Amount: $	Effective Date of Increase:

1. Who requires an Application: Refer to "**Definitions of Coverage**" in #3 on the Instructions page. Select a box for each Enrollee required to provide evidence of insurability.

Employee (EE)	❑ **Over Guaranteed Issue Limit** ❑ **New Hire**	❑ **Opting up to Higher Level of Coverage**	❑ **Late Entrant**	❑ **Change in Family Status**	❑ **Earnings Increase** *(Employee Only)*
Spouse (SP)	❑ **Over Guaranteed Issue Limit**	❑ **Opting up to Higher Level of Coverage**	❑ **Late Entrant**	❑ **Change in Family Status** *(e.g. marriage)*	
Child (CH)	❑ **Over Guaranteed Issue Limit**	❑ **Opting up to Higher Level of Coverage**	❑ **Late Entrant**	❑ **Changes in Family Status** *(e.g. newborn)*	

2. Coverage Summary: Complete all three columns for each Enrollee**. Life Coverages**: Be sure to include any Basic Life coverage as a dollar amount value for all Enrollees requesting Supplemental/Voluntary Life coverage. For most policies, Life coverage can be calculated as 1,2,3 etc. times salary or in dollar amount increments for increment plans.

Enrollees for Life Coverage	**Current Coverage Amount In Force** *(This includes any GI coverage if eligible or any existing coverage prior to this enrollment.)*	**Additional Amount Requested** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the additional amount requested.)*
Employee: Basic Life Suppl. Life or Voluntary Life Salary multiples for BAE Plans	$___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___ ___ **X Multiple**	$___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___ ___ **X Multiple**	$___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___ ___ **X Multiple**
Spouse: Basic Life Suppl. Life or Voluntary Life	$___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___
Child: Basic Life Suppl. Life or Voluntary Life	**Total Number of Children** _____ $___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___	**Total Number of Children** _____ $___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___	**Total Number of Children** _____ $___, ___ ___ ___, ___ ___ ___ $___, ___ ___ ___, ___ ___ ___

THE FOLLOWING PAGES TO BE COMPLETED BY **EMPLOYEE** USING BLACK OR BLUE INK ONLY.

Employee Section	**Personal Health Application**	**BEFORE MAILING**
Employee First Name: MI: Last Name:		• **Answer all the questions and DATE and SIGN this form in both areas indicated.** • Keep a copy for your records. • **Mail the completed Employer and Employee section to**: Gerber Life [1311 Mamaroneck Ave White Plains, NY 10605]
Mailing Address:		
City: ST: ZIP:		
Day Time Phone: Evening Phone:		
Social Security Number: Email Address:		
Employer:		
Employee's Occupation:		
Spouse Day Time Phone**:**	Spouse Evening Phone	

1. Enrollees Required to Provide Evidence of Insurability (This is critical information and if left blank will cause a delay in processing your insurance request). List the names of Enrollees identified in Employer Section I.

First Name, MI, Last Name	**ENROLLEES**	**HEIGHT (ft/in) Required**	**WEIGHT (lbs) Required**	**DATE OF BIRTH Required**	**GENDER**
	Employee				M F
	Spouse				M F
	Child				M F

2. Health Questions (**Questions 1-24 are to be answered by all Enrollees listed above. If additional space is required, please attach a separate sheet. Sign and date each sheet.**)

For questions 1-6, during the past <u>10 years</u> have any of the Enrollees:

	EE		**SP**		**CH**	
1. Had any surgery or been told to have surgery?	Y	N	Y	N	Y	N
2. Been in a hospital or other institution for diagnosis or treatment?	Y	N	Y	N	Y	N
3. Had any injuries from a car accident or filed a Workers' Compensation Claim?	Y	N	Y	N	Y	N
4. Been declined for any life or disability insurance coverage?	Y	N	Y	N	Y	N
5. Consulted or been examined by any healthcare provider for anything <u>other than</u> a routine physical with normal findings or acute illness such as cold, flu or sore throat?	Y	N	Y	N	Y	N
6. Had any lab tests, X-ray, electrocardiogram or other diagnostic testing <u>other than</u> those requested as part of a routine physical with normal findings?	Y	N	Y	N	Y	N

*****For each "YES" answer, identify the question number, Enrollee name and provide details requested. Attach additional paper if necessary*****

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

EMPLOYEE FIRST NAME:_____ MI: _____ LAST NAME:_____

For questions 7-24, during the past 10 years have any of the Enrollees at any time been treated or told by a medical professional they have a problem with any of the following:

	EE		SP		CH	
7. Heart condition, chest pain, high blood pressure, elevated cholesterol, heart murmur, abnormal pulse, stroke, or blood, circulatory or vascular system?	Y	N	Y	N	Y	N
8. Cancer, tumors, leukemia, moles, melanoma or basal cell carcinoma?	Y	N	Y	N	Y	N
9. Diabetes, thyroid, liver, hepatitis, glands or spleen?	Y	N	Y	N	Y	N
10. Asthma, bronchitis, pneumonia, respiratory problems or sleep apnea?	Y	N	Y	N	Y	N
11. Ulcers, stomach, colitis, rectum, intestines, gallbladder, or upper or lower digestive system?	Y	N	Y	N	Y	N
12. Arthritis or rheumatism?	Y	N	Y	N	Y	N
13. Kidneys, bladder or urinary tract?	Y	N	Y	N	Y	N
14. Genital or reproductive organ problems?	Y	N	Y	N	Y	N

*****For each "YES" answer, identify the question number, Enrollee name and provide details requested. Attach additional paper if necessary. *****

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

EMPLOYEE FIRST NAME:_____ MI: _____ LAST NAME:_____

For questions 15 – 24, during the past 10 years have any of the Enrollees at any time been treated or told by a medical professional they have a problem with any of the following:

	EE		SP		CH	
15. Drug or alcohol abuse, or used alcohol or nicotine on a regular basis? Indicate amount used daily: _____	Y	N	Y	N	Y	N
16. Eyes, ears, nose or throat?	Y	N	Y	N	Y	N
17. Psychiatric, mental or nervous disorders, including depression and anxiety?	Y	N	Y	N	Y	N
18. Back, neck, spine, bones or joints?	Y	N	Y	N	Y	N
19. Immune system, anemia or other blood conditions?	Y	N	Y	N	Y	N
20. Brain or nervous system problems, or epilepsy?	Y	N	Y	N	Y	N
21. Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), immune deficiency disorder or do you have enlarged lymph nodes or unexplained weight loss?	Y	N	Y	N	Y	N
22. Are you **currently** pregnant? If yes, what was your pre-pregnancy weight? ____lbs.	Y	N	Y	N	Y	N
23. Are you **currently** taking medication for any condition or disease?	Y	N	Y	N	Y	N
24. Any symptoms, injury, birth defect, congenital defect, disease or disorder not mentioned above?	Y	N	Y	N	Y	N

*****For each "YES" answer, identify the question number, Enrollee name and provide details requested. Attach additional paper if necessary*****

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Enrollee name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Employee Primary Care Physician Name & Address:

_____

_____

_____

Spouse Primary Care Physician Name & Address:

_____

_____

_____

Notice: *Enrollee is required to notify Gerber Life in writing of any changes in any Enrollee's medical condition to the best of their knowledge, between the date the Enrollee signs this form and the date the coverage is approved.*

I REPRESENT, on behalf of myself and any person who shall have or claim any interest in said policy, that, to the best of my knowledge and belief, all of the above answers and information are complete and true, and I agree that they shall be taken as the basis of the issuance of insurance for me and for each of the eligible dependents listed above. I understand that Gerber Life may refuse to accept for this insurance any individual listed above who, in the opinion of Gerber Life, is not insurable. No insurance is inforce until this application is accepted by Gerber Life. My employer may make deductions from my earnings in the amount of my premiums including premiums for dependent coverage. I have read the notice explaining the use of the Medical Information Bureau (MIB). I authorize Gerber Life, its Medical Director or reinsurers to make a brief report of my personal health information, or the personal health information of any family member to be insured, to the MIB to determine eligibility for this insurance. A copy is available upon request.

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.

_____	____/____/____	_____	____/____/____
EMPLOYEE'S SIGNATURE or Legal Representative/ Relationship to Employee (**required**)	DATE SIGNED	SPOUSE'S SIGNATURE or Legal Representative/ Relationship to Spouse (**required only if applying for coverage**)	DATE SIGNED

Each Enrollee must sign and date above.

PHA-05-AR (09-12)

EMPLOYEE FIRST NAME:_____ MI: _____ LAST NAME:_____

ENROLLEE AUTHORIZATION: THIS SECTION IS VERY IMPORTANT. YOUR REQUEST CANNOT BE PROCESSED WITHOUT IT.

GERBER LIFE INSURANCE COMPANY

Authorization to Obtain, Use, and Disclose Personal Information (Insurance Eligibility)

PURPOSES

This authorization applies to any Personal Information (defined below) that may be obtained, used or disclosed about the Proposed Insured, or any family member to be insured, by the Gerber Life Insurance Company (the "Company," "we", or "us") for the purpose of determining the Proposed Insured's eligibility for insurance or the eligibility for insurance of any family member to be insured, which may include the processing of an application for insurance or any other legally permissible activities that relate to any coverage with the Company.

PERSONAL INFORMATION

I understand and agree that the types of "Personal Information" that may be obtained, used or disclosed about the Proposed Insured, or any family member to be insured, on the basis of this authorization may include, to the extent permitted by law:

(i) any and all health records about the Proposed Insured, or any family member to be insured, including, but not limited to, information regarding medical, mental, or physical condition and treatment, prescription drug history, lab results, drug or alcohol use, and the diagnosis and treatment of Human Immunodeficiency Virus ("HIV") or other sexually transmitted diseases; and,

(ii) non-health information about the Proposed Insured, or any family member to be insured, including, but not limited to, information regarding finances, demographics (date of birth, birthplace, state of residence, etc.), employment, general reputation, insurance (including previous application activities), credit history, criminal history, and driving history.

Personal Information does not include psychotherapy notes unless such notes are included with the medical record.

AUTHORIZATION FOR OTHERS TO DISCLOSE TO US

I authorize all of the following classes of people or entities to disclose Personal Information about the Proposed Insured, or any family member to be insured, to the Company and its authorized agents and representatives: physicians, medical practitioners, hospitals, clinics, laboratories, pharmacies, pharmacy benefit managers, medical care facilities, and all other providers of medical services or sources of medical records; consumer reporting agencies; financial sources; business associates; past or current employers; benefit plan sponsors; government units, including the Department of Motor Vehicles; the MIB Inc., (formerly known as Medical Information Bureau); and insurance companies. I further authorize the Company, and its authorized agents and representatives, to collect and process such Personal Information. **By signing below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of such Personal Information does not apply to this authorization.**

AUTHORIZATION FOR US TO DISCLOSE TO OTHERS (AND POTENTIAL FOR RE-DISCLOSURE)

I understand that the Company may disclose Personal Information for the purposes stated in this authorization to the Company's underwriters, administrators, reinsurers, contractors or others who may perform business services for the Company, or to the beneficiaries or other owners of the Proposed Insured's policy. In addition, Personal Information may be disclosed (i) to the MIB, Inc. in an effort to deter fraud, misrepresentation, or criminal activity, or (ii) as otherwise required or permitted by law. Personal Information which is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected under federal or state privacy laws.

FAILURE TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the Company may not be able to issue the insurance for which I am applying or may not be able to make benefit payments.

DURATION AND REVOCATION

Unless revoked earlier, this authorization will remain in effect for 24 months from the date signed. I understand that I may revoke this authorization at any time, by written notice to:

Gerber Life Insurance Company
ATTN: Group Medical Underwriting
[1311 Mamaroneck Avenue
White Plains, NY 10605]

I understand that my right to revoke this authorization is limited to the extent that the Company has already taken action in reliance upon this authorization or the law allows the Company to contest the issuance of a policy or a claim under a policy.

COPIES OF THIS FORM

I agree that a copy of this authorization form (including faxes and electronic transmissions of this form) will be as valid as the original for purposes of obtaining or disclosing the required Personal Information about the Proposed Insured or any family member to be insured. I also understand that I am entitled to obtain a copy of this authorization form.

_____ _____

Date Signature of Proposed Insured or Authorized Representative

_____

Relationship to Proposed Insured

DO NOT RETURN THIS PAGE. RETAIN FOR YOUR RECORDS.

Gerber Life Insurance Company Notice of Information Practices

Gerber Life Insurance Company respects your right to privacy and values your trust. This Notice of Information Practices explains how we collect, use and protect your personal information and your rights regarding that information.

INFORMATION WE COLLECT

In order to determine your eligibility for insurance and to service your insurance policy, we may collect information about you or any family member to be insured, such as your name, address, age, medical history, insurance history, driving records and other personal characteristics.

Most of this information will come directly from you. However, there are times when we may need to collect or verify information using other sources such as medical professionals, health facilities, employers, business associates, neighbors and other insurance companies to which you may have applied for coverage. We may also request information from an insurance support organization. Investigative Consumer Reports prepared by insurance support organizations may be retained by those organizations and may be disclosed to other entities for which it performs services.

INFORMATION WE DISCLOSE

We do not disclose information unless permitted by you or any family member to be insured, or by law. We may, as allowed by law, disclose information, without your authorization, to third parties, such as persons or organizations that perform professional or insurance functions for us, insurance support organizations, other insurance companies to which you may have applied, and treating medical professionals.

HOW WE PROTECT YOUR INFORMATION

We maintain physical, electronic and procedural safeguards to protect information which we gather. We permit access only to authorized persons who are trained in the proper handling of this information.

HOW YOU CAN REVIEW YOUR INFORMATION

You, or any family member to be insured, have the right to request a copy of the personal information that we have about you. If we receive such a request, we will provide you a copy of your requested personal information within 30 days, as long as the information is reasonably locatable and retrievable. We may charge a reasonable fee to cover the costs incurred to provide you with copies of requested personal information.

You, or any family member to be insured, have the right to correct, amend or delete personal information we may have recorded about you. We will respond to your written request to correct, amend or delete personal information about you, within our possession, within 30 business days from the date your request is received.

If you wish to exercise your rights as provided in this notice, please write us at: Gerber Life Insurance Company Attn: Privacy Officer 445 State Street Fremont, MI 49412. When you write to us, please provide us with your full name, complete address and your policy number.

Summary of Your HIPAA Authorization

You have authorized any physician, medical practitioner, psychiatrist, psychologist, hospital, Veterans Administration clinic or other medical or medical related facility, insurance company, consumer reporting agency, or other organization, institution or person that has any records or knowledge of you or your health or mental condition, or that of any family member to be insured, your general character, driving records, and hobbies of a hazardous nature, to give any such information to Gerber Life, its reinsurers, or other persons or organizations performing business or legal services in connection with your application for insurance, as may be otherwise lawfully required, or as you may further authorize. You have further authorized a consumer reporting agency to make an investigative report on you or any family member to be insured if it is requested by Gerber Life.

In addition, you have authorized the MIB, Inc., formerly known as Medical Information Bureau, to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to you or your health, or that of any family member to be insured.

You understand the information obtained by use of this Authorization will be used by Gerber Life to determine your eligibility for insurance or the eligibility of any family member to be insured. Any information obtained will not be released by Gerber Life to any persons or organizations in an individually identifiable form EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with your application for insurance, as may be otherwise lawfully required or as you may further authorize.

To facilitate rapid submission of such information, you have authorized all said sources (with the exception of MIB) to give such records or knowledge to any agency employed by Gerber Life to collect and transmit such information. A photographic copy of your Authorization shall be as valid as the original. You agree that your Authorization shall be valid for 24 months from the date the enrollment form is signed, if not revoked earlier. You may revoke your authorization at any time by providing written notice to Gerber Life; however your right to revoke your Authorization may be limited. You have a right to receive a copy of your Authorization upon your request.

Summary of Your MIB Authorization

You have authorized Gerber Life to make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, and other insurance companies to whom you, your spouse or your children may apply for Life or Health Insurance, or other persons or organizations, performing business or legal services in connection with this application or a claim, or as may be otherwise lawfully required.

In addition, you have authorized MIB to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to you or your health, or the health of any family member to be insured.

DO NOT RETURN THIS PAGE. RETAIN FOR YOUR RECORDS.

MIB, INC. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Gerber Life Insurance Company (the "Company," "we", or "us") 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, your spouse or your children apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction 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, Massachusetts 02184-8734].

Gerber Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

FCRA (Fair Credit Reporting Act)

Depending on the size of the policy applied for, we may request that an investigative consumer report about the Proposed Insured, or any family member to be insured, be given to us. It will be conducted by a national organization skilled in obtaining information about people. A credit report may be requested in connection with this application to determine eligibility of insurance or premium to be charged.

The kind of information we may be seeking includes such facts as residence verification, marital status, occupation, general reputation, personal characteristics and mode of living. It will be obtained through personal interviews with the Proposed Insured's friends, neighbors, associates and other acquaintances. Inquiries will not be directed toward determining the sexual orientation of the Proposed Insured or any family member to be insured.

The Proposed Insured, or any family member to be insured, upon written request will be informed whether or not an investigative report was requested, and if a report was ordered, the name and address of the consumer reporting agency. A copy of this report is available upon request.

Acknowledgements and Understandings

You acknowledge receipt of the written notices in connection with state and Federal Credit Reporting Acts and the MIB.

It is understood and agreed that:

- all statements and answers made in all parts of this application are complete and true to the best of your knowledge and belief, and are made to induce the Company to issue an insurance policy.
- all statements and answers are representations and not warranties
- all such statements and answers shall be the basis for and become part of any policy issued as a result of this application.
- any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while the Proposed Insured or any family member to be insured is alive and all statements and answers in all parts of the application continue to be true and complete.
- you will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR RDB.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	This is a filing of updated applications. All pertinent information is supplied throughout this filing.		

		Item Status:	Status Date:
Satisfied - Item:	Third Party Authorization		
Comments:			
Attachment(s):			
AUTH.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Certification of Compliance		
Comments:			
Attachment(s):			
AR CoC.pdf			

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Gerber Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
LEA-03 (AR) (09-12)	53.0
SEA-990-AR (09-12)	51.0
PHA-05-AR (09-12)	50.1

Robert J. Lodewick
Vice President, General Counsel & Secretary

October 25, 2012
Date

Gerber Life Insurance Company
1311 Mamaroneck Avenue
White Plains, New York 10605
Tel: 914.272.4000 • Fax: 914.272.4099

Robert J. Lodewick
Vice-President, General Counsel and Corporate Secretary
914.272.4017 (p)
914.272.4099 (fax)
Robert.Lodewick@us.nestle.com

October 25, 2012

To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Gerber Life Insurance Company

By: _____
Robert J. Lodewick
Title: Vice President, General Counsel & Secretary

STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Company Name: Gerber Life Insurance Company

Form Title(s): Late Entrant Application, Supplemental Group Term Life Insurance Employee Enrollment Application, Personal Health Enrollment Application

Form Number(s): LEA-03 (AR) (09-12), SEA-990-AR (09-12), PHA-05-AR (09-12)

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Robert J. Lodewick
Vice President, General Counsel & Secretary

October 25, 2012
Date