

State: Arkansas **Filing Company:** 4 Ever Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life
Project Name/Number: Group Health Statements & Applications/62.002.21, et al

Filing at a Glance

Company: 4 Ever Life Insurance Company
Product Name: Group Term Life
State: Arkansas
TOI: L04G Group Life - Term
Sub-TOI: L04G.500 Other
Filing Type: Form
Date Submitted: 11/12/2012
SERFF Tr Num: BCSF-128766430
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: SM-111212-62002-AR

Implementation: On Approval
Date Requested:
Author(s): Sharon Mathews
Reviewer(s): Linda Bird (primary)
Disposition Date: 11/15/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** 4 Ever Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life
Project Name/Number: Group Health Statements & Applications/62.002.21, et al

General Information

Project Name: Group Health Statements & Applications Status of Filing in Domicile: Not Filed
Project Number: 62.002.21, et al 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: Small and Large
Group Market Type: Employer, Association, Trust Overall Rate Impact:
Filing Status Changed: 11/15/2012 Deemer Date:
State Status Changed: 11/15/2012 Submitted By: Sharon Mathews
Created By: Sharon Mathews
Corresponding Filing Tracking Number:

Filing Description:

RE: 4 Ever Life Insurance Company
FEIN #36-2149353 NAIC #80985
Group Term Life Insurance
Form 62.002 R612 – Group Insurance Health Statement – Short Form – Employee
Form 62.003 R612 – Group Insurance Health Statement – Short Form – Spouse
Form 62.004 - Group Insurance Health Statement - Short Form - Child
Form 62.500 – Application for Group Insurance
Form 62.600 – Application for Group Insurance

Dear Reviewer:

We are submitting the captioned forms for your review and approval. These forms will be used with our group term life product, 62.200, approved on November 7, 2000 and any similar form we may have approved in the future.

Forms 62.002 R612 and 62.003 R612 will replace 62.002 and 62.003 approved on November 7, 2000. The only change made to these forms is the addition of the following sentence to the third paragraph: "In addition, I authorize 4 Ever Life Insurance Company or its reinsurer to make a brief report of my personal health information to the MIB, Inc." Form 62.004 is a new form. These forms are used with employee contributory plans or when the amount of insurance exceeds the guarantee issue amount. The forms could also be used for initial enrollment or late entrants.

Forms 62.500 and 62.600 are group applications. Form 62.500 will be used for employer or association groups. Form 62.600 will be used for groups under ten lives which are issued through a trust.

Statements of variable text are enclosed for all forms.

The forms are in final printed format subject only to changes in font style, margins, ink and paper stock. Printing standards will not be lower than those required under the laws of Florida.

If you have any questions or need additional information, please contact me by email at smathews@bcsf.com or by telephone at 630 472-7845. Thank you for your prompt response.

Sincerely,
Sharon Mathews, FLMI, AIRC, HIA, CCP

State: Arkansas **Filing Company:** 4 Ever Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life
Project Name/Number: Group Health Statements & Applications/62.002.21, et al

Senior Contract Writer

Company and Contact

Filing Contact Information

Sharon Mathews, Senior Contract Writer Smathews@bcfs.com
 2 Mid America Plaza 630-472-7845 [Phone]
 Suite 200 630-472-7822 [FAX]
 Oakbrook Terrace, IL 60181

Filing Company Information

4 Ever Life Insurance Company	CoCode: 80985	State of Domicile: Illinois
2 Mid America Plaza	Group Code: 23	Company Type:
Suite 200	Group Name:	State ID Number: 80985
Oakbrook Terrace, IL 60181	FEIN Number: 36-2149353	
(630) 472-7842 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$40.00
 Retaliatory? No
 Fee Explanation: \$20.00 per form X 2 forms = \$40.00
 Per Company: No

Company	Amount	Date Processed	Transaction #
4 Ever Life Insurance Company	\$40.00	11/12/2012	64810256
4 Ever Life Insurance Company	\$210.00	11/13/2012	64855548

SERFF Tracking #:

BCSF-128766430

State Tracking #:**Company Tracking #:**

SM-111212-62002-AR

State:

Arkansas

Filing Company:

4 Ever Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Term Life

Project Name/Number:

Group Health Statements & Applications/62.002.21, et al

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/15/2012	11/15/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	11/13/2012	11/13/2012

Response Letters

Responded By	Created On	Date Submitted
Sharon Mathews	11/13/2012	11/13/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Correction to Filing Description	Note To Reviewer	Sharon Mathews	11/12/2012	11/12/2012

State: Arkansas
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life
Project Name/Number: Group Health Statements & Applications/62.002.21, et al

Filing Company: 4 Ever Life Insurance Company

Disposition

Disposition Date: 11/15/2012

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		No
Supporting Document	Statements of Variability		Yes
Form	Group Insurance Health Statement - Short Form - Employee		Yes
Form	Group Insurance Health Statement - Short Form - Spouse		Yes
Form	Group Insurance Health Statement - Short Form - Child		Yes
Form	Application for Group Insurance		Yes
Form	Application for Group Insurance		Yes

State: Arkansas **Filing Company:** 4 Ever Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life
Project Name/Number: Group Health Statements & Applications/62.002.21, et al

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/13/2012
Submitted Date	11/13/2012
Respond By Date	12/13/2012

Dear Sharon Mathews,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$210.00 filing fee is received.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

*Sincerely,
Linda Bird*

State: Arkansas **Filing Company:** 4 Ever Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life
Project Name/Number: Group Health Statements & Applications/62.002.21, et al

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/13/2012
Submitted Date	11/13/2012

Dear Linda Bird,

Introduction:

We have your 11/13/12 objection letter.

Response 1

Comments:

An additional filing fee of \$210 will be transmitted via EFT.

Related Objection 1

Comments: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$210.00 filing fee is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Your continued review of this filing is appreciated.

Sincerely,

Sharon Mathews

State: Arkansas **Filing Company:** 4 Ever Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life
Project Name/Number: Group Health Statements & Applications/62.002.21, et al

Note To Reviewer

Created By:

Sharon Mathews on 11/12/2012 02:44 PM

Last Edited By:

Linda Bird

Submitted On:

11/15/2012 08:28 AM

Subject:

Correction to Filing Description

Comments:

The Filing Description incorrectly stated that printing standards will not be lower than those required under the laws of Florida. Reference to Florida should have been Connecticut. We apologize for the proofing error.

Sincerely,

Sharon Mathews

State: Arkansas
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life
Project Name/Number: Group Health Statements & Applications/62.002.21, et al

Filing Company: 4 Ever Life Insurance Company

Form Schedule

Lead Form Number: 62.002 R612									
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		Group Insurance Health Statement - Short Form - Employee	62.002 R612	AEF	Revised	Previous Filing Number:		50.500	62.002 R612.pdf
						Replaced Form Number:	62.002		
2		Group Insurance Health Statement - Short Form - Spouse	62.003 R612	AEF	Revised	Previous Filing Number:		50.400	62.003 R612.pdf
						Replaced Form Number:	62.003		
3		Group Insurance Health Statement - Short Form - Child	62.004	AEF	Initial			50.400	62.004.pdf
4		Application for Group Insurance	62.500	AEF	Initial			50.100	62.500.pdf
5		Application for Group Insurance	62.600	AEF	Initial			51.500	62.600.pdf

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

SERFF Tracking #:

BCSF-128766430

State Tracking #:

Company Tracking #:

SM-111212-62002-AR

State: Arkansas

Filing Company:

4 Ever Life Insurance Company

TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other

Product Name: Group Term Life

Project Name/Number: Group Health Statements & Applications/62.002.21, et al

PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



[Oakbrook Terrace, Illinois 60181]

**Return to: [NABCO
PO Box 3056
Southeastern, PA 19398-3056]**

\$ _____
Insurance Amount

GROUP INSURANCE HEALTH STATEMENT – SHORT FORM EMPLOYEE

Name of Employee _____ Social Security Number _____ - _____ - _____
 Last Name First Name Middle Initial
 Employee's Residence Address _____
 Street City State Zip Code
 Telephone Number(s): (Day) _____ (Evening) _____
 Male Date of Birth _____ Place of Birth _____
 Female Month Day Year

Name of Group Employer/Policyholder _____ Group Policy No. _____
 Occupation (Describe) _____ Date Employed _____
 Month Day Year

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED

		Yes	No			Yes	No
1. Height	_____ ft. _____ in.						
2. Weight (clothed)	_____ lbs.						
3. Do you have any physical or mental impairments or physical deformity?		<input type="checkbox"/>	<input type="checkbox"/>	5. Have you had any illness, injury, operation or condition within the past (5) years which has:			
4. Have you ever been treated for, or taken medication for, any of the following:				A. Caused you to consult any physician or other practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	
A. Heart, blood pressure or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>		B. Confined you to a hospital, sanatorium or clinic?	<input type="checkbox"/>	<input type="checkbox"/>	
B. Lungs or Bronchi?	<input type="checkbox"/>	<input type="checkbox"/>		6. Have you missed work in the last year due to sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	
C. Brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>		7. Have you ever been declined or rated for life or health insurance, or been offered a policy other than as applied for?	<input type="checkbox"/>	<input type="checkbox"/>	
D. Liver or digestive tract?	<input type="checkbox"/>	<input type="checkbox"/>		8. If you answered YES to any part of questions 3-7; attach a separate sheet giving the details, including diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.			
E. Kidneys, bladder or genital organs?	<input type="checkbox"/>	<input type="checkbox"/>		9. Attach a separate sheet giving the name(s), address(es) and telephone number of your regular doctor(s).			
F. Thyroid, diabetes or glands?	<input type="checkbox"/>	<input type="checkbox"/>					
G. Cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>					
H. Any other physical or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
I. Any treatment for alcoholism or drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>					
J. Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>					
K. Any Condition which you were medically advised is related to AIDS?	<input type="checkbox"/>	<input type="checkbox"/>					

I apply for insurance and understand that if I am disabled or not able to perform the duties of a person of the same sex or age or am confined at home or in a hospital at the time of this application (or for any future increase) the insurance will not be effective until the later of day when I am not confined or the day this application is approved by the Company. I agree the copy of this form may be accepted as my signature.

I understand that the insurance applied for shall become effective on the date specified by 4 Ever Life Insurance Company ("the Company") only if this application is accepted by the Company and the first premium is paid during the lifetime of the insured. I represent that to the best of my knowledge and belief all statements and answers recorded on this application are true and complete.

I authorize any physician, medical practitioner, hospital, clinic, MIB, Inc. or medically related facility, insurance company, or employer that has any health related records or knowledge of me or my dependents to give to the Company or its reinsurers all such information to use to determine eligibility for insurance or for benefits under an existing policy. In addition, I authorize 4 Ever Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB, Inc. This Authorization shall be valid for 26 months and a copy shall be as valid as the original. I may receive a copy of this form upon request.

I acknowledge that I have read, or had read to me, this completed application and that I realize that any false statement or misrepresentation in application may result in loss of coverage under the policy. In addition, I acknowledge that 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.

Date Signed

Employee's Signature



[Oakbrook Terrace, Illinois 60181]

**Return to: [NABCO
PO Box 3056
Southeastern, PA 19398-3056]**

\$ _____
Insurance Amount

GROUP INSURANCE HEALTH STATEMENT – SHORT FORM

SPOUSE

Name of Employee _____ Social Security Number _____ - _____ - _____
Last Name First Name Middle Initial

Name of Spouse _____ Social Security Number _____ - _____ - _____
Last Name First Name Middle Initial

Spouse's Residence Address _____
Street City State Zip Code

Telephone Number(s): (Day) _____ (Evening) _____

Male Date of Birth (Spouse) _____ Place of Birth _____
 Female Month Day Year

Date of Birth (Employee) _____ Place of Birth _____
Month Day Year

If Dependent Children are to be covered, please indicate the amount of coverage desired, subject to the provisions of the Policy: _____

Name of Group Employer/Policyholder _____ Group Policy No. _____

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED

1. Height _____ ft. _____ in.					
2. Weight (clothed) _____ lbs.					
	Yes	No			Yes No
3. Do you have any physical or mental impairments or physical deformity?	<input type="checkbox"/>	<input type="checkbox"/>			
4. Have you ever been treated for, or taken medication for, any of the following:					
A. Heart, blood pressure or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>			
B. Lungs or Bronchi?	<input type="checkbox"/>	<input type="checkbox"/>			
C. Brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>			
D. Liver or digestive tract?	<input type="checkbox"/>	<input type="checkbox"/>			
E. Kidneys, bladder or genital organs?	<input type="checkbox"/>	<input type="checkbox"/>			
F. Thyroid, diabetes or glands?	<input type="checkbox"/>	<input type="checkbox"/>			
G. Cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>			
H. Any other physical or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
I. Any treatment for alcoholism or drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>			
J. Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>			
K. Any Condition which you were medically advised is related to AIDS?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Have you had any illness, injury, operation or condition within the past (5) years which has:					
A. Caused you to consult any physician or other practitioner?			<input type="checkbox"/>	<input type="checkbox"/>	
B. Confined you to a hospital, sanatorium or clinic?			<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you missed work in the last year due to sickness or injury?			<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you ever been declined or rated for life or health insurance, or been offered a policy other than as applied for?			<input type="checkbox"/>	<input type="checkbox"/>	
8. If you answered YES to any part of questions 3-7; attach a separate sheet giving the details, including diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.					
9. Attach a separate sheet giving the name(s), address(es) and telephone number of your regular doctor(s).					

I apply for insurance and understand that if I am disabled or not able to perform the duties of a person of the same sex or age or am confined at home or in a hospital at the time of this application (or for any future increase) the insurance will not be effective until the later of day when I am not confined or the day this application is approved by the Company. I agree the copy of this form may be accepted as my signature.

I understand that the insurance applied for shall become effective on the date specified by 4 Ever Life Insurance Company ("the Company") only if this application is accepted by the Company and the first premium is paid during the lifetime of the insured. I represent that to the best of my knowledge and belief all statements and answers recorded on this application are true and complete.

I authorize any physician, medical practitioner, hospital, clinic, MIB, Inc. or medically related facility, insurance company, or employer that has any health related records or knowledge of me or my dependents to give to the Company or its reinsurers all such information to use to determine eligibility for insurance or for benefits under an existing policy. In addition, I authorize 4 Ever Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB, Inc. This Authorization shall be valid for 26 months and a copy shall be as valid as the original. I may receive a copy of this form upon request.

I acknowledge that I have read, or had read to me, this completed application and that I realize that any false statement or misrepresentation in application may result in loss of coverage under the policy. In addition, I acknowledge that 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.

Date Signed

Spouse's Signature



[Oakbrook Terrace, Illinois 60181]

{Administrator: [North American Benefits Company
PO Box 3056
Southeastern, PA 19398-3056
(800) 537-4565]}

APPLICATION FOR GROUP INSURANCE

1. Full and Legal Name of Proposed Policyholder: _____
2. Main Mailing Address (include street address): _____
3. Telephone Number: () _____
4. Tax ID Number: _____
5. Correspondent (Name/Title): _____
6. Email: _____
7. Industry (Nature of Business): _____
8. Names of Subsidiaries/Affiliated Companies to be included:

Name of Subsidiary or Affiliated Companies	Location (City/State)	Relationship	Number of [Employees]

9. Number of [Full-Time Employees]: _____ {(Full-Time defined as working at least [40] hours/week.)}
10. Number of [Employees] Eligible for Coverage: _____
11. Premium Deposit of \$ _____ must accompany this application.
12. Premiums are to be payable in advance: Monthly Quarterly Semi-Annually Annually
13. Is the insurance coverage herein applied for to replace any similar form of coverage now or previously in force with this or another company? Yes No If yes, provide a copy of the current plan or plans Policy or Certificate of Coverage.
14. Requested Effective Date: _____
15. Waiting Period for Eligible [Employees]:
 - Present [Employees]: None Upon the completion of _____
 - Future [Employees]: None Upon the completion of _____

{[Coverage to be effective the [1st] of the month following completion of waiting period. Yes No]}

16. Definition of Earnings (Please check all that apply):
 - Base Salary Commissions Averaged over ___ months Overtime Prior Years W2
 - Bonuses Averaged over ___ months K1 Earnings*

*If K1 Earnings are being paid, are they based on Calendar Year, or Tax Year

17. Coverage Applied For: (Please check all that apply)

{ **Basic Life / Accidental Death & Dismemberment (AD&D):**

[Employee] Contributions Not Required Required

Class	Description of Employee Classification	Life Amount	AD&D Amount

{Reduction Schedule:

- Amounts of Life and AD&D Insurance Reduce:
 - At Age [65] to [65%] of the Scheduled Benefit Amount
 - At Age [70] to [40%] of the Scheduled Benefit Amount
 - At Age [75] to [25%] of the Scheduled Benefit Amount

Other: _____ }

{Dependent Life Insurance:

Spouse {under age [65]}: The lesser of [50%] of the [Employee's] Basic Life amount \$ _____
 {Child(ren) {birth through [14] days old \$ _____}
 Age [15] days old through [5] months \$ _____
 Age [6] months old to age [19] (age [23] if a full-time student) \$ _____ } } }

{ Short Term Disability: [Employee] Contributions Not Required Required

Classification: _____

[Employee] Benefit Amount: _____% of weekly base earnings, maximum of \$ _____
 Flat Amount \$ _____ per week

Elimination Period: _____ day Accident _____ day Sickness
 Maximum Benefit Period: _____ weeks }

{ Supplemental Life / Accidental Death & Dismemberment (AD&D):

[Employee] contributions are required. _____ # eligible _____ # participating

Classification: _____

[Employee] Benefit Amount: Flat Amount \$ _____ per individual
 One Two Three times annual salary to a maximum of \$ _____
 Other _____

{ (Supplemental Accidental Death & Dismemberment amount if elected must match Supplemental Life amount) }

{Reduction Schedule:

- Supplemental [Employee] Insurance reduces upon the attainment of age [65] to [65%] of the approved Supplemental amount.
- Other: _____ }

{ **Dependent Life Insurance:** {(Not available unless Supplemental [Employee] Life is elected)}

Spouse {under age [65]}: Flat Amount \$ _____; or Increments of \$ _____ to maximum of \$ _____ (Dependent Spouse Life amounts may not exceed [50%] of [Employee's] approved amount)

{Child(ren) {birth through [14] days old \$ _____}
 Age [15] days old through [5] months \$ _____
 Age [6] months to age [19] (age [23] if a full-time student) \$ _____ }

Will dependent spouse premium be based on [Employee] age or spouse age? }

{ Voluntary Life / Accidental Death & Dismemberment (AD&D):

[Employee] contributions are required. _____ # eligible _____ # participating

Classification: _____

[Employee] Benefit Amount: Flat Amount \$ _____ per individual

One Two Three times annual salary to a maximum of \$ _____ (May not exceed [5] times salary).

Increments of \$ _____ to a maximum of \$ _____ (May not exceed [5] times salary or \$ _____).

Other _____ }

{ (Voluntary [Employee] Accidental Death & Dismemberment amount if elected must match Voluntary Life amount) }

{Reduction Schedule:

Voluntary [Employee] Insurance reduces upon the attainment of age [65] to [65%] of the approved Voluntary amount.

Other: _____ }

{ **Dependent Life Amount:** {(Not available unless Voluntary [Employee] Life is elected)}

Spouse {under age [65] }: Flat Amount \$ _____; or Increments of \$ _____ to maximum of \$ _____ (Dependent Spouse Life amounts may not exceed [50%] of [Employee's] approved Voluntary Life amount)

{Child(ren) {birth through [14] days old \$ _____}

Age [15] days old through [5] months \$ _____

Age [6] months to age [19] (age [23] if a full-time student) \$ _____ }

Will dependent spouse premium be based on [Employee] age or spouse age? } }

{18. Are the Spouse and or Child/Children confined to an Institution? Yes No If yes, they will not be covered and must be listed below.

}

{19.]List the [Employees(s)] not actively at work as of the policy effective date. Please give a detailed description of the reason for [Employees] not actively at work. [Employees] not actively at work are not insured unless accepted in writing by the Insurance Company. (Attach another sheet of paper for additional space.)

<u>[Employee] Name</u>	<u>Date of Birth</u>	<u>Insurance Amount</u>	<u>Date of Disability</u>	<u>Detailed Reasons for Disability</u>

20. Additional Comments:

Application is hereby made by the undersigned [Employer] for group insurance.

It is agreed that nothing contained in this Application shall be binding until the date contained on this Application is received and approved by the Insurance Company.

The insurance to be provided under the Policy applies only to the classes of insureds described in this application and only with respect to those benefits specified, subject to all the terms of the Policy relating thereto.

The [Employer] agrees to promptly furnish {the Administrator and} the Insurance Company with any information required by them as needed to ensure proper administration of the insurance. The [Employer] further agrees to allow {its Administrator and} the Insurance Company to inspect all records that pertain to the insurance.

No agent has the authority to waive any of the insurance company's rights or requirements, or to make or alter any contract or policy.

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

[Employer] Signature: _____	Date: _____
Print Name: _____	Title: _____

Agent Signature: _____	Date: _____
Print Name: _____	SSN: _____
Pay Commissions To: _____	SSN/Tax ID: _____
Address: _____	Phone: _____
Agent Email: _____	

{THE SOLD CASE QUOTE MUST ACCOMPANY THIS COMPLETED APPLICATION}



{Administrator: [North American Benefits Company
PO Box 3056
Southeastern, PA 19398-3056
(800) 537-4565]}

[Oakbrook Terrace, Illinois 60181]

PARTICIPATION AGREEMENT AND APPLICATION FOR GROUP INSURANCE

1. Full and Legal Name of Proposed Participating Policyholder: _____
2. Main Mailing Address (include street address): _____
3. Telephone Number: () _____
4. Tax ID Number: _____
5. Correspondent (Name/Title): _____
6. Email: _____
7. Industry (Nature of Business): _____
8. Names of Subsidiaries/Affiliated Companies to be included:

Name of Subsidiary or Affiliated Companies	Location (City/State)	Relationship	Number of [Employees]

9. Number of [Full-Time Employees]: _____ {(Full-Time defined as working at least [40] hours/week).}
10. Number of [Employees] Eligible for Coverage: _____
11. Premium Deposit of \$ _____ must accompany this application.
12. Premiums are to be payable in advance: Monthly Quarterly Semi-Annually Annually
13. Is the insurance coverage herein applied for to replace any similar form of coverage now or previously in force with this or another company? Yes No If yes, provide a copy of the current plan or plans Policy or Certificate of Coverage.
14. Requested Effective Date: _____
15. Waiting Period for Eligible [Employees]:
 Present [Employees]: None Upon the completion of _____
 Future [Employees]: None Upon the completion of _____

{[Coverage to be effective the [1st] of the month following completion of waiting period. Yes No]}

16. Definition of Earnings (Please check all that apply):
 Base Salary Commissions Averaged over ___ months Overtime Prior Years W2
 Bonuses Averaged over ___ months K1 Earnings*
 *If K1 Earnings are being paid, are they based on Calendar Year, or Tax Year

17. Coverage Applied For: (Please check all that apply)

{ **Basic Life / Accidental Death & Dismemberment (AD&D):**

[Employee] Contributions Not Required Required

Class	Description of Employee Classification	Life Amount	AD&D Amount

{Reduction Schedule:

None

Amounts of Life and AD&D Insurance Reduce:

At Age [65] to [65%] of the Scheduled Benefit Amount

At Age [70] to [40%] of the Scheduled Benefit Amount

At Age [75] to [25%] of the Scheduled Benefit Amount

Other: _____ }

{Dependent Life Insurance:

Spouse {under age [65]}: The lesser of [50%] of the [Employee's] Basic Life amount \$ _____

{Child(ren) {birth through [14] days old \$ _____ }

Age [15] days old through [5] months \$ _____

Age [6] months old to age [19] (age [23] if a full-time student) \$ _____ } } }

{ **Short Term Disability:** **[Employee] Contributions** Not Required Required

Classification: _____

[Employee] Benefit Amount: _____ % of weekly base earnings, maximum of \$ _____

Flat Amount \$ _____ per week

Elimination Period: _____ day Accident _____ day Sickness

Maximum Benefit Period: _____ weeks }

{ **Supplemental Life / Accidental Death & Dismemberment (AD&D):**

[Employee] contributions are required. _____ # eligible _____ # participating

Classification: _____

[Employee] Benefit Amount: Flat Amount \$ _____ per individual

One Two Three times annual salary to a maximum of \$ _____

Other: _____

{ [(Supplemental Accidental Death & Dismemberment amount if elected must match Supplemental Life amount)]}

{Reduction Schedule:

Supplemental [Employee] Insurance reduces upon the attainment of age [65] to [65%] of the approved Supplemental amount.

Other: _____]}

{ **Dependent Life Insurance:** {(Not available unless Supplemental [Employee] Life is elected)}

Spouse {under age [65]}: Flat Amount \$ _____; or Increments of \$ _____ to maximum of \$ _____ (Dependent Spouse Life amounts may not exceed [50%] of [Employee's] approved amount)

{Child(ren) {birth through [14] days old \$ _____ }

Age [15] days old through [5] months \$ _____

Age [6] months to age [19] (age [23] if a full-time student) \$ _____ }

Will dependent spouse premium be based on [Employee] age or spouse age? }

{ Voluntary Life / Accidental Death & Dismemberment (AD&D):

[Employee] contributions are required. _____ # eligible _____ # participating

Classification: _____

[Employee] Benefit Amount: Flat Amount \$ _____ per individual

One Two Three times annual salary to a maximum of \$ _____ (May not exceed [5] times salary).

Increments of \$ _____ to a maximum of \$ _____ (May not exceed [5] times salary or \$ _____).

Other _____ }

{ (Voluntary [Employee] Accidental Death & Dismemberment amount if elected must match Voluntary Life amount) }

{Reduction Schedule:

Voluntary [Employee] Insurance reduces upon the attainment of age [65] to [65%] of the approved Voluntary amount.

Other: _____ }

{ **Dependent Life Amount:** (Not available unless Voluntary [Employee] Life is elected)

Spouse {under age [65]}: Flat Amount \$ _____; or Increments of \$ _____ to maximum of \$ _____ (Dependent Spouse Life amounts may not exceed [50%] of [Employee's] approved Voluntary Life amount)

{Child(ren) {birth through [14] days old \$ _____}

Age [15] days old through [5] months \$ _____

Age [6] months to age [19] (age [23] if a full-time student) \$ _____ }

Will dependent spouse premium be based on [Employee] age or spouse age? }

{18. Are the Spouse and or Child/Children confined to an Institution? Yes No If yes, they will not be covered and must be listed below.

}

{19.]List the [Employees(s)] not actively at work as of the policy effective date. Please give a detailed description of the reason for [Employees] not actively at work. [Employees] not actively at work are not insured unless accepted in writing by the Insurance Company. (Attach another sheet of paper for additional space.)

<u>[Employee] Name</u>	<u>Date of Birth</u>	<u>Insurance Amount</u>	<u>Date of Disability</u>	<u>Detailed Reasons for Disability</u>

20. Additional Comments:

Application is hereby made by the undersigned Participating [Employer] for group insurance under the Policy issued to the [First Tennessee Bank, NA] Trustee of the [North American Benefits Company (NABCO) Insurance Trust]. The insurance to be provided under the Policy or any policies issued in replacement or substitution thereof by the Insurance Company only applies to the classes of insureds described in this application and only with respect to those benefits specified, subject to all the terms of the Policy relating thereto.

The Participating [Employer] agrees to promptly furnish the Trustee {or its Administrator} and the Insurance Company with any information required by them as needed to ensure proper administration of the insurance plans of the Trust. The Participating [Employer] further agrees to allow the Trustee{, its Administrator} and the Insurance Company to inspect all records that pertain to the insurance plans of the Trust.

Participating [Employer] hereby adopts the Agreement and Declaration of Trust identified above, as originally established and amended from time to time, and confirms the appointment of Trustee, and agrees to be bound by the terms of the Trust Agreement.

Participating [Employer] hereby appoints the Trust Administrator to represent it in all dealings with the Trustee which have to do with the insurance fund.

Participating [Employer] agrees that in the event of its withdrawal as a Participating [Employer], no further claim (except as may be provided under any extended benefits provision of the Policy) will be made against any funds accruing to any portion of the insurance fund.

No agent has the authority to waive any of the insurance company's rights or requirements, or to make or alter any contract or policy.

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

[Employer] Signature: _____	Date: _____
Print Name: _____	Title: _____

Agent Signature: _____	Date: _____
Print Name: _____	SSN: _____
Pay Commissions To: _____	SSN/Tax ID: _____
Address: _____	Phone: _____
Agent Email: _____	

{THE SOLD CASE QUOTE MUST ACCOMPANY THIS COMPLETED APPLICATION}

SERFF Tracking #:

BCSF-128766430

State Tracking #:

Company Tracking #:

SM-111212-62002-AR

State:

Arkansas

Filing Company:

4 Ever Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Term Life

Project Name/Number:

Group Health Statements & Applications/62.002.21, et al

Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	Statements of Variability		
Comments:			
Attachment(s):			
SOV Group Health Statements.pdf			
SOV 62.500.pdf			
SOV 62.600.pdf			

Readability Certification

I certify that the form in this filing meets the minimum reading ease score. Listed below is the individual flesch score for the form submitted in this filing:

<u>Form Title</u>	<u>Form Number</u>	<u>Flesch Score</u>
Group Insurance Health Statement Short Form – Employee	62.002 R612	50.4
Group Insurance Health Statement - Short Form – Spouse	62.003 R612	50.4
Group Insurance Health Statement - Short Form – Child	62.004	50.4
Application for Group Insurance	62.500	50.1
Application for Group Insurance	62.600	51.5



Linda Mickok, JD
Vice President, Compliance

11/12/12

**4 Ever Life Insurance Company
Statement of Variability
July 11, 2012**

62.002 R612 – Group Insurance Health Statement – Short Form - Employee

Location / Variable Text	Explanation
[Oakbrook Terrace, Illinois 60181]	The company, city, and state are bracketed to allow the company to change the address on the form if the address changes.
[NABCO, PO Box 3056, Southeaster, PA 19398-3056]	The name and the address of the administrator are bracketed to allow for change in the administrator and/or the administrator's address.

62.003 R612 – Group Insurance Health Statement – Short Form - Spouse

Location / Variable Text	Explanation
[Oakbrook Terrace, Illinois 60181]	The company, city, and state are bracketed to allow the company to change the address on the form if the address changes.
[NABCO, PO Box 3056, Southeaster, PA 19398-3056]	The name and the address of the administrator are bracketed to allow for change in the administrator and/or the administrator's address.

62.004 R612 – Group Insurance Health Statement – Short Form - Child

Location / Variable Text	Explanation
[Oakbrook Terrace, Illinois 60181]	The company, city, and state are bracketed to allow the company to change the address on the form if the address changes.
[NABCO, PO Box 3056, Southeaster, PA 19398-3056]	The name and the address of the administrator are bracketed to allow for change in the administrator and/or the administrator's address.

**4 Ever Life Insurance Company
Statement of Variability
Form 62.500
August 28, 2012**

Variability, as indicated by the use of "{" }" braces, allows for the inclusion or exclusion of the bracketed material in its entirety. This is needed to delete text that is not applicable to the case-specific plan details (e.g. removing all dependent references when writing insured-only coverage.)

Variability, as indicated by the use of "["]" brackets, allows text to change subject to underwriting modification or negotiations with the policyholder. Use of such variability is limited to that allowed by law and regulation.

Location / Variable Text	Explanation
[Oakbrook Terrace, Illinois 60181]	The company city and state is bracketed to allow the company to change the address on the form if the address changes.
{Administrator: [North American Benefits Company.]}	Reference to Administrator is enclosed in braces and will display if an administrator is used. The name and address of the administrator is bracketed to allow for change in the administrator and/or the administrator's address.
Item 9. [Full-Time Employees] {{[Full-Time defined as working at least [40] hours/week.]}}	Alternate text for Full-Time Employees is: Employees, Members or Insureds The text is enclosed in braces and will display at the policyholder's request. The text is also enclosed in brackets to allow for a policyholder specific definition. The range for 40 hours is 10-40.
Item 10. [Employees] <i>as used in this item and throughout the form.</i>	Alternate text for Employees is Members or Insureds.
Item 15. {{[Coverage to be effective the 1 st of the month following completion of waiting period.]}}	The text is enclosed in braces as it will not display for association groups. The range for 1 st is 1 st through the 31 st day.
Item 17.	
{Basic Life/Accidental Death & Dismemberment (AD&D).}	This entire section is enclosed in braces and will display if Basic Life/Accidental Death & Dismemberment (AD&D) coverage is offered.
{Reduction Schedule.}	This entire section is enclosed in braces and will display if an age reduction schedule is used.
At Age [65] to [65%]. . . .	The range for 65 is 50-65. The range for 65% is 35%-65%.
At age [70] to [40%]. . . .	The range for 70 is 50-70. The range for 40% is 20%-50%.
At age [75] to [25%]. . . .	The range for 75 is 50-90. The range for 25% is 10%-25%.
{Dependent Life Insurance.}	This entire section is enclosed in braces and will display if Dependent Life Insurance is offered.
Spouse {under age [65]}: The lesser of [50%] of the [Employee's] Basic Life Amount \$_____.	{under age [65]} will display if there is an age limitation. The range for [65] is 60-70. The range for 50% is 25%-50%.
{Child(ren).....}	The entire Children section is enclosed in braces and will display only if children's coverage is offered.

<p>{birth through [14] days. . . . }</p> <p>Age [15] days old through [5] months. . .</p> <p>Age [6] months old to age [19] (age [23] if a full-time student)</p>	<p>This section will display if coverage is provided from the moment of birth. The range for 14 days is 14 or 15 The range for 15 days if 14 or 15. The range for 5 months is 5 or 6 months. The range for 6 months is 5 or 6. The range for 19 is 19 to 26. The range for 23 is 23-26.</p>
<p>Short Term Disability</p>	<p>The entire section is enclosed in braces and will display if Short Term Disability coverage is offered.</p>
<p>Supplemental Life/Accidental Death & Dismemberment (AD&D)</p> <p>{{Supplemental Accidental Death & Dismemberment amount if elected must match Supplemental Life amount.}}</p> <p>{Reduction Schedule: Supplemental [Employee] Insurance reduced upon the attainment of age [65] to [65%] of the. . . . }</p> <p>{Dependent Life Insurance. . . . }</p> <p>{{(Not available unless Supplemental [Employee] Life is elected)}}</p> <p>Spouse {under age [65]}: (Dependent Spouse Life amounts may not exceed [50%] of [Employee's] approved amount.)</p> <p>{Child(ren).....}</p> <p>{birth through [14] days. . . . }</p> <p>Age [15] days old through [5] months. . .</p> <p>Age [6] months old to age [19] (age [23] if a full-time student)</p>	<p>The entire section is enclosed in braces and will display if Supplemental Life/Accidental Death & Dismemberment (AD&D) coverage is offered.</p> <p>This text will display if the AD&D amount must match the Supplemental Life amount. The statement will also be removed when no AD&D.</p> <p>The Reduction Schedule is enclosed in braces and will display if an age reduction schedule is used. The range for 65 is 65-70. The range for 65% is 50%-65%.</p> <p>This entire section is enclosed in braces and will display if Dependent Life Insurance is offered.</p> <p>This text will display if Supplemental [Employee] Life insurance is elected.</p> <p>{under age [65]} will display if there is an age limitation. The range for 65 is 60-70. The range for 50% is 25%-50%.</p> <p>The entire Children section is enclosed in braces and will display only if children's coverage is offered. This section will display if covered is provided from the moment of birth. The range for 14 days is 14 or 15 The range for 15 days if 14 or 15. The range for 5 months is 5 or 6 months. The range for 6 months is 5 or 6. The range for 19 is 19 to 26. The range for 23 is 23-26.</p>
<p>{Voluntary Life/Accidental Death & Dismemberment (AD&D) }</p> <p>(May not exceed [5] times salary. . . .)</p> <p>{{(Voluntary [Employee] Accidental Death & Dismemberment amount if elected must match Voluntary Life amount.}}</p> <p>{Reduction Schedule: Voluntary [Employee] Insurance reduced upon the attainment of age [65] to [65%] of the. . . . }</p> <p>{Dependent Life Insurance. . . . }</p>	<p>The entire section is enclosed in braces and will display if Voluntary Life/Accidental Death & Dismemberment (AD&D) coverage is offered.</p> <p>The range for 5 is 1-5.</p> <p>This text will display if the AD&D amount must match the Voluntary Life amount. This statement will also be removed when no AD&D.</p> <p>The Reduction Schedule is enclosed in braces and will display if an age reduction schedule is used. The range for 65 is 65-70. The range for 65% is 50%-65%.</p> <p>This entire section is enclosed in braces and will display if Dependent Life Insurance is offered.</p>

<p>{{(Not available unless Voluntary [Employee] Life is elected}}</p> <p>Spouse {under age [65]}: (Dependent Spouse Life amounts may not exceed [50%] of [Employee's] approved amount.)</p> <p>{Child(ren).....</p> <p>{birth through [14] days. . . .}</p> <p>Age [15] days old through [5] months. . .</p> <p>Age [6] months old to age [19] (age [23] if a full-time student)</p>	<p>This text will display if Voluntary [Employee] Life insurance is elected.</p> <p>{under age [65]} will display if there is an age limitation. The range for 65 is 60-70. The range for 50% is 25%-50%.</p> <p>The entire Children section is enclosed in braces and will display only if children's coverage is offered. This section will display if coverage is provided from the moment of birth. The range for 14 days is 14 or 15 The range for 15 days is 14 or 15. The range for 5 months is 5 or 6 months. The range for 6 months is 5 or 6. The range for 19 is 19 to 26. The range for 23 is 23-26.</p>
<p>Item 18.</p>	<p>Item 18. is enclosed in braces and will display only if Spouse and Child coverage is offered.</p>
<p>Page 4 [Employer] <i>as used throughout this section.</i></p> <p>{the Administrator and}</p> <p>{The sold case quote must accompany this completed application.}</p>	<p>Alternate text for Employer is Association or Policyholder.</p> <p>This text will display only if an Administrator is used.</p> <p>This item will display only if the sold case quote must accompany the application.</p>

4 Ever Life Insurance Company
Statement of Variability
Form 62.600
August 28, 2012

Variability, as indicated by the use of "{" }" braces, allows for the inclusion or exclusion of the bracketed material in its entirety. This is needed to delete text that is not applicable to the case-specific plan details (e.g. removing all dependent references when writing insured-only coverage.)

Variability, as indicated by the use of "["]" brackets, allows text to change subject to underwriting modification or negotiations with the policyholder. Use of such variability is limited to that allowed by law and regulation.

Location / Variable Text	Explanation
[Oakbrook Terrace, Illinois 60181]	The company city and state is bracketed to allow the company to change the address on the form if the address changes.
{Administrator: [North American Benefits Company.]}	Reference to Administrator is enclosed in braces and will display if an administrator is used. The name and address of the administrator is bracketed to allow for change in the administrator and/or the administrator's address.
Item 9. [Full-Time Employees]	Alternate text for Full-Time Employees is: Employees, Members or Insureds
{{[Full-Time defined as working at least [40] hours/week.]}}	The text is enclosed in braces and will display at the policyholder's request. The text is also enclosed in brackets to allow for a policyholder specific definition. The range for 40 hours is 10-40.
Item 10. [Employees] <i>as used in this item and throughout the form.</i>	Alternate text for Employees is Members or Insureds.
Item 15. {[Coverage to be effective the 1 st of the month following completion of waiting period.]}	The text is enclosed in braces as it will not display for association groups. The range for 1 st is 1 st through the 31 st day.
Item 17.	
{Basic Life/Accidental Death & Dismemberment (AD&D).}	This entire section is enclosed in braces and will display if Basic Life/Accidental Death & Dismemberment (AD&D) coverage is offered.
{Reduction Schedule.}	This entire section is enclosed in braces and will display if an age reduction schedule is used.
At Age [65] to [65%]. . . .	The range for 65 is 50-65. The range for 65% is 35%-65%.
At age [70] to [40%]. . . .	The range for 70 is 50-70. The range for 40% is 20%-50%.
At age [75] to [25%]. . . .	The range for 75 is 50-90. The range for 25% is 10%-25%.
{Dependent Life Insurance.}	This entire section is enclosed in braces and will display if Dependent Life Insurance is offered.
Spouse {under age [65]}: The lesser of [50%] of the [Employee's] Basic Life Amount \$_____.	{under age [65]} will display if there is an age limitation. The range for [65] is 60-70. The range for 50% is 25%-50%.
{Child(ren).....}	The entire Children section is enclosed in braces and will display only if children's coverage is offered.

<p>{birth through [14] days. . . . }</p> <p>Age [15] days old through [5] months. . .</p> <p>Age [6] months old to age [19] (age [23] if a full-time student)</p>	<p>This section will display if coverage is provided from the moment of birth. The range for 14 days is 14 or 15 The range for 15 days if 14 or 15. The range for 5 months is 5 or 6 months. The range for 6 months is 5 or 6. The range for 19 is 19 to 26. The range for 23 is 23-26.</p>
<p>Short Term Disability</p>	<p>The entire section is enclosed in braces and will display if Short Term Disability coverage is offered.</p>
<p>Supplemental Life/Accidental Death & Dismemberment (AD&D)</p> <p>{{Supplemental Accidental Death & Dismemberment amount if elected must match Supplemental Life amount.}}</p> <p>{Reduction Schedule: Supplemental [Employee] Insurance reduced upon the attainment of age [65] to [65%] of the. . . . }</p> <p>{Dependent Life Insurance. . . . }</p> <p>{{(Not available unless Supplemental [Employee] Life is elected)}}</p> <p>Spouse {under age [65]}: (Dependent Spouse Life amounts may not exceed [50%] of [Employee's] approved amount.)</p> <p>{Child(ren).....}</p> <p>{birth through [14] days. . . . }</p> <p>Age [15] days old through [5] months. . .</p> <p>Age [6] months old to age [19] (age [23] if a full-time student)</p>	<p>The entire section is enclosed in braces and will display if Supplemental Life/Accidental Death & Dismemberment (AD&D) coverage is offered.</p> <p>This text will display if the AD&D amount must match the Supplemental Life amount. The statement will also be removed when no AD&D.</p> <p>The Reduction Schedule is enclosed in braces and will display if an age reduction schedule is used. The range for 65 is 65-70. The range for 65% is 50%-65%.</p> <p>This entire section is enclosed in braces and will display if Dependent Life Insurance is offered.</p> <p>This text will display if Supplemental [Employee] Life insurance is elected.</p> <p>{under age [65]} will display if there is an age limitation. The range for 65 is 60-70. The range for 50% is 25%-50%.</p> <p>The entire Children section is enclosed in braces and will display only if children's coverage is offered. This section will display if covered is provided from the moment of birth. The range for 14 days is 14 or 15 The range for 15 days if 14 or 15. The range for 5 months is 5 or 6 months. The range for 6 months is 5 or 6. The range for 19 is 19 to 26. The range for 23 is 23-26.</p>
<p>{Voluntary Life/Accidental Death & Dismemberment (AD&D) }</p> <p>(May not exceed [5] times salary. . .)</p> <p>{{(Voluntary [Employee] Accidental Death & Dismemberment amount if elected must match Voluntary Life amount.}}</p> <p>{Reduction Schedule: Voluntary [Employee] Insurance reduced upon the attainment of age [65] to [65%] of the. . . . }</p> <p>{Dependent Life Insurance. . . . }</p>	<p>The entire section is enclosed in braces and will display if Voluntary Life/Accidental Death & Dismemberment (AD&D) coverage is offered.</p> <p>The range for 5 is 1-5.</p> <p>This text will display if the AD&D amount must match the Voluntary Life amount. This statement will also be removed when no AD&D.</p> <p>The Reduction Schedule is enclosed in braces and will display if an age reduction schedule is used. The range for 65 is 65-70. The range for 65% is 50%-65%.</p> <p>This entire section is enclosed in braces and will display if Dependent Life Insurance is offered.</p>

<p>{{(Not available unless Voluntary [Employee] Life is elected}}</p> <p>Spouse {under age [65]}: (Dependent Spouse Life amounts may not exceed [50%] of [Employee's] approved amount.)</p> <p>{Child(ren).....</p> <p>{birth through [14] days. . . .}</p> <p>Age [15] days old through [5] months. . .</p> <p>Age [6] months old to age [19] (age [23] if a full-time student)</p>	<p>This text will display if Voluntary [Employee] Life insurance is elected.</p> <p>{under age [65]} will display if there is an age limitation. The range for 65 is 60-70. The range for 50% is 25%-50%.</p> <p>The entire Children section is enclosed in braces and will display only if children's coverage is offered. This section will display if coverage is provided from the moment of birth. The range for 14 days is 14 or 15 The range for 15 days is 14 or 15. The range for 5 months is 5 or 6 months. The range for 6 months is 5 or 6. The range for 19 is 19 to 26. The range for 23 is 23-26.</p>
<p>Item 18.</p>	<p>Item 18. is enclosed in braces and will display only if Spouse and Child coverage is offered.</p>
<p>Page 4 [Employer] <i>as used throughout this section.</i></p> <p>[First Tennessee Bank, NA] Trustee of the [North American Benefits Company (NABCO) Insurance Trust]</p> <p>{or its Administrator} {, its Administrator}</p> <p>{The sold case quote must accompany this completed application.}</p>	<p>Alternate text for Employer is Association or Policyholder.</p> <p>The trustee and the trust are bracketed to allow for change.</p> <p>This text will display only if an Administrator is used.</p> <p>This item will display only if the sold case quote must accompany the application.</p>