
State: Arkansas **Filing Company:** Gerber Life Insurance Company
TOI/Sub-TOI: L021 Individual Life - Endowment/L021.000 Life - Endowment
Product Name: Individual Endowment Applications
Project Name/Number: MIB language change to Single Pay endowment application/

Filing at a Glance

Company: Gerber Life Insurance Company
Product Name: Individual Endowment Applications
State: Arkansas
TOI: L021 Individual Life - Endowment
Sub-TOI: L021.000 Life - Endowment
Filing Type: Form
Date Submitted: 11/16/2012
SERFF Tr Num: GLIN-128770240
SERFF Status: Closed-Accepted For Informational Purposes
State Tr Num:
State Status: Closed-Accepted for Informational Purposes
Co Tr Num:

Implementation
Date Requested:
Author(s): Jennifer Wittmann
Reviewer(s): Linda Bird (primary)
Disposition Date: 11/28/2012
Disposition Status: Accepted For Informational Purposes
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Gerber Life Insurance Company
TOI/Sub-TOI: L021 Individual Life - Endowment/L021.000 Life - Endowment
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General Information

Project Name: MIB language change to Single Pay endowment Status of Filing in Domicile: Not Filed application

Project Number: Date Approved in Domicile:
 Requested Filing Mode: Informational Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: Resubmission Previous Filing Number: GLIM-128577937
 Individual Market Type: Overall Rate Impact:
 Filing Status Changed: 11/28/2012
 State Status Changed: 11/28/2012 Deemer Date:
 Created By: Jennifer Wittmann Submitted By: Jennifer Wittmann
 Corresponding Filing Tracking Number:

Filing Description:

Your department previously approved forms AIE-12 AR and ARIE-12-AR on 7/27/2012 - SERFF Tr. # GLIN-128577937. We resubmit the forms as an informational filing to address the correction of a technical error discovered after approval.

After forms AIE-12-AR and ARIE-12-AR were approved, a clerical error was discovered on each of the approved forms. Language contained in our previously approved MIB provision that authorized the Medical Information Bureau (MIB), to release information to Gerber Life Insurance was inadvertently omitted. Each attached form has been corrected to add back the omitted language in the MIB authorization section of each approved form as follows:

In addition, I authorize the Medical Information Bureau (MIB) to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to me or my health.

The corrected forms and a redlined version of each form that shows the correction are attached.

On behalf of the Company, I certify no other changes were made to the forms.

Company and Contact

Filing Contact Information

Jennifer Wittmann, Legal & Compliance jennifer.wittmann@us.nestle.com
 Associate
 1311 Mamaroneck Avenue 914-272-4000 [Phone]
 White Plains, NY 10605 914-272-4099 [FAX]

Filing Company Information

Gerber Life Insurance Company	CoCode: 70939	State of Domicile: New York
1311 Mamaroneck Avenue	Group Code:	Company Type: Life and
White Plains, NY 10605	Group Name:	Health Insurance
(914) 272-4000 ext. [Phone]	FEIN Number: 13-2611847	State ID Number:

Filing Fees

State: Arkansas **Filing Company:** Gerber Life Insurance Company
TOI/Sub-TOI: L021 Individual Life - Endowment/L021.000 Life - Endowment
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Fee Required? Yes
 Fee Amount: \$40.00
 Retaliatory? No
 Fee Explanation: 2 forms filed @\$20 each
 Per Company: No

Company	Amount	Date Processed	Transaction #
Gerber Life Insurance Company	\$40.00	11/16/2012	64983289
Gerber Life Insurance Company	\$60.00	11/26/2012	65156911

SERFF Tracking #:

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State Tracking #:

Company Tracking #:

State:

Arkansas

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Linda Bird	11/28/2012	11/28/2012

SERFF Tracking #:

GLIN-128770240

State Tracking #:

Company Tracking #:

State:

Arkansas

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Gerber Life Insurance Company

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Disposition

Disposition Date: 11/28/2012

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	redlined versions of forms		Yes
Form	Application for Individual Endowment Policy		Yes
Form	Application for Individual Endowment Policy		Yes

SERFF Tracking #:

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State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Gerber Life Insurance Company

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Product Name: Individual Endowment Applications

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Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Individual Endowment Policy	AIE-12-AR	AEF	Other	INFORMATIONAL		AIE-12-AR.pdf
2		Application for Individual Endowment Policy	ARIE-12-AR	AEF	Other	INFORMATIONAL		ARIE-12-AR.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
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

Application for Individual Endowment Policy **Gerber Life Insurance Company [1311 Mamaroneck Avenue, White Plains, NY 10605]**

Select Amount: [\$10,000 \$25,000 \$50,000 \$100,000 \$150,000]
 Select Maturity: [10 Years 15 Years 18 Years Other _____ (enter number between 10-20)]

SEND NO MONEY NOW!

INSURED

Full Name _____ Social Security Number _____ - _____ - _____
(Last) (First) (Middle Initial)
 Address _____ Apt# _____ City _____ State _____ Zip _____
 Email _____ Preferred Telephone Number () _____
 Sex _____ Height _____ ft. _____ in. _____ Weight _____ lbs. Date of Birth _____
(Month Day Year)
 Occupation _____ Employer _____
 Check box if owner is different from insured. If different please provide Full Name _____
(Last) (First) (Middle Initial)

BENEFICIARY: Please enter the name of the person to receive benefits if you, the insured, die before policy maturity:

Name: _____ Relationship: _____

- ▶ 1) In the past 5 years, have you: been hospitalized or consulted with or examined or treated by any doctor or health facility? *(You do not need to include colds, minor viruses, or minor injuries which prevented normal activities for a period of less than 5 days or normal pregnancy or childbirth.)* Yes No
- ▶ 2) In the past 5 years, have you: been advised by a member of a medical profession to reduce the use of alcohol or to seek treatment for the use of alcohol or drugs, or used any controlled substance except as prescribed by a physician? Yes No
- ▶ 3) Have you ever plead guilty to or been convicted of a felony or misdemeanor, or do you have such a charge currently pending against you? Yes No
- ▶ 4) In the past 10 years, have you been treated or diagnosed by a member of a medical profession for the following: Heart disease or disorder; cancer or tumor; diabetes; drug or alcohol abuse; high blood pressure or stroke; mental or nervous disorder; or any disorder of the blood, kidneys, liver, lungs, stomach, intestines or central nervous system; pneumonia or swollen lymph nodes; AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection? Yes No

Give full details if you answered "Yes" to any question above and list each condition. (Use and sign separate sheet if necessary.)

Nature of Condition	When Condition Started	Do you still have the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No

- ▶ 5) Do you have any existing life insurance or annuity contract? Yes No
 If yes, please complete the information below.

Company Name	Amount	Policy #	Year Issued

- ▶ 6) Will any life insurance or annuity policy be replaced, changed or used to pay for the insurance applied for in this application? ... Yes No

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and 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 is alive and all statements and answers in all parts of the application continue to be true and complete. I 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.

I authorize any physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, consumer reporting agency, or other organization or person that has any records or knowledge of me or my health or mental condition, general character and driving records, to give such information to Gerber Life, its reinsurers, or other persons performing business or legal services in connection with my application for insurance. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB Inc. (MIB). In addition, I authorize the Medical Information Bureau (MIB) to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to me or my health. I understand the information obtained by use of this Authorization will be used by Gerber Life to determine my eligibility for insurance. To facilitate rapid submission of such information, I authorize all said sources (with the exception of MIB) to give such information to any agency employed by Gerber Life to collect and transmit it. A photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for 24 months from the date shown below, and that upon my request I have a right to receive a copy of this Authorization.

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.

X Insured's Signature _____ City/State _____ Date _____



Gerber Life Insurance Company

445 State Street, Fremont MI 49412
www.gerberlife.com

Application for Additional Endowment Policy under Additional Policy Rider

Application for Individual Endowment Policy **Gerber Life Insurance Company [1311 Mamaroneck Avenue, White Plains, NY 10605]**

Amount: \$ _____ **Maturity: Years** _____

INSURED

Full Name _____ Social Security Number _____
(Last) (First) (Middle Initial)

Address _____ Apt# _____ City _____ State _____ Zip _____

Email _____

OWNER (complete only if different from the insured)

Full Name _____ Social Security Number _____
(Last) (First) (Middle Initial)

Address _____ Apt# _____ City _____ State _____ Zip _____

Email _____

BENEFICIARY: Please enter the name of the person to receive benefits if you, the insured, die before policy maturity:

Name _____ Relationship _____

Since applying for your first endowment policy, has the insured received any treatment for or diagnosis of, or been advised by a medical professional to have a treatment for: heart disease or disorder; cancer or tumor; diabetes; drug or alcohol abuse; high blood pressure or stroke; mental or nervous disorder; or any disorder of the blood, kidneys, liver, lungs, intestines or central nervous system; pneumonia or unexplained swollen lymph nodes; AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection or plead guilty to or been convicted of a felony or misdemeanor, or have charges pending against you? Yes No

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief. This application will be attached to and made 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 is alive and all statements and answers in all parts of the application continue to be true and complete. I 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.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I authorize any physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, consumer reporting agency, or other organization or person that has any records or knowledge of me or my health or mental condition, general character and driving records, to give such information to Gerber Life, its reinsurers, or other persons performing business or legal services in connection with my application for insurance. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB Inc. (MIB). In addition, I authorize the Medical Information Bureau (MIB) to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to me or my health. I understand the information obtained by use of this Authorization will be used by Gerber Life to determine my eligibility for insurance. To facilitate rapid submission of such information, I authorize all said sources (with the exception of MIB) to give such information to any agency employed by Gerber Life to collect and transmit it. A photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for 24 months from the date shown below, and that upon my request I have a right to receive a copy of this Authorization.

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.

X **Insured's Signature** _____ **City/State** _____ **Date** _____

X **Owner's Signature** _____ **City/State** _____ **Date** _____
(Only complete if Owner is different from insured)

SERFF Tracking #:

GLIN-128770240

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Gerber Life Insurance Company

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	redlined versions of forms		
Comments:			
Attachment(s):			
ARIE-12-AR-rdlined.pdf			
AIE-12-AR-redlined.pdf			



Gerber Life Insurance Company

445 State Street, Fremont MI 49412
www.gerberlife.com

Application for Additional Endowment Policy under Additional Policy Rider

Application for Individual Endowment Policy **Gerber Life Insurance Company [1311 Mamaroneck Avenue, White Plains, NY 10605]**

Amount: \$ _____ **Maturity: Years** _____

INSURED

Full Name _____ Social Security Number _____ - _____ - _____
(Last) (First) (Middle Initial)

Address _____ Apt# _____ City _____ State _____ Zip _____

Email _____

OWNER (complete only if different from the insured)

Full Name _____ Social Security Number _____ - _____ - _____
(Last) (First) (Middle Initial)

Address _____ Apt# _____ City _____ State _____ Zip _____

Email _____

BENEFICIARY: Please enter the name of the person to receive benefits if you, the insured, die before policy maturity:

Name _____ Relationship _____

Since applying for your first endowment policy, has the insured received any treatment for or diagnosis of, or been advised by a medical professional to have a treatment for: heart disease or disorder; cancer or tumor; diabetes; drug or alcohol abuse; high blood pressure or stroke; mental or nervous disorder; or any disorder of the blood, kidneys, liver, lungs, intestines or central nervous system; pneumonia or unexplained swollen lymph nodes; AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection or plead guilty to or been convicted of a felony or misdemeanor, or have charges pending against you? Yes No

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief. This application will be attached to and made 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 is alive and all statements and answers in all parts of the application continue to be true and complete. I 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.

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I authorize any physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, consumer reporting agency, or other organization or person that has any records or knowledge of me or my health or mental condition, general character and driving records, to give such information to Gerber Life, its reinsurers, or other persons performing business or legal services in connection with my application for insurance. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB Inc. (MIB). **In addition, I authorize the Medical Information Bureau (MIB) to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to me or my health.** I understand the information obtained by use of this Authorization will be used by Gerber Life to determine my eligibility for insurance. To facilitate rapid submission of such information, I authorize all said sources (with the exception of MIB) to give such information to any agency employed by Gerber Life to collect and transmit it. A photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for 24 months from the date shown below, and that upon my request I have a right to receive a copy of this Authorization.

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X **Insured's Signature** _____ **City/State** _____ **Date** _____

X **Owner's Signature** _____ **City/State** _____ **Date** _____
(Only complete if Owner is different from insured)

Application for Individual Endowment Policy **Gerber Life Insurance Company [1311 Mamaroneck Avenue, White Plains, NY 10605]**

Select Amount: [\$10,000 \$25,000 \$50,000 \$100,000 \$150,000]
 Select Maturity: [10 Years 15 Years 18 Years Other _____ (enter number between 10-20)]

SEND NO MONEY NOW!

INSURED

Full Name _____ Social Security Number _____ - _____ - _____
(Last) (First) (Middle Initial)

Address _____ Apt# _____ City _____ State _____ Zip _____

Email _____ Preferred Telephone Number () _____

Sex _____ Height _____ ft. _____ in. _____ Weight _____ lbs. Date of Birth _____
(Month Day Year)

Occupation _____ Employer _____

Check box if owner is different from insured. If different please provide Full Name _____
(Last) (First) (Middle Initial)

BENEFICIARY: Please enter the name of the person to receive benefits if you, the insured, die before policy maturity:

Name: _____ Relationship: _____

- ▶ 1) In the past 5 years, have you: been hospitalized or consulted with or examined or treated by any doctor or health facility? *(You do not need to include colds, minor viruses, or minor injuries which prevented normal activities for a period of less than 5 days or normal pregnancy or childbirth.)* Yes No
- ▶ 2) In the past 5 years, have you: been advised by a member of a medical profession to reduce the use of alcohol or to seek treatment for the use of alcohol or drugs, or used any controlled substance except as prescribed by a physician? Yes No
- ▶ 3) Have you ever plead guilty to or been convicted of a felony or misdemeanor, or do you have such a charge currently pending against you? Yes No
- ▶ 4) In the past 10 years, have you been treated or diagnosed by a member of a medical profession for the following: Heart disease or disorder; cancer or tumor; diabetes; drug or alcohol abuse; high blood pressure or stroke; mental or nervous disorder; or any disorder of the blood, kidneys, liver, lungs, stomach, intestines or central nervous system; pneumonia or swollen lymph nodes; AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection? Yes No

Give full details if you answered "Yes" to any question above and list each condition. (Use and sign separate sheet if necessary.)

Nature of Condition	When Condition Started	Do you still have the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No

- ▶ 5) Do you have any existing life insurance or annuity contract? Yes No
 If yes, please complete the information below.

Company Name	Amount	Policy #	Year Issued

- ▶ 6) Will any life insurance or annuity policy be replaced, changed or used to pay for the insurance applied for in this application? ... Yes No

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and 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 is alive and all statements and answers in all parts of the application continue to be true and complete. I 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.

I authorize any physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, consumer reporting agency, or other organization or person that has any records or knowledge of me or my health or mental condition, general character and driving records, to give such information to Gerber Life, its reinsurers, or other persons performing business or legal services in connection with my application for insurance. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB Inc. (MIB). **In addition, I authorize the Medical Information Bureau (MIB) to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to me or my health.** I understand the information obtained by use of this Authorization will be used by Gerber Life to determine my eligibility for insurance. To facilitate rapid submission of such information, I authorize all said sources (with the exception of MIB) to give such information to any agency employed by Gerber Life to collect and transmit it. A photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for 24 months from the date shown below, and that upon my request I have a right to receive a copy of this Authorization.

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X Insured's Signature _____ City/State _____ Date _____