

State: Arkansas **Filing Company:** Catholic Financial Life
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Application for Membership and Insurance
Project Name/Number: MIB update/CNO-175

Filing at a Glance

Company: Catholic Financial Life
Product Name: Application for Membership and Insurance
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 12/12/2012
SERFF Tr Num: CAKN-128802762
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: CNO-175

Implementation: On Approval
Date Requested:
Author(s): Donna Peterson
Reviewer(s): Linda Bird (primary)
Disposition Date: 12/18/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
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Filing Company: Catholic Financial Life

General Information

Project Name: MIB update Status of Filing in Domicile: Pending
Project Number: CNO-175 Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments: We filed this application with the Interstate Compact. Wisconsin, our state of domicile, is part of that filing.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 12/18/2012
State Status Changed: 12/18/2012
Deemer Date: Created By: Donna Peterson
Submitted By: Donna Peterson Corresponding Filing Tracking Number:

Filing Description:

We are a fraternal benefit society filing a life application for membership and insurance. We are making this filing to include MIB required language. The filing will replace Forms: 2010 LF APP and 2010 LF APP2
State no: 45939
SERFF no: FRCS-126669812
Approved on: 6/16/2010

The application form consists of two parts. The first part, form 2012 LF APP is the application that will be completed by the agents of the Society with the applicant. (paper).

The second part, form 2012 LF APP2 is the supplementary application used when applicable underwriting requirements dictate. It will be completed in the home office by the Society's underwriters via the telephone. To verify the authenticity of the transaction the underwriter will ask the complete name, date of birth and last four digits of the applicant's social security number when calling.

At the time of delivery of the policy, the applicant is given two copies for their review and signature. One copy remains with the applicant to be attached to and made a part of his/her contract. These forms will be used with the Society's whole life, term, and universal life products. The forms are in final printed format.

The Amendment of Application form 2010 APP AMND approved on 6/16/2010 (SERFF no: FRCS-126669812 State no: 45939 will be used with this application.

Changes were made to the part 1 application only. The part 2 app was given a new form number but nothing else was changed. We are completing this filing to include the new MIB required language.

Part one changes made are:

- 1) The application was "stretched" from 4 to 6 pages to give the agents more white space and room for writing. Some of the sections were re-ordered for better flow.
- 2) Page 1; the conversion check box was removed, as this application will not be used for conversions.
- 3) Page 1-3 the member information was re-ordered for easier flow when information gathering. The same new format was used for all membership sections.
- 4) Page 4 Section D was added - Sales Illustration Certification
- 5) Page 5 Section E Q3 - the phrase 'or nicotine' was added and a new Q4 was added for both the primary insured and the

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additional proposed insured.

6) Page 5 Section H Medical Information Bureau was changed to MIB, Inc.(their official name)

7) Page 6 Section H continued, the first sentence was added to comply with the new MIB language requirements.

Additions were highlighted in yellow for easy recognition. All highlighting will be removed upon approval.

Company and Contact

Filing Contact Information

Donna Peterson, donna.peterson@catholicfinanciallife.org
 1100 W Wells Street 414-278-6509 [Phone]
 Milwaukee, WI 53233

Filing Company Information

Catholic Financial Life	CoCode: 56030	State of Domicile: Wisconsin
1100 West Wells Street	Group Code:	Company Type: Fraternal
Milwaukee, WI 53233	Group Name:	State ID Number: 2796
(414) 273-6266 ext. 6509[Phone]	FEIN Number: 39-0201015	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 1 two-part application form
 Per Company: No

Company	Amount	Date Processed	Transaction #
Catholic Financial Life	\$50.00	12/12/2012	65666335
Catholic Financial Life	\$50.00	12/13/2012	65693603

SERFF Tracking #:

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/18/2012	12/18/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	12/12/2012	12/12/2012

Response Letters

Responded By	Created On	Date Submitted
Donna Peterson	12/13/2012	12/13/2012

SERFF Tracking #:

CAKN-128802762

State Tracking #:

Company Tracking #:

CNO-175

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Disposition

Disposition Date: 12/18/2012

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
Form	Application for Membership and Insurance		Yes
Form	Part II Supplementary		Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/12/2012
Submitted Date	12/12/2012
Respond By Date	01/14/2013

Dear Donna Peterson,

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 \$50.00 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*

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Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/13/2012
Submitted Date	12/13/2012

Dear Linda Bird,

Introduction:

Response 1

Comments:

I just submitted an additional \$50 as requested. I mistakenly thought this was one form with two parts. I didn't look at it as two separate forms. Thank you for the head's up. Donna

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 \$50.00 filing fee is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,

Donna Peterson

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Form Schedule

Lead Form Number: 2012 LF APP

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Membership and Insurance	2012 LF APP	AEF	Initial		50.000	Generic Part I.pdf
2		Part II Supplementary	2012 LF APP2	AEF	Initial		50.000	Generic Part II.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 Membership and Insurance to:

Catholic Financial Life
1100 West Wells Street
Milwaukee, Wisconsin 53233
(800) 927-2547

[] New Business [] Changes to Certificate No: [] New Member

A. MEMBERSHIP

Proposed Primary Insured

Name: [] First [] Middle Initial [] Last

[] Male [] Female [] SS/ITIN No [] DOB [] Age [] State of Birth

Address: [] Street [] City [] State [] Zip

Primary phone: [] Secondary phone: []

Best way to reach you for additional information: [] Primary number [] Secondary number

Best Days: M T W T H F Best times [] a.m. [] p.m.

Email: []

Proof of Identity [] (E.g. driver's license, birth certificate, 1-151 green card)

Are you a US Citizen? [] Yes [] No (If answer is No, indicate number of years in US: [])

Previous Name/s: []

Do you have a valid driver's license? [] Yes [] No If yes, list state and number: []

Occupation: [] Employer [] Annual Income []

Are you Catholic? [] Yes [] No Parish []

If no, do you otherwise qualify for membership? Explain []

Owner (Must complete section if Owner is not the Insured)

If an entity is named, list entity name, Tax ID Number, and name and address for contact person below. A Verification of Trust form is required when a Trust is named.

Name: [] First [] Middle Initial [] Last

[] Individual [] Entity [] Relationship to proposed insured [] Tax ID Number

[] Male [] Female [] SS/ITIN No [] DOB

Address: [] Street [] City [] State [] Zip

Primary phone: [] Email: []

Proof of Identity [] (E.g. driver's license, birth certificate, 1-151 green card)

Are you a US Citizen? [] Yes [] No (If answer is No, indicate number of years in US: [])

Do you have a valid driver's license? [] Yes [] No If yes, list state and number: []

Successor Owner (Recommended whenever an individual is named in Owner section above)

Name: _____
First Middle Initial Last

Male Female _____
SS/ITIN No DOB Relationship to proposed insured

Address: _____
Street City State Zip

Primary phone: _____

Payor (complete if Payor is other than Insured or Owner)

Name: _____
First Middle Initial Last

Individual _____ Entity _____
Relationship to proposed insured Tax ID Number

Male Female _____
SS/ITIN No DOB

Address: _____
Street City State Zip

Primary phone: _____

Additional Proposed Insured

Name: _____
First Middle Initial Last

Male Female SS/ITIN No _____ DOB: _____ Age _____ State of Birth _____

Address: _____
Street City State Zip

Primary phone: _____ Secondary phone: _____

Best way to reach you for additional information: Primary number Secondary number

Best Days: M T W T H F Best times _____ a.m. p.m.

Email: _____

Proof of Identity _____
(E.g. driver's license, birth certificate, 1-151 green card)

Are you a US Citizen? Yes No (If answer is No, indicate number of years in US: _____)

Previous Name/s: _____

Do you have a valid driver's license? Yes No If yes, list state and number: _____

Occupation: _____ Employer _____ Annual Income _____

Are you Catholic? Yes No Parish _____

If no, do you otherwise qualify for membership? Explain _____

Children to be insured under Children's Term Rider (Complete only if CTR is requested/List additional children in Remarks)

Name: _____ HT _____ WT _____
First Middle Initial Last

Male Female SS/ITIN No _____ DOB: _____ Age _____

Name: _____ HT _____ WT _____
First Middle Initial Last

Male Female SS/ITIN No _____ DOB: _____ Age _____

Name: _____ HT _____ WT _____
First Middle Initial Last

Male Female SS/ITIN No _____ DOB: _____ Age _____

Are there any children on whom coverage is not being requested? Yes No

If yes; child's name _____ Reason _____

Beneficiary (List additional beneficiaries in Remarks)

INDIVIDUAL ESTATE TRUST GIFT to PARISH or OTHER CHARITY

Primary: Full Name Relationship DOB (if available) SS/ITIN/Tax ID No (if available)

Contingent: Full Name Relationship DOB (if available) SS/ITIN/Tax ID No (if available)

Custodian for minors: _____
Name Relationship DOB (if available) SS/ITIN/Tax ID No (if available)

The share of any beneficiary who does not survive shall be paid in equal shares to the beneficiary's surviving children

B. REPLACEMENT/SUITABILITY

1. Does any proposed insured have any existing coverage and/or pending applications for individual life insurance or annuities with this or any other company? (other than group) Yes No

2. If #1 is YES, does any proposed insured intend to replace, discontinue or change any such coverage? Yes No

If YES to 1 or 2 provide the following information, and complete and return any required replacement forms

Insured Name	Policy No:	Amount	Company

C. COVERAGE**Base Plan**

Plan Of Insurance: _____

Face Amount \$ _____ Single Premium _____ UL or KL increase/layer amount: \$ _____ (new total face amount \$ _____)**Riders** Waiver of Premium Term Rider (Primary Insured) \$ _____ Children's Term Rider \$ _____ Term Rider (Additional Insured) \$ _____ Guaranteed Insurability \$ _____**Premium Class (Select only one)**Primary Tobacco Select Tobacco Non-Tobacco Select Select PlusAdditional Insured Primary Tobacco Select Tobacco Non-Tobacco Select Select Plus**We will issue at the best Premium Class for which the Proposed Insured qualifies****Contract and Billing Options**Mode: Annual Semi-Annual Monthly EFT (If special draw date required, state day: _____)

Bill premium for mode elected \$ _____

Amount remitted (if any) \$ _____

Benefit Option (UL only) #1 Level #2 IncreasingDividend Option: Cash Paid Up Life Additions Interest Reduced PremiumAutomatic Loan Yes No**D. SALES ILLUSTRATION CERTIFICATION** (Complete ONLY if plan chosen requires an illustration)

Select one:

 Certification that no illustration conforming to the policy was used.

- The advisor certifies that no illustration conforming to the policy issued was provided to the Owner, but that one will be provided no later than the time of policy delivery. Also, it has been explained that any non-guaranteed elements of the policy applied for are subject to change.
- The Owner acknowledges that he/she has received no illustration which conforms to the policy applied for, and that no later than the time of policy delivery he/she will receive an illustration that conforms to the policy as issued, if any.

 Certification that a Computer Screen illustration was used.

- The advisor certifies that he/she displayed a computer screen illustration or illustrations to the Owner that complies with state requirements and for which no paper copy was issued. The illustration(s) were based on the personal and policy information given in the application.
- The Owner acknowledges that he/she has viewed a computer screen illustration based on the information given in the application, that no paper copy of the illustration was furnished, and that no later than the time of policy delivery he/she will receive an illustration that conforms to the policy as issued, if any.

E. PRELIMINARY DECLARATION OF INSURABILITY (Record details for Yes answers in Remarks)**Primary Insured** Height _____ Weight _____

- Has the Proposed Insured ever been diagnosed or treated for diabetes, cancer, heart disease, alcoholism, drug abuse or high blood pressure? Yes No
- Has the Proposed Insured ever had insurance or reinstatement denied, postponed, limited, or offered on a substandard basis? Yes No
- Has the Proposed Insured used tobacco or nicotine in any form in the past 12 months? Yes No
- Is the Proposed Insured taking any prescription medications? Yes No

Additional Proposed Insured: Height _____ Weight _____

- Has the Proposed Insured ever been diagnosed or treated for diabetes, cancer, heart disease, alcoholism, drug abuse or high blood pressure? Yes No
- Has the Proposed Insured ever had insurance or reinstatement denied, postponed, limited, or offered on a substandard basis? Yes No
- Has the Proposed Insured used tobacco or nicotine in any form in the past 12 months? Yes No
- Is the Proposed Insured taking any prescription medications? Yes No

F. REMARKS**G. FAMILY HISTORY**

	Name	Age	Health Issue/Age at Death/Cause
Father			
Mother			
Sibling(s)			

H. AUTHORIZATION TO OBTAIN and DISCLOSE INFORMATION

I (we) received the notification about the Federal Fair Credit Reporting Act and MIB, Inc.

I AUTHORIZE the following to release information about me to Catholic Financial Life or its reinsurers. Those authorized include a physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc., consumer reporting agencies and/or employers.

I UNDERSTAND that this information may include diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, and other non-medical information (such as credit reports and employer reports) concerning me. I authorize all sources, except MIB, Inc. to give records or knowledge to any agency employed by Catholic Financial Life. I authorize them to collect and transmit such information.

H. AUTHORIZATION TO OBTAIN and DISCLOSE INFORMATION (Continued)

I AUTHORIZE Catholic Financial Life or its reinsurers to make a brief report of my personal medical history to MIB, Inc.

I UNDERSTAND the Society will use the information obtained through this Authorization to determine eligibility for insurance. Any information obtained will not be released to any person or entity EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services with my application. The Society may release this information when lawfully required, or as I further authorize.

I KNOW that I, or my authorized representative, may request a copy of this Authorization.

I AGREE that a photographic or faxed copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two (2) years from the date shown below.

I. AGREEMENT (check one)

A Conditional Receipt was given to me for this life insurance plan. I acknowledge that I have read it and understand its terms, conditions and limitations. I understand that I will not receive any insurance coverage for my money unless a policy is issued as applied for.

No Conditional Receipt was given to me for this insurance plan. I acknowledge that I have not paid any premium for this insurance. I understand that this insurance is not in effect and that the first premium must be paid upon delivery of the contract.

I hereby apply for insurance in the amount on the plan and the rate stated in this application. I agree that the entire contract consists of:

- 1) This application for life insurance
- 2) Any accepted and signed amendments
- 3) Any required statement of insurability
- 4) Any required medical examination statements and
- 5) The Articles of Incorporation and By-Laws of the Society

IT IS AGREED:

- 1) I have read the application and all statements in this application are to the best of my knowledge and belief true, complete and correctly recorded.
- 2) No Agent of the Society has the authority to waive any question contained in the application or to modify the application in any way.
- 3) No Agent is authorized to change or waive any terms of this agreement or to make any promises or representations other than those contained in this agreement.
- 4) No information acquired by any Agent shall bind the Society unless set out in writing in this application.
- 5) The contract applied for shall take effect on the later of the date requested by the applicant, or the approval date of the application from the Society at the Home Office.
- 6) When I accept the contract issued on this application, I am approving and ratifying any corrections, additions, or changes made by the Society. The Society may not make changes in the plan of insurance or payment without my written consent.
- 7) Except as provided in the Receipt for Payment and Conditional Life Insurance Agreement, no insurance will take effect unless and until:
 - a. A contract of insurance is issued and delivered
 - b. The first full premium is paid during the life time of the person to be covered; and
 - c. The health of all persons to be insured remains as stated in this application.

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.

Dated at _____ on _____
City State Month/Day/Year

Signature of Proposed Insured
(A **parent** must sign application if Proposed Insured is under age 16)

Signature of Proposed Additional Insured

Signature(s) of any Persons ages 16-20 to be covered under Children's Term Rider

Signature of Owner (if other than insured)

Signature of Agent Agent No. _____

Split Agent No. _____ Percentage _____



PART II SUPPLEMENTARY

Application for Membership and Insurance to:
 Catholic Financial Life
 1100 West Wells Street
 Milwaukee, Wisconsin 53233
 (800) 927-2547

Full Legal Name _____

Date of Birth _____

Social Security Number _____

Policy Number _____

Interviewer _____

Date of Interview _____

PROPOSED INSURED MUST COMPLETE ALL QUESTIONS. ALL "YES" ANSWERS MUST BE EXPLAINED AND REFERENCED IN REMARKS.		
	Yes	No
Has or does the person proposed for this insurance coverage:		
1) Ever engaged in or expect to engage within the next two years any of the following:		
a. Aviation activities as a pilot or crew member?	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin or Scuba Diving; organized motor vehicle or motor boat racing; mountain climbing; professional rodeo competition; skydiving; parachuting, hang-gliding?	<input type="checkbox"/>	<input type="checkbox"/>
2) Are you or do you intend to become a member of the Armed Forces (including Reserves or National Guard)?	<input type="checkbox"/>	<input type="checkbox"/>
3) a. Drink alcoholic beverages? If yes, how much per week? _____ (one drink = 12 oz. beer, 4 oz. wine, or 1 oz. hard liquor) Amount _____	<input type="checkbox"/>	<input type="checkbox"/>
b. Now or ever used heroin, cocaine, marijuana, or illegal, restricted or controlled substance, except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
c. Ever had or been advised by a physician, practitioner, or court of law to have treatment for alcohol, drug, or substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>
4) a. Had insurance or reinstatement refused, postponed, limited, offered, or quoted on a rated or substandard basis?	<input type="checkbox"/>	<input type="checkbox"/>
b. Will this insurance replace or change any existing life insurance or annuity contract?	<input type="checkbox"/>	<input type="checkbox"/>
c. Made within the past 5 years a claim for or received benefits compensation, or pension for any injury, sickness, disability, or impaired condition?	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 5 years been unable to work, attend school, or perform normal activities of like age and gender, or been confined at home.	<input type="checkbox"/>	<input type="checkbox"/>
5) Ever been cited for driving while intoxicated (DWI), or driving under the influence (DUI)?	<input type="checkbox"/>	<input type="checkbox"/>
a. Ever been cited for any other driving violation in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
6) Ever been convicted in a court of law for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
7) a. Have you traveled outside the United States within the past 2 years or intend to travel outside the United States within the next 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you lived outside of the United States within the past 2 years or intend to live outside the United States within the next 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
8) Do you now use or have you ever used tobacco or nicotine in any form?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, indicate the type of tobacco used: <input type="checkbox"/> cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigar <input type="checkbox"/> chewing tobacco <input type="checkbox"/> other If applicable, the date you stopped: _____		
9) a. Were your parents, brothers or sisters diagnosed and treated for mental illness, diabetes, heart, kidney or liver disease, high blood pressure, stroke or cancer? If yes, name person(s).	<input type="checkbox"/>	<input type="checkbox"/>
b. Give name, cause and age at death of father, mother, brother(s), sister(s) if deceased: _____ _____		
10) Full name and complete address of personal physician; the date, reason last seen and diagnosis: _____ _____		
11) Have you declared bankruptcy in the last 7 years or had any suits, judgments or liens against you? If yes, discharged date: _____	<input type="checkbox"/>	<input type="checkbox"/>

COMPLETION OF QUESTIONS 12-19 IS REQUIRED IN ALL CASES. ANY "YES" ANSWERS MUST BE FULLY EXPLAINED AND REFERENCED IN REMARKS.

AIDS TEST RESULTS OBTAINED AT AN ANONYMOUS COUNSELING AND TESTING SITE DESIGNATED BY THE STATE EPIDEMIOLOGIST OR AT A SIMILAR FACILITY IN ANOTHER JURISDICTION OR HOME TESTING ARE CONFIDENTIAL AND NEED NOT BE DISCLOSED. NONE OF THESE APPLICATION QUESTIONS SHOULD BE INTERPRETED AS ASKING ABOUT AIDS, UNLESS THE QUESTION SPECIFICALLY MENTIONS AIDS.

Has or does the person proposed for insurance coverage:	Yes	No
12) Ever been diagnosed or treated by a member of the medical profession for a disorder, disease or persistent discomfort of the following systems:		
a. Respiratory (lungs, bronchi, trachea, etc.) such as, but not limited to, TB, asthma, emphysema, bronchitis, shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
b. Circulatory (heart, blood, arteries, veins, etc.) such as, but not limited to, high blood pressure, heart attack, chest pains, murmur?	<input type="checkbox"/>	<input type="checkbox"/>
c. Digestive (Throat, esophagus, stomach, intestine, liver, gall bladder, etc.) such as, but not limited to, ulcer, colitis, cirrhosis, hemorrhoids, bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
d. Nervous (brain, nerves, etc.) such as, but not limited to, paralysis, stroke, fainting, dizziness, epilepsy, convulsions, recurring headaches?	<input type="checkbox"/>	<input type="checkbox"/>
e. Musculo-skeletal (muscles, bones, joints, spine, etc.) such as, but not limited to, neck/back problems, fracture, arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genito-urinary (kidney, bladder, reproductive organs, etc.) such as, but not limited to, kidney stones, infection, bleeding, male or female disorders?	<input type="checkbox"/>	<input type="checkbox"/>
g. Glandular (thyroid, pancreas, adrenal, lymph glands, etc.) such as, but not limited to, abnormal growth or function, including diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
13) Been diagnosed or treated by a member of the medical profession for:		
a. impaired sight, or eye disorder	<input type="checkbox"/>	<input type="checkbox"/>
b. impaired hearing, or ear disorder	<input type="checkbox"/>	<input type="checkbox"/>
c. hernia	<input type="checkbox"/>	<input type="checkbox"/>
d. skin disease	<input type="checkbox"/>	<input type="checkbox"/>
e. any sexually transmitted disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
14) Been diagnosed or treated by a member of the medical profession for any mental, nervous, psychological, or emotional condition or disorder, such as, but not limited to, anxiety, depression, or nervous breakdown?	<input type="checkbox"/>	<input type="checkbox"/>
15) Have you ever been diagnosed or treated for cancer, tumor, cyst, or growth?	<input type="checkbox"/>	<input type="checkbox"/>
16) Gained or lost more than 10 pounds in the past year? Amount: _____ Cause: _____	<input type="checkbox"/>	<input type="checkbox"/>
17) Within the past 5 years: (Refer to disclaimer concerning AIDS test results at top of page)		
a. Have you been treated, examined or advised by a member of the medical profession?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had a physical examination? If yes, list the reason for and results below.	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Been on, or now on, prescribed diet or medication? List description of medication or diet, date prescribed and name and address of prescriber in remarks	<input type="checkbox"/>	<input type="checkbox"/>
e. Currently take any herbs, vitamins, mineral supplements or other non-prescription remedies? List description of non-prescribed medications in remarks.	<input type="checkbox"/>	<input type="checkbox"/>
18) Been diagnosed or treated by a member of the medical profession the past 10 years for complications of pregnancy (such as C-section) or now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
19) a. Been treated or diagnosed by a member of the medical profession as having any disorder of the blood or immune system, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Ever been treated by a member of the medical profession as having the AIDS (TTLV-III) Virus or tested positive to FDA licensed blood tests?	<input type="checkbox"/>	<input type="checkbox"/>

SERFF Tracking #:

CAKN-128802762

State Tracking #:

Company Tracking #:

CNO-175

State:

Arkansas

Filing Company:

Catholic Financial Life

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Application for Membership and Insurance

Project Name/Number:

MIB update/CNO-175

Supporting Document Schedules

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



READABILITY CERTIFICATION

Company Name: Catholic Fraternal Life

I hereby certify that the forms listed below have the following readability scores as calculated by the Flesch Reading Ease Test.

Form Number	Score
2012 LF APP	50
2012 LF APP2	50

Elizabeth Emory Gabrys

Elizabeth Emory Gabrys FAA MAAA
Vice President & Chief Actuary

December 10, 2012

Date