

**State:** Arkansas **Filing Company:** Colorado Bankers Life Insurance Company  
**TOI/Sub-TOI:** ML02 Multi-Line - Other/ML02.000 Multi-Line - Other  
**Product Name:** C-APP 2012  
**Project Name/Number:** C-APP/C-APP

## Filing at a Glance

Company: Colorado Bankers Life Insurance Company  
Product Name: C-APP 2012  
State: Arkansas  
TOI: ML02 Multi-Line - Other  
Sub-TOI: ML02.000 Multi-Line - Other  
Filing Type: Form  
Date Submitted: 11/30/2012  
SERFF Tr Num: FDLB-128787085  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: C-APP 2012  
  
Implementation: On Approval  
Date Requested:  
Author(s): Michael Hartman, Howard Moy  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 12/03/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** ML02 Multi-Line - Other/ML02.000 Multi-Line - Other  
**Product Name:** C-APP 2012  
**Project Name/Number:** C-APP/C-APP

**Filing Company:** Colorado Bankers Life Insurance Company

## General Information

Project Name: C-APP  
Project Number: C-APP  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Deemer Date:  
Submitted By: Michael Hartman

Status of Filing in Domicile: Not Filed  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 12/03/2012  
State Status Changed: 12/03/2012  
Created By: Michael Hartman  
Corresponding Filing Tracking Number:

### Filing Description:

Re:.....Colorado Bankers Life Insurance Company®  
NAIC #84786 - FEIN #84-0674027  
New Form Filing –

C-APP 2012.....Individual Life Insurance Application

Dear Reviewer:

An affiliated Company, Colorado Bankers Life Insurance Company, (CBLIC), has requested Dearborn National Life Insurance Company to assist them with the filing of the above referenced forms. This form is new and does not replace any existing form.

C-APP 2012 is a combination application that will be used with policy form number P-0892 which was approved by your Department on March 8, 1993; policy form number RT986-R which was approved on March 7, 1991 and policy form number RCT-122007 AR which was approved on March 5, 2008 (SERFF tracking no. FDLB-125487289).

This form is considered exempt in Colorado Banker's Life home state of Colorado and it is not required to be filed and/or approved.

This form is in final printed format subject only to changes in font style, margins, page numbers, ink and paper stock. Printing standards will not be lower than those required under the laws of your State.

If you have any questions or need additional information, please contact me toll free at 1-800-348-4512, ext. 6034, direct at 630-824-6034 or michael\_hartman@dearbornnational.com. Thank you for your prompt response.

## Company and Contact

### Filing Contact Information

Michael Hartman, Contract Specialist  
1020 31st Street  
Downers Grove, IL 60515

michael\_hartman@fdlic.com  
630-824-6034 [Phone]  
630-824-5428 [FAX]

**State:** Arkansas **Filing Company:** Colorado Bankers Life Insurance Company  
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**Filing Company Information**

Colorado Bankers Life Insurance Company	CoCode: 84786	State of Domicile: Colorado
5990 Greenwood Plaza Blvd., #325	Group Code: 917	Company Type: Life and Health
Greenwood Village, CO 80111	Group Name:	State ID Number:
(303) 220-8500 ext. [Phone]	FEIN Number: 84-0674027	

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form.  
  
 1 x \$50 = \$50.00  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Colorado Bankers Life Insurance Company	\$50.00	11/30/2012	65318190

SERFF Tracking #:

FDLB-128787085

State Tracking #:

Company Tracking #:

C-APP 2012

State: Arkansas

Filing Company:

Colorado Bankers Life Insurance Company

TOI/Sub-TOI: ML02 Multi-Line - Other/ML02.000 Multi-Line - Other

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/03/2012	12/03/2012

**State:** Arkansas  
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## Disposition

Disposition Date: 12/03/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Name Change Endorsement		No
Supporting Document	Address Change Endorsement		No
Supporting Document	Authorization Letter		Yes
Supporting Document	Explanation of Variable Text		Yes
Supporting Document	Readability Certification		Yes
Form	Individual Life Insurance Application		Yes

State: Arkansas

Filing Company:

Colorado Bankers Life Insurance Company

TOI/Sub-TOI: ML02 Multi-Line - Other/ML02.000 Multi-Line - Other

Product Name: C-APP 2012

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## Form Schedule

### Lead Form Number: C-APP 2012

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Individual Life Insurance Application	C-APP 2012	AEF	Initial		39.700	C-APP 2012.pdf

### Form Type Legend:

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

**1. PRIMARY INSURED AND BENEFICIARY INFORMATION**

Last Name		First Name		MI	Height	Weight	Phone Number for Contact	
Primary Street Address (No P.O. Box)		City	State	Zip Code	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex	Day #: _____	Best time to
Social Security Number	Date of Birth	Age	Occupation	State/Country of Birth		Length of Current Employment Years      Months		
Primary Beneficiary (Name) _____ (Relationship) _____ (xx#) - -				Contingent Beneficiary (Name) _____ (Relationship) _____ (xx#) - -				
Email Address :			<b>Secondary Addressee Option.</b> Provide name, complete address and telephone number. <i>Under this option, we will send the Secondary Addressee notice of the lapse of this insurance due to non-payment of the premium.</i>					
Primary Insured's Annual Household Income: \$ _____								

**2. OWNER (If Other than Primary Insured)**

Last Name		First Name		MI	Sex	Tax ID# or xx #	
Primary Street Address				City	State	Zip Code	
Relationship to Proposed Insured				Email Address			

**3. POLICY DATA (Riders Not Available in All States)**

<input type="checkbox"/> <b>Modified Whole Life Insurance (the Security Builder product)</b>	<input type="checkbox"/> <b>10 Yr. Renewable Term Life Insurance (the Financial Security Plan)</b>	<input type="checkbox"/> <b>10 Yr. Renewable &amp; Convertible Term Life Insurance w/Critical Condition Accelerated Benefit Rider (the Timber Ridge Plan)</b>
<b>Initial Premium: Cost</b> Life Insurance + Riders other than FPAR \$ _____ Annuity Rider (FPAR) \$ _____	<b>Initial Premium: Cost</b> Life Insurance + Riders other than FPAR \$ _____ Annuity Rider (FPAR) \$ _____	<b>Initial Premium: Cost</b> Life Insurance + Riders \$ _____
<b>Base Policy – Face Amount</b> \$ _____	<b>Base Policy – Face Amount</b> \$ _____	<b>Base Policy – Face Amount</b> \$ _____
<b>Benefit Riders – Coverage Amount:</b> <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death \$ _____ <input type="checkbox"/> 10-Yr. Level Term \$ _____ <input type="checkbox"/> Disability Income Benefit \$ _____ <input type="checkbox"/> Additional Benefit Rider _____ (Units)	<b>Benefit Riders – Coverage Amount:</b> <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death \$ _____ <input type="checkbox"/> 10-Yr. Level Term \$ _____ <input type="checkbox"/> Additional Benefit Rider _____ (Units)	<b>Benefit Riders – Coverage Amount:</b> <input type="checkbox"/> Critical Condition Family Rider <input type="checkbox"/> Additional Benefit Rider _____ (Units)
<b>Payment with Application</b> \$ _____	<b>Payment with Application</b> \$ _____	<b>Payment with Application</b> \$ _____
Automatic Premium Loan Provision Desired? (Modified Whole Life Only) ... <input type="checkbox"/> Yes <input type="checkbox"/> No      Automatic Premium Withdrawal Benefit from Annuity Rider? ... <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Premiums Payable (All Premium Payments must be made payable to Colorado Bankers Life Insurance Company)**

<b>Direct Billing</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	<b>Other Billing (must complete separate payment authorization)</b>	
<input type="checkbox"/> EFT <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <b>or</b>	<b>Payroll Deduction</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <b>or</b>	<input type="checkbox"/> Gov't Allotment <input type="checkbox"/> Other _____

**Persons<sup>1</sup> to be Covered Under an Additional Benefit or Critical Condition Family Rider**

<b>Legal Spouse<sup>2</sup> (Name)</b>	Sex	Date of Birth (DOB) / /	Height	Weight	xx No. (xx#) - -	State of Birth	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Child 1 (Name)</b>	Sex	DOB / /	Ht.	Wt.	<b>Child 3 (Name)</b>	Sex	DOB / /	Ht.	Wt.
<b>Child 2 (Name)</b>	Sex	DOB / /	Ht.	Wt.	<b>Child 4 (Name)</b>	Sex	DOB / /	Ht.	Wt.

<sup>1</sup>For additional insured children, attach separate page to application with name, sex, date of birth, height, and weight. <sup>2</sup>For purposes of this application, a Legal Spouse means a person who is the husband, wife or partner of another in a legally recognized marriage, civil union, or domestic partnership.

**4. HEALTH INFORMATION ( IMPORTANT! -Circle, mark or highlight any condition which applies and for any "Yes" answer, give complete details in Section 4, Part III)**

**Part I: Questions 1- 5 apply to all Persons to be Insured (including the Primary Insured, and any Legal Spouse and any Child to be insured).**

1. Has **any** Person to be Insured ever had, been told he/she had, or been treated for any of the following:
  - a. Cancer, tumor, ulcer, neurological disorder or related disease? .....  Yes  No
  - b. Disease of, or an abnormal diagnostic test regarding, the breast or reproductive organs? .....  Yes  No
  - c. Heart attack, angina pectoris, chest pain, stroke, high blood pressure or any other disease of the heart or blood vessels? .....  Yes  No
  - d. Disease of the kidney, urinary bladder, stomach, intestines, liver, gall bladder, lungs or respiratory system, nervous or mental disorder? .  Yes  No
  - e. Diabetes, chronic hepatitis, leukemia, internal organ transplant, cirrhosis of the liver, paralysis, or disease of the eyes? .....  Yes  No
2. Has **any** Person to be Insured ever been diagnosed or treated for or been told by a member of the medical profession he/she will require treatment for a disorder of the Immune System including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other AIDS-related condition, or had a positive test for the AIDS virus Human Immunodeficiency Virus (HIV)? .....  Yes  No
3. Has **any** Person to be Insured ever had or been treated for alcohol or drug abuse or addiction? .....  Yes  No
4. Has **any** Person to be Insured been hospitalized, consulted a physician, or received treatment for any illness or injury in the past 5 years, other than as stated above? .....  Yes  No
5. Has **any** Person to be Insured ever been declined or rated-up for life or health insurance? (Provide dates and details in Part III.) .....  Yes  No

**Part II: Questions 6-12 apply only to persons applying to be insured under the basic accelerated benefit rider or the family accelerated benefit rider.**

6. Has any Person to be Insured used any tobacco products in the past 12 months? .....  Yes  No
7. Has any Person to be Insured missed more than 5 consecutive days of work due to accident or sickness in the past 12 months? .....  Yes  No
8. Within the past 2 years, has any Person to be Insured been advised to have any diagnostic test, hospitalization, surgical procedure or treatment that has not been done? .....  Yes  No
9. Has any Person to be Insured had a parent, brother or sister who prior to age 60 suffered from cancer, diabetes, stroke, heart attack (myocardial infarction), heart disease, kidney disease, or mental illness? .....  Yes  No
10. Does any Person to be Insured currently have any growth, cyst or lump or any new pigmented area of skin that has not been evaluated by a physician? .....  Yes  No
11. Within the past 5 years has any Person to be Insured had any symptoms for which future medical assessment is planned, contemplated, or for which he/she has not yet consulted a physician? .....  Yes  No
12. Is any Person to be Insured currently taking or been advised to take prescription drugs? .....  Yes  No

**Part III: If additional space is needed to give details for any question, please state the information on a separate page, giving all the categories of information that are requested below; the Proposed Insured (if not a minor) to whom such information relates should sign that separate page.**

Q#	Person to be Insured	Nature of Condition	Date and Duration	Medication	Name of Doctor, Hospital or Facility	Address and Telephone Number

**5. REPLACEMENT INFORMATION**

- a. Do you have any existing life insurance or annuity coverage with CBL or any other company? .....  Yes  No
- b. If 5.a. is "yes", is this insurance intended to replace or change any of that existing life insurance or annuity coverage? .....  Yes  No  N/A

**6. GENERAL INFORMATION - About this application to Colorado Bankers Life Insurance Company ("CBL")**

- |  |   |
|--|---|
| <p>(A) <b>I (we) state</b> that the information given in this application, and any supplement to it, is true to the best of my (our) knowledge and belief. <b>I (we) agree</b> that this application will be the basis for and part of any insurance issued from it. No information about me (us) will be considered to have been given by me (us) to <b>CBL</b> unless it is stated in this application or any supplement to it.</p> <p>(B) <b>I (we) understand</b> <b>CBL</b> will have no liability under this application unless and until it is approved by <b>CBL</b> and the first premium is paid or an authorization for its payment has been signed by the applicant while the health and other conditions affecting the insurability of the person to be insured are as described in this application. Also, I/we understand that if the policy applied for includes a Critical Condition Benefit Rider, benefits under that Rider will take effect based on the effective date of that Rider as issued and applicable provisions within that Rider.</p> <p>(C) <b>I (we) understand</b> that benefits may be denied during the first 2 years after the insurance applied for is issued if: (a) I (we) did not give true and complete information and answers in this application; or (b) the health of any person to be insured, given in this application, changes before the first premium for the insurance applied for is paid or properly authorized to be paid.</p> <p>(D) <b>I (we) understand</b> that the agent is not authorized to: (a) accept risks or pass on a person to be insured's qualifications for insurance; (b) make or change insurance contracts; or (c) waive any of <b>CBL's</b> rights or requirements.</p> <p>(E) <b>I (we) acknowledge</b> receipt of the Information Disclosure Notice required by the Fair Credit Reporting Act.</p> <p>(F) <b>I (we) understand</b> that 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.]</p> | <p>(G) <b>AUTHORIZATION TO RELEASE INFORMATION. I/we (the person(s) to be insured) authorize</b> any physician, medical practitioner, pharmacists, pharmacy benefits managers, health care clearing houses, hospital, clinic, nurses, records custodians, health maintenance organization, including Mayo, Kaiser Foundation, Veterans Administration or other medical or medically related facility, insurance company, or EMSI, or MIB, Inc., or other organization, institute, or person that has any records or knowledge of me/us or my/our family, or our health, medical or pharmacy history or physical or mental condition, to give to <b>CBL</b>, its reinsurers, agents, contractors, employees, representatives, affiliates, assigns, and EMSI, as necessary any such information including alcohol abuse treatment, drug abuse treatment, psychiatric histories, pharmacy prescriptions, HIV (AIDS virus) testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's and to testify as to such information, for the purpose of evaluating my/our application for insurance or claim for benefits. I/we understand I/we may revoke this authorization at any time, by requesting such action of <b>CBL</b> and/or the other party to whom such revocation is to apply, in writing, unless action has already been taken in reliance upon this authorization, or during a contestability period under applicable law. I/we also authorize <b>CBL</b>, or its reinsurers, to make a brief report of my Protected Health Information available to MIB, Inc. A photostatic copy of this authorization will be valid as the original, and I/we, or my/our representative, can obtain a copy on request. I/we also understand that when my/our medical records are disclosed pursuant to the authorization the information contained in those records may become subject to further disclosure by <b>CBL</b>. In such case, the information may no longer be protected by the rules governing this authorization. This authorization is valid for twenty-four (24) months after the date it was signed.</p> |
|--|---|

\_\_\_\_\_ (Applicant's Initials) I (Applicant/Owner) authorize **CBL**, if I have given my email address in this application, to send all present and future notices regarding the insurance applied for, to me at that email address. I may revoke this authorization at any time by sending a written notice to **CBL** to do so.

DATED AT \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Applicant/Owner's Signature                      Print Proposed Insured's Name                      Proposed Insured's Signature (if different than Applicant/Owner)

\_\_\_\_\_  
Legal Spouse's Signature (If to be insured and signature not given above)                      Print Legal Spouse's Name (If to be insured and not given above)

SERFF Tracking #:

FDLB-128787085

State Tracking #:

Company Tracking #:

C-APP 2012

State: Arkansas

Filing Company:

Colorado Bankers Life Insurance Company

TOI/Sub-TOI: ML02 Multi-Line - Other/ML02.000 Multi-Line - Other

Product Name: C-APP 2012

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## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Authorization Letter		
Comments:			
Attachment(s):			
Authorization Letter.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Explanation of Variable Text		
Comments:			
Attachment(s):			
EOVT.pdf			

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



November 30, 2012

Re: Colorado Bankers Life Insurance Company®  
NAIC #84786 - FEIN #84-0674027  
New Form Filing –  
Individual Life Insurance Application  
C-APP 2012

Dear Reviewer:

I authorize Dearborn National® Life Insurance Company to file the captioned form(s) on behalf of Colorado Bankers Life Insurance Company®.

Very truly yours,

A handwritten signature in black ink that reads "PA Wells".

Patricia A. Wells  
Vice President – Corporate Services

5990 Greenwood Plaza Boulevard, Greenwood Village, Colorado 80111  
Toll Free: 800.367.7814 ▲ Fax: 303.220.8056 ▲ [www.dearbornnational.com](http://www.dearbornnational.com)

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Colorado Bankers Life Insurance Company® (Greenwood Village, CO), licensed in 49 states (excluding New York where it is not licensed and does not solicit business), the District of Columbia, Guam and Puerto Rico.

**Colorado Bankers Life Insurance Company®**  
**Explanation of Variable Text**  
**November 30, 2012**

**Application Amendment:**

**Form #: C-APP 2012**

<b>Title Section</b>	
5990 Greenwood Plaza Boulevard Greenwood Village, CO 80111	The address is bracketed to allow a change if the Company address changes.
<b>Footer Section</b>	
[Products and services.....]	The Company disclaimer is bracketed to allow a change if company information changes.

**COLORADO BANKERS LIFE INSURANCE COMPANY®**

**READABILITY CERTIFICATION**

This is to certify that the form listed below scores lower than the minimum required score. We ask the Commissioner to authorize the lower score due to the nature and type of this form.

I hereby certify that the following (forms) achieved a Flesch reading ease test score of:

<b><u>Form Description</u></b>	<b><u>Form Number</u></b>	<b><u>Flesch Score</u></b>
Individual Life Insurance Application	C-APP 2012	39.7



Patricia A. Wells  
Vice President – Corporate Services

Date: November 30, 2012