

State: Arkansas **Filing Company:** USABLE Life
TOI/Sub-TOI: H02I Individual Health - Accident Only/H02I.000 Health - Accident Only
Product Name: Accident Elite Application, AEP-APP - Revised MIB
Project Name/Number: Accident Elite Applications, AEP/AR001910100004

Filing at a Glance

Company: USABLE Life
Product Name: Accident Elite Application, AEP-APP - Revised MIB
State: Arkansas
TOI: H02I Individual Health - Accident Only
Sub-TOI: H02I.000 Health - Accident Only
Filing Type: Form
Date Submitted: 12/11/2012
SERFF Tr Num: LSVX-G128806523
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num: AR001910100004

Implementation: 12/11/2012
Date Requested:
Author(s): SPI Life and Specialty Ventures
Reviewer(s): Donna Lambert (primary)
Disposition Date: 12/12/2012
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** USABLE Life
TOI/Sub-TOI: H021 Individual Health - Accident Only/H021.000 Health - Accident Only
Product Name: Accident Elite Application, AEP-APP - Revised MIB
Project Name/Number: Accident Elite Applications, AEP/AR001910100004

General Information

Project Name: Accident Elite Applications, AEP
 Project Number: AR001910100004
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Deemer Date:
 Submitted By: SPI Life and Specialty Ventures

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Individual Market Type:
 Filing Status Changed: 12/12/2012
 State Status Changed: 12/12/2012
 Created By: SPI Life and Specialty Ventures
 Corresponding Filing Tracking Number:

Filing Description:

We are filing for your review and approval a revised individual accident application. It has been revised pursuant to the MIB requirement to change the MIB authorization to comply with final HIPAA Regulations. This application will replace the previously approved AEP-APP (9-08) application which was approved on 10/23/2008 under SERFF Filing ID LSVX-125864040 (AR Filing ID 40615. It can be used with our Accident Policy, AEP (9-05), which was approved on 9/9/2005.

We made the following revision to the application: In the authorization section, added the phrase "(b) authorize USABLE Life or its reinsurer to make a brief report of my personal health information to MIB."

The following form was previously approved by your department and will be also be used with this form:

APP-NOTICE (9-08) - Application Notice - 10/23/2008

The application may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document, but we assure that its content will not change and its readability compliance will not be affected.

Company and Contact

Filing Contact Information

Rob Wittenburg, Legal Product Specialist rwittenburg@usablelife.com
 PO Box 1650 501-212-8877 [Phone] 8877 [Ext]
 Little Rock, AR 72203-1650 501-235-8484 [FAX]

Filing Company Information

USABLE Life	CoCode: 94358	State of Domicile: Arkansas
PO Box 1650	Group Code: 876	Company Type: Life & Health
Little Rock, AR 72203-1650	Group Name: Life and Speciality Ventures (LSV)	State ID Number:
(501) 375-7200 ext. [Phone]	FEIN Number: 71-0505232	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00

State: Arkansas **Filing Company:** USable Life
TOI/Sub-TOI: H021 Individual Health - Accident Only/H021.000 Health - Accident Only
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Retaliatory? No

Fee Explanation:

Per Company: No

Company	Amount	Date Processed	Transaction #
USable Life	\$50.00	12/11/2012	65655637

SERFF Tracking #:

LSVX-G128806523

State Tracking #:

Company Tracking #:

AR001910100004

State: Arkansas **Filing Company:** US Able Life
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/12/2012	12/12/2012

SERFF Tracking #:

LSVX-G128806523

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

AR001910100004

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Disposition

Disposition Date: 12/12/2012

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Flesch Certification	Approved	Yes
Form	Accident Policy Application & Change Form	Approved	Yes

State: Arkansas

Filing Company: US Able Life

TOI/Sub-TOI: H021 Individual Health - Accident Only/H021.000 Health - Accident Only

Product Name: Accident Elite Application, AEP-APP - Revised MIB

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Form Schedule

Lead Form Number: AEP-APP (1-13)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved 12/12/2012	Accident Policy Application & Change Form	AEP-APP (1-13)	AEF	Revised	Previous Filing Number:	40615	47.400	AEP-APP (1-13).PDF
						Replaced Form Number:	AEP-APP (9-08)		

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



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

ACCIDENT POLICY APPLICATION & CHANGE FORM

Office Use Only	
Policy Number	
Group Number	
Effective Date	
Dept./Loc.	
Class	

Agent Name/Number	<input type="checkbox"/> New Application <input type="checkbox"/> Change Form
	<input type="checkbox"/> Reinstatement Policy # _____ <input type="checkbox"/> Replaces Policy # _____

SECTION 1 – PERSONAL IDENTIFICATION

Name (First, MI, Last)			For Name Change, Give Prior Last Name			Social Security No.		
Home Address				City	State	Zip	County	
Date of Birth	Age	Birth State or Country	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female		Work Phone ()	Home Phone ()	
Type of Business						Applicant's email address (if any)		
Name of Employer			Date Employed Full-Time	Occupation		Hours Worked Weekly		

DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage.

Full Name (First, MI, Last)	Relationship	Sex	Date of Birth			Birth State or Country
			Mo.	Day	Yr.	

SECTION 2 – PLAN SELECTION ■ New Applicant ■ Application for Change

CHECK COVERAGE DESIRED:

- Applicant
 Applicant & Spouse
 Applicant & Children
 Applicant, Spouse & Children

Applying for Accident Policy Plan:

PREMIUM

- Basic (3 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8)
 Select (4 units of all Modules)
 Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$

Optional Accidental Disability Rider*:

- Off-The Job or 24-Hour
 \$400
 \$600
 \$800
 \$

- Optional Sickness Disability Rider*
 \$400
 \$600
 \$

TOTAL MONTHLY PREMIUM \$

Industry Class Monthly Premiums	Class A/B			Class C			Class D		
	Basic	Select	Ultra	Basic	Select	Ultra	Basic	Select	Ultra
Applicant	\$15.80	\$19.36	\$27.88	\$23.36	\$28.64	\$41.32	\$27.80	\$34.08	\$49.12
Applicant & Spouse	22.48	27.52	39.68	29.88	36.64	52.80	33.92	41.60	60.00
Applicant & Children	26.28	32.16	46.40	30.28	37.12	53.52	34.24	41.92	60.44
Applicant, Spouse & Children	32.96	40.32	58.20	36.80	45.12	65.00	40.36	49.44	71.32
Optional Rider(s)	Off-The-Job		24-Hour	Off-The-Job		24-Hour	Off-The-Job		24-Hour
Accident Disability Rider*:									
\$400	\$3.12		\$8.40	\$5.52		\$17.92	N/A		N/A
\$600	4.68		12.60	8.28		26.88	N/A		N/A
\$800	6.24		16.80	11.04		35.84	N/A		N/A
Sickness Disability Rider*	Class A/B			Class C			Class D		
\$400	\$7.44			\$8.08			N/A		
\$600	11.16			12.12			N/A		

*Coverage applies to primary insured only.

Employee's Name (Last, First, M.I.)	Social Security #	Employer
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SECTION 4 – BENEFICIARY ■ Name Beneficiary ■ Change of Beneficiary

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Birthdate	Relationship	Primary or Secondary	Indicate Percentage
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	

SECTION 5 – AUTHORIZATION

1. Is this insurance to replace or change other insurance? Yes No If "Yes", give details including name of company. _____
2. Have you received the Outline of Coverage (in those states where required by law)? Yes No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded; (b) authorize USABLE Life or its reinsurer to make a brief report of my personal health information to MIB; (c) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USABLE Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (d) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (e) agree that this authorization shall be valid for two (2) years from the application date; (f) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (g) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Information Practices Notice. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void the policy.

Important Note – The entire contract will consist of this application and the insurance issued in response to it. The insurance will not be effective on the proposed insured unless: (1) The policy is delivered to the primary insured; (2) The first modal premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the proposed insured as stated in this application. I understand that my policy will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

Insurance Fraud Warning – It is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

I have read and understand the above statements and agreements.

X _____ Signed at: _____
Applicant's Signature (City and State)

Agent's Statement: I have accurately recorded the information supplied by the applicant. Date of Application _____
(Month, Day, Year)

X _____
Agent's Signature

Date Received Home Office

SERFF Tracking #:

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	12/12/2012
Bypass Reason:	Not a policy filing.		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	12/12/2012
Bypass Reason:	Not a policy or rate filing. Application only.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	12/12/2012
Bypass Reason:	Not a policy filing.		
		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	12/12/2012
Comments:			
Attachment(s):			
AR Readability Certification.PDF			

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: USAbLe Life

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

Form Number	Score
AEP-APP (1-13)	47.4



Signed: _____

Name: Sally A. Murphy
Senior Counsel, Chief Compliance Officer and
Title: Assistant Secretary

Date: 12/11/2012 _____