

SERFF Tracking Number: PSEN-128067126 State: Arkansas  
 Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company State Tracking Number:  
 Company Tracking Number: FLA PARAMED COA  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life  
 Product Name: FLA Paramed COA  
 Project Name/Number: /

## Filing at a Glance

Company: Fidelity Life Association, A Legal Reserve Life Insurance Company  
 Product Name: FLA Paramed COA SERFF Tr Num: PSEN-128067126 State: Arkansas  
 TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- Closed State Tr Num:  
 Sub-TOI: L04I.213 Specified Age or Duration - Co Tr Num: FLA PARAMED COA State Status: Approved-Closed  
 Fixed/Indeterminate Premium - Single Life  
 Filing Type: Form Reviewer(s): Linda Bird  
 Authors: Barbara Ritzke, Deb Howver, Joanne Miller Disposition Date: 02/22/2012  
 Date Submitted: 02/14/2012 Disposition Status: Approved-Closed  
 Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Pending  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Individual Market Type:  
 Overall Rate Impact: Filing Status Changed: 02/22/2012  
 State Status Changed: 02/22/2012  
 Deemer Date: Created By: Deb Howver  
 Submitted By: Deb Howver Corresponding Filing Tracking Number:  
 Filing Description:  
 The purpose of this filing is to update the address and phone number on Paramed Exam forms LA-602C and LA-602F previously approved on 2/26/2010 under SERFF tracking number NICS-126500596 and state tracking number 44998. On November 21, 2011, Fidelity Life Association, A Legal Reserve Life Insurance Company changed its address from P.O. Box 9269, Oak Brook, IL 60522-9269 to P.O. Box 5030, Des Plaines, IL 60017 and changed its phone number from (630) 522-0392 to (866) 947-8739. Due to the fact that the address and phone number on these forms was inadvertently not bracketed, we find it necessary to update and bracket that information on both forms. No other

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changes have been made. LA-602C(1/12) is intended to replace LA-602C and LA-602F(1/12) is intended to replace LA-602F.

## Company and Contact

### Filing Contact Information

Debbie Howver, deb@myactuary.com  
 35W841 Burr Oak Lane 224-402-2156 [Phone]  
 West Dundee, IL 60118 847-551-1795 [FAX]

### Filing Company Information

(This filing was made by a third party - problemsolvingenterprises)

Fidelity Life Association, A Legal Reserve Life Insurance Company CoCode: 63290 State of Domicile: Illinois  
 8700 W. Bryn Mawr Avenue Group Code: Company Type:  
 Suite 900S Group Name: State ID Number:  
 Chicago, IL 60631 FEIN Number: 36-1068685  
 (630) 522-0392 ext. [Phone]  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? Yes  
 Fee Explanation: 2 forms @ \$50.00/form = \$100.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fidelity Life Association, A Legal Reserve Life Insurance Company	\$100.00	02/14/2012	56331399

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/22/2012	02/22/2012

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## Disposition

Disposition Date: 02/22/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Third Party Authorization Letter		Yes
Form	Paramed Exam Medical Questionnaire		Yes
Form	Paramed Exam Medical Examiner's Confidential Report		Yes

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## Form Schedule

### Lead Form Number: LA-602C(1/12)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LA-602C(1/12)	Other	Paramed Exam Medical Questionnaire	Revised	Replaced Form #: LA-602C Previous Filing #: NICS-126500596	51.500	FLA_LA-602C(1-12)_Paramed COA_120207.pdf
	LA-602F(1/12)	Other	Paramed Exam Medical Examiner's Confidential Report	Revised	Replaced Form #: LA-602F Previous Filing #: NICS-126500596	61.700	FLA_LA-602F(1-12)_Paramed COA_120207.pdf



**Medical Questionnaire (Continued) Name of Insured \_\_\_\_\_**

Questions apply to Proposed Insured named above. Use the Details Section below as needed to explain "Yes" answers.

**6. Have you ever:**

- a. Used cocaine or any other illegal drugs?  Yes  No
- b. Sought treatment or counseling, or been advised to quit, reduce, seek treatment or counseling for the use of alcohol or drugs?  Yes  No
- c. Attended or been advised to attend a drug or alcohol self-help group?  Yes  No
- d. Been convicted of drug possession or distribution?  Yes  No
- e. Attempted suicide?  Yes  No

**7. Details. Give complete details of all Yes answers.**

Question Number	Date of Occurrence	Details, diagnosis, treatment, medication, results	Duration	Name and address of medical practitioners, hospitals, and medical facilities consulted

- 8. a. What is your height? \_\_\_\_\_ weight? \_\_\_\_\_
- b. Have you lost any weight in the past year? **If yes, How much?** \_\_\_\_\_ **Reason?** \_\_\_\_\_  Yes  No

**9. In the past five years, have you: (If Yes to a or b: give complete details of each occurrence.)**

- a. Consulted a doctor, medical or mental health professional?  Yes  No
- b. Had or been advised to have any blood tests, electrocardiograms, or other tests or studies other than a Human Immunodeficiency Virus (HIV) test or an Acquired Immune Deficiency Syndrome (AIDS) test?  Yes  No

10. Have you ever tested positive for the HIV antibody?  Yes  No

11. In the past two years, have you been advised to have any surgery or hospitalization which has not been completed?  Yes  No

12. In the past ten years, have you been under observation or received treatment in any hospital or other institution or medical facility?  Yes  No

- 13. Are you currently:
  - a. Receiving any illness or disability pension benefits or compensation?  Yes  No
  - b. Taking, or have been prescribed any medication: **(If Yes, provide reason and name the medication and prescribing physician.)**  Yes  No

14. Do you have any mental or physical disease or disorder, or are you under medical or psychiatric observation or treatment not already stated above?  Yes  No

**15. Who is your personal physician? (If none, state none.)**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Why? \_\_\_\_\_  
 What tests were made? \_\_\_\_\_  
 Were the results normal? **(If no, give details in #16)**  Yes  No

**16. Details. Give complete details of all Yes answers.**

Question Number	Date of Occurrence	Details, diagnosis, treatment, medication, results	Duration	Name and address of medical practitioners, hospitals, and medical facilities consulted

All statements and answers to the questions listed above are true, complete, and correctly recorded, to the best of my knowledge and belief. I agree: that they shall form a part of the application to the Company dated \_\_\_\_\_ with policy number \_\_\_\_\_; that they shall be subject to the terms of the agreement found in same; and that they shall become a part of any policy based on this application. I will write to the Company if I choose to be interviewed if any investigative report is prepared.

I (we) hereby authorize upon request: any physician or medical practitioner; any hospital, clinic or other medically related facility; any insurance company; the Medical information Bureau; and any other organization, institution or person, that has any records or knowledge relating to the Proposed Insured's health, habits, employment, income and finances should the Company make a request, to give any such records or knowledge to: the Company; its reinsurers, affiliates and producers; the Medical Information Bureau; and third parties who perform services for the Company in order to underwrite and administer any policy issued and offer financial products and services. This authorization is valid 24 months from the date this form is signed. An exact copy of this authorization is valid as the original. A copy of this authorization will be given to me (us) or my (our) authorized representative on request.

Signed at (city and state) \_\_\_\_\_ Signature of Proposed Insured \_\_\_\_\_

On (month/day/year) \_\_\_\_\_ Signature of Witness \_\_\_\_\_

Agent       Examiner       Other

File Number: \_\_\_\_\_

**Medical Examiner's Confidential Report**

**INSTRUCTIONS TO EXAMINER** - This examination, once begun, is the property of the Company, and must not be destroyed, suppressed, or given to Proposed Insured. It should be sent to the administrative office upon completion. Examination must be made in private. Proposed Insured must be properly prepared for careful physical examination. Please weigh and measure the Proposed Insured. Explain all positive findings under "Remarks." If for any reason you don't care to give certain special confidential information on this form, please enter such information on a separate sheet and mail directly to the Medical Director of the Company.

1. Proposed Insured \_\_\_\_\_
2. Height \_\_\_\_\_ft. \_\_\_\_\_in. Did you measure?  Yes  No Weight \_\_\_\_\_lbs. Did you weigh?  Yes  No
3. MEASUREMENTS (for males only)  
 Chest: Full inspiration \_\_\_\_\_in. Forced expiration \_\_\_\_\_in. Abdomen: (at umbilicus) \_\_\_\_\_in.
4. Have you ever drawn a blood specimen and mailed it along with a urine specimen?  Yes  No  
 Lab name \_\_\_\_\_
5. BLOOD PRESSURE: Initial reading \_\_\_\_\_ Additional readings \_\_\_\_\_  
 Report all readings. If initial reading is 140/90 or higher, or if the Proposed Insured has had hypertension or marked obesity, provide two additional blood pressure readings taken at intervals.
6. PULSE: Pulse at rest \_\_\_\_\_ Describe any irregularities

If examination is done by a physician, answer questions 7 and 8. Otherwise, go directly to question 9.

7. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the:
 

a. Brain or nervous system? (Test reflexes and coordination.)	a. <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Eyes, ears, nose, or throat?	b. <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Thyroid or lymph glands?	c. <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Heart or blood vessels?	d. <input type="checkbox"/> Yes <input type="checkbox"/> No
(If there is history of rheumatic fever, or if you find any abnormality of heart size, rhythm or sounds, please complete question 8)	
e. Lungs?	e. <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Skin or extremities?	f. <input type="checkbox"/> Yes <input type="checkbox"/> No
g. Genito-urinary system?	g. <input type="checkbox"/> Yes <input type="checkbox"/> No
h. Stomach or abdominal organs?	h. <input type="checkbox"/> Yes <input type="checkbox"/> No
i. Is the liver enlarged?	i. <input type="checkbox"/> Yes <input type="checkbox"/> No

**Remarks**

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Name of Proposed Insured \_\_\_\_\_

**Medical Examiner's Confidential Report (Continued)**

8. To be completed if question 7d is answered Yes, or if requested: (Explain all Yes answers under "Remarks.")
- a. Is there a history of rheumatic fever or other infectious heart disease? a.  Yes  No
  - b. Is there a history of congenital heart disease or other valvular abnormality? b.  Yes  No
  - c. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)? c.  Yes  No
  - d. Is the first heart sound (S-1) normal? d.  Yes  No
  - e. Is the second heart sound (S-2) normal? e.  Yes  No
  - f. Are there gallops (S-3 or S-4)? f.  Yes  No
  - g. Is/are there ejection sound(s) or systolic click(s)? g.  Yes  No
  - h. Is/are there murmur(s) present? h.  Yes  No

(If Yes, please describe under "Remarks," including timing (systolic or diastolic), intensity (grades 1 through 6), location and transmission or radiation. Construct a chest diagram in "Remarks" if you wish).

9. a. Does the Proposed Insured appear in any way unhealthy, disabled, or older than the stated age?  Yes  No
- b. Do you know of any facts bearing upon the risk by which are not brought out by the foregoing questions?  Yes  No
- c. Was anyone else besides the Proposed Insured present at time of exam? (If Yes, who? \_\_\_\_\_)  Yes  No

10. a. Are you acquainted with the Proposed Insured?  Yes  No
- If Yes, how well do you know the Proposed Insured?
- Known well  Not known well
- Relative (state relationship) \_\_\_\_\_ How long known? \_\_\_\_\_
- b. Are you the Proposed Insured's personal physician?  Yes  No

11. Exam was done at:

Proposed Insured's office  Examiner's office  Proposed Insured's home  Other \_\_\_\_\_

12. How did you identify the Proposed Insured?  Driver's license number: \_\_\_\_\_

Federal or state issued photo i.d. number: \_\_\_\_\_  Other: type \_\_\_\_\_ Number \_\_\_\_\_

**Remarks**

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I hereby certify that I have personally examined \_\_\_\_\_ in private and have correctly and fully reported my findings.

Examined at \_\_\_\_\_, dated \_\_\_\_\_, at \_\_\_\_\_  AM  PM

Signature of Examiner \_\_\_\_\_  Paramed  MD

**Examiner**

Print Examiner's name \_\_\_\_\_

Examiner's phone number \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Paramed company \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

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## Supporting Document Schedules

	Item Status:	Status Date:
<p><b>Satisfied - Item:</b> Flesch Certification  <b>Comments:</b>  <b>Attachments:</b>            AR_ Certification.pdf            FLA_Paramamed COA Readability Certification.pdf            AR_ Certification Bulletin 11-83.pdf</p>		
<p><b>Bypassed - Item:</b> Application  <b>Bypass Reason:</b> Not applicable to this filing--no policy forms are being submitted.  <b>Comments:</b></p>		
<p><b>Bypassed - Item:</b> Life &amp; Annuity - Acturial Memo  <b>Bypass Reason:</b> Not applicable to this filing.  <b>Comments:</b></p>		
<p><b>Satisfied - Item:</b> Third Party Authorization Letter  <b>Comments:</b>  <b>Attachment:</b>            FLA_ Letter of Authorization_120118_signed.pdf</p>		

## ARKANSAS CERTIFICATION

I, Ciaran Brady, Vice President - Operations for Fidelity Life Association, do hereby attest and certify to the following:

- The Company has further reviewed its issuance procedures and is compliance with Regulation 49, Life and Health Insurance Guaranty Association Notices.
- This submission meets the provisions of Regulation 19, Unfair Sex Discrimination in the Sale of Insurance, as well as all applicable requirements of the Arkansas Insurance Department.

FIDELITY LIFE ASSOCIATION



Digitally signed by Ciaran Brady  
DN: cn=Ciaran Brady, o=Fidelity Life  
Association, ou=Vice President -  
Operations,  
email=Ciaran.Brady@fidelitylife.com,  
c=US  
Date: 2012.02.13 20:14:14 -06'00'

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Ciaran Brady, Vice President – Operations

February 13, 2012

Date

READABILITY CERTIFICATION

Company Name: Fidelity Life Association, A Legal Reserve Life Insurance Company  
NAIC Number: 63290  
FEIN Number: 36-1068685

Subject: Paramed Exam Questionnaire, Form LA-602C(1/12);  
Paramed Exam Report, Form LA-602F(1/12).

As an officer of Fidelity Life Association, I hereby certify that the following forms achieve a Flesch score that meets or exceeds requirements as follows:

Form Number(s):	Flesch Score:
<u>LA-602C(1/12)</u>	<u>51.5</u>
<u>LA-602F(1/12)</u>	<u>61.7</u>



Digitally signed by Ciaran Brady  
DN: cn=Ciaran Brady, o=Fidelity Life  
Association, ou=Vice President - Operations,  
email=Ciaran.Brady@fidelitylife.com, c=US  
Date: 2012.02.13 20:01:00 -06'00'

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Ciaran Brady, Vice President - Operations

February 13, 2012  
Date

## ARKANSAS CERTIFICATION

I, Ciaran Brady, Vice President - Operations for Fidelity Life Association, do hereby certify to the following:

- The Company has reviewed Bulletin 11-83, Guidelines for Non-Guaranteed Costs on Participating and Non-Participating Life Insurance, and confirms compliance of such guidelines.

FIDELITY LIFE ASSOCIATION, A Legal Reserve Life Insurance Company

 Digitally signed by Ciaran Brady  
DN: cn=Ciaran Brady, o=Fidelity Life  
Association, ou=Vice President -  
Operations,  
email=Ciaran.Brady@fidelitylife.com,  
c=US  
Date: 2012.02.13 20:30:42 -06'00'

Ciaran Brady, Vice President – Operations

February 13, 2012

Date



Fidelity Life Association  
8700 W. Bryn Mawr Avenue  
Chicago, IL 60631  
Tel: 630.522.0392 Fax: 866.375.8175

January 18, 2012

To Whom It May Concern:

Please allow this letter to serve as authorization for Problem Solving Enterprises, Inc to make rate, rule and form filings on behalf of Fidelity Life Association, a Legal Reserve Life Insurance Company. Problem Solving Enterprises serves as actuarial and compliance consultants for Fidelity Life Association.

Any questions may be directed to me at 630-371-1888.

Sincerely,

A handwritten signature in black ink, appearing to read 'C. Brady', with a red checkmark below it.

Digitally signed by Ciaran Brady  
DN: cn=Ciaran Brady, o=Fidelity Life  
Association, ou=Vice President -  
Operations,  
email=Ciaran.Brady@fidelitylife.co  
m, c=US  
Date: 2012.01.18 14:41:49 -06'00'

Ciaran Brady  
Vice President of Operations