

SERFF Tracking Number: UCTA-128156155 State: Arkansas  
Filing Company: The Order of United Commercial Travelers of America State Tracking Number:  
Company Tracking Number:  
TOI: L07I Individual Life - Whole Sub-TOI: L07I.111 Single Premium - Single Life  
Product Name: Single Premium Whole Life - Application  
Project Name/Number: /

## Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Single Premium Whole Life - Application SERFF Tr Num: UCTA-128156155 State: Arkansas

TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: L07I.111 Single Premium - Single Life Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird

Authors: Denise Sharif, Jane

Visocan, Lyndsay Fields

Date Submitted: 03/08/2012

Disposition Date: 03/12/2012  
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: 03/12/2012

State Status Changed: 03/12/2012

Deemer Date:

Created By: Denise Sharif

Submitted By: Denise Sharif

Corresponding Filing Tracking Number:

Filing Description:

SUBMISSION

Application: SPWL APP 12

We are requesting the Department's review and approval of this filing. The filing is for an application for Single Premium Whole Life Insurance.

The application is replacing Form number SPWL App-08 which was previously approved on April 8, 2008. It is being

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revised to update the authorization language; none of the health questions have been changed.

Any required filing documents have been completed and are included with the filing. We appreciate your time and consideration in the review of this filing. Thank you.

Sincerely,

Denise Sharif  
Compliance Supervisor  
(800) 848-0123, Ext. 103  
Email: dsharif@uct.org

## Company and Contact

### Filing Contact Information

Denise Sharif, Compliance Supervisor dsharif@uct.org  
1801 Watermark Dr. 614-487-9680 [Phone] 103 [Ext]  
Suite 100 614-487-9675 [FAX]  
Columbus, OH 43215

### Filing Company Information

The Order of United Commercial Travelers of America CoCode: 56383 State of Domicile: Ohio  
1801 Watermark Dr. Group Code: Company Type:  
Suite 100 Group Name: State ID Number:  
Columbus, OH 43215 FEIN Number: 31-4273120  
(614) 487-9680 ext. 103[Phone]

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation: \$50.00 for application  
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	\$50.00	03/08/2012	56983241

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## Correspondence Summary

### Dispositions

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

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## **Disposition**

Disposition Date: 03/12/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Form</b>	Application for SPWL		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	12	SPWL APP	Application/ Enrollment Form	Application for SPWL Initial		40.300	SPWL APP 12.pdf



<p>5. Within the past 2 years, has the Proposed Insured:</p> <p>(a) been administered oxygen or recommended the use of oxygen?</p> <p>(b) had a heart attack, stroke, transient ischemic attack (TIA, also known as a mini-stroke), had or been advised to have heart surgery (including angioplasty or stent placement)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. Within the past 2 years, has the Proposed Insured been diagnosed with or treated for:</p> <p>(a) dementia, Alzheimer's disease, schizophrenia, or any mental disorder?</p> <p>(b) cancer (other than basal cell carcinoma), leukemia, lymphoma, tumor, or chronic blood disorder (including sickle cell anemia)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7. In the past 5 years, has the Proposed Insured been incarcerated?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>8. Has the Proposed Insured <i>ever</i> been diagnosed with or treated for:</p> <p>(a) chronic kidney disease or disorder, or received kidney dialysis?</p> <p>(b) hepatitis (except Hepatitis A), or any liver or pancreas disease?</p> <p>(c) Congestive Heart Failure (CHF)?</p> <p>(d) Multiple sclerosis, lupus, or ALS (also known as Lou Gehrig's disease)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### 4. HEALTH QUESTIONS

(If "yes", please provide details – attach additional sheet if necessary)

<p>9. In the past 2 years, has the Proposed Insured had an application for life or health insurance or reinstatement declined, rated, or modified in any way?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>10. Has any Proposed Insured <i>ever</i> been diagnosed with, been treated by a member of the medical profession, taken medication for, or been advised to have diagnostic tests for: (check applicable conditions)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Internal cancer  <input type="checkbox"/> Leukemia  <input type="checkbox"/> Lymphoma  <input type="checkbox"/> Hodgkin's disease  <input type="checkbox"/> Malignant melanoma  <input type="checkbox"/> Dementia, Alzheimer's or Parkinson's disease  <input type="checkbox"/> Malignant or benign tumors of any kind  <input type="checkbox"/> Emphysema or other chronic lung disease  <input type="checkbox"/> Blood disorder </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Heart Attack  <input type="checkbox"/> Stroke  <input type="checkbox"/> Transient Ischemic Attack  <input type="checkbox"/> Heart Surgery  <input type="checkbox"/> Coronary Artery Surgery  <input type="checkbox"/> Heart or circulatory system disease  <input type="checkbox"/> Angioplasty  <input type="checkbox"/> Paralysis, epilepsy, or other nervous system disease  <input type="checkbox"/> Diabetes Mellitus </td> </tr> </table>		<input type="checkbox"/> Internal cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Hodgkin's disease <input type="checkbox"/> Malignant melanoma <input type="checkbox"/> Dementia, Alzheimer's or Parkinson's disease <input type="checkbox"/> Malignant or benign tumors of any kind <input type="checkbox"/> Emphysema or other chronic lung disease <input type="checkbox"/> Blood disorder	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Transient Ischemic Attack <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Coronary Artery Surgery <input type="checkbox"/> Heart or circulatory system disease <input type="checkbox"/> Angioplasty <input type="checkbox"/> Paralysis, epilepsy, or other nervous system disease <input type="checkbox"/> Diabetes Mellitus
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<p>11. Does the Proposed Insured require the use of a wheel chair due to chronic illness?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>12. In the last 2 years, has the Proposed Insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>13. In the past 3 years, has the Proposed Insured been treated for alcohol and/or drug abuse?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>14. In the past 3 years, has the Proposed Insured been convicted of or put on probation for: (1) a felony; (2) driving under the influence (DUI); or (3) driving while intoxicated (DWI)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Give details to any "Yes" answers to the Health Questions

Question #	Explanation (including Medications)	Dates / Duration	Name of Physician and/or Hospital

## 5. REPLACEMENT INFORMATION

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Does the Proposed Insured have any existing life insurance or annuities currently in force or pending with this or any other company? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Will this policy, if issued, replace or modify insurance or annuities with this or any other company?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "yes", provide the following information:

Name of Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Reason for replacement? \_\_\_\_\_

## 6. AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued.

**WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.**

**If not a current member of The Order of United Commercial Travelers of America (UCT), I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.**

Signed At: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

Dated: \_\_\_\_\_  
(Month/Day/Year)

## 7. AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

### TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

- List any other life insurance or annuity policies you have sold to the Applicant that are still in force.  
\_\_\_\_\_  
\_\_\_\_\_
- List any other life insurance or annuity policies you have sold to the Applicant in the past five (5) years that are no longer in force.  
\_\_\_\_\_
- Do you have any knowledge or reason to believe that the Applicant is intending to replace an existing insurance?  Yes  No

I certify that:

I have accurately recorded the information supplied by the Applicant; and I have given an outline of coverage for the policy applied for to the applicant.

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's Printed Name: \_\_\_\_\_ Agent License Number: \_\_\_\_\_

**HIPAA & MIB AUTHORIZATION & ACKNOWLEDGEMENT  
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA**

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization **EXCEPT** to reinsurance companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance or reinsuring company, MIB, Inc., or other organization, institution, or person, that has my records or knowledge of me or my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original. I understand that I or my authorized representative may request to receive a copy of this authorization.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the Information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I authorize The Order of United Commercial Travelers of America, or its reinsurers, to make a brief report of my protected health information to MIB, Inc. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

I also understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, or a request for change in policy benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

\_\_\_\_\_

**Applicant Name**

\_\_\_\_\_

**Social Security Number**

\_\_\_\_\_

**Date of Birth**

\_\_\_\_\_

**Signature of Applicant**

\_\_\_\_\_

**Date**

**AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK – Deposit Slips NOT Accepted**

<b>AUTHORIZATION</b>	<b>IN FAVOR</b>	<u>The Order of United Commercial Travelers of America</u>		<b>AUTHORIZATION</b>
	<b>OF:</b>	<u>1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.</u>		
		<b>Name of Bank Customer:</b> _____		
		<b>Insured's Name:</b> _____		
		<b>Account Number:</b> _____	<b>Routing Number:</b> _____	
	<b>To (Name of Bank):</b> _____			
	<b>Address of Bank:</b> _____			
	<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>			
	<b>Date</b>	<b>Signature of Bank Customer</b>		

**Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.**

**To: Bank above:**  
 In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.



**NOTICE TO APPLICANT**

In making this application for insurance to The Order of United Commercial Travelers of America, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated confidential. The Order of United Commercial Travelers of America, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Order of United Commercial Travelers of America, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at [www.mib.com](http://www.mib.com).

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## Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Readability Cert 3-8-12.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application

**Comments:**

**Attachment:**

SPWL APP 12.pdf

**Item Status:** **Status Date:**

**Bypassed - Item:** Life & Annuity - Actuarial Memo

**Bypass Reason:** Not applicable.

**Comments:**

## READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

The Order of United Commercial Travelers of America  
1801 Watermark Dr., Suite 100  
Columbus, OH 43215

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

<b>Title of Form</b>	<b>Form Number</b>	<b>Flesch Score</b>
Application for Single Premium Whole Life Insurance	SPWL APP 12	40.3

In determining the Flesch Scores shown above, the following "text" was excluded:

1. The name and address of the company;
2. The name, number and title of the form;
3. The table of contents or index;
4. Captions and sub-captions;
5. Specification pages, schedules and tables;
6. Any provisions required by federal law or regulation; and
7. Any medical terminology.

The type size of the text is at least 10-point.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in the state.

  
\_\_\_\_\_  
Signature of Insurance Company Officer



<b>APPLICATION FOR SINGLE PREMIUM WHOLE LIFE INSURANCE</b>	<i>Requested Effective Date of Policy</i>
--	---

**1. PROPOSED INSURED AND BENEFICIARY INFORMATION**

Last Name	First Name	MI	<b>RESIDENCE ADDRESS</b>		
INSURANCE APPLIED FOR  <b>FACE AMOUNT</b> <b>SINGLE PREMIUM</b>  \$ _____                      \$ _____			<i>Street:</i> _____  <i>City:</i> _____  <i>State:</i> _____ <i>Zip Code:</i> _____  <i>EMAIL Address :</i> _____  <b>TELEPHONE:</b> (    ) _____ - _____		
			<b>AGE</b>	<b>DATE &amp; STATE OF BIRTH</b>	<b>SEX</b>
Month    Day    Year    State		<input type="checkbox"/> Male  <input type="checkbox"/> Female			
Has the Proposed Insured used any form of tobacco in the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Primary Beneficiary</b>			<b>Social Security Number</b>	<b>Relationship to Proposed Insured</b>	
<b>Contingent Beneficiary</b>			<b>Social Security Number</b>	<b>Relationship to Proposed Insured</b>	

**2. OWNER (If other than Proposed Insured)**

Last Name	First Name	MI	Date of Birth	Tax ID or Social Security#	Relationship to Proposed Insured
Street			City	State	Zip Code

Are you a member of The Order of United Commercial Travelers of America? <input type="checkbox"/> Yes <input type="checkbox"/> No
Council Name: _____                      Council Location (City & State) _____

**3. ELIGIBILITY QUESTIONS**

(If any question in this section is answered “yes”, the Proposed Insured is not eligible for coverage)	
<b>1. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection, or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immunodeficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2. Is the Proposed Insured currently bedridden, receiving home health care, hospitalized, confined to a nursing home or long-term care facility, or been advised in the past 6 months to be hospitalized or to go into a nursing home or long-term care facility and refused?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3. Is the Proposed Insured in the end stages of a terminal illness, or been told his/her life expectancy is 12 months or less, or receiving or on the waiting list for hospice care?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4. Is the Proposed Insured currently awaiting an organ transplant?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>5. Within the past 2 years, has the Proposed Insured:</p> <p>(a) been administered oxygen or recommended the use of oxygen?</p> <p>(b) had a heart attack, stroke, transient ischemic attack (TIA, also known as a mini-stroke), had or been advised to have heart surgery (including angioplasty or stent placement)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. Within the past 2 years, has the Proposed Insured been diagnosed with or treated for:</p> <p>(a) dementia, Alzheimer's disease, schizophrenia, or any mental disorder?</p> <p>(b) cancer (other than basal cell carcinoma), leukemia, lymphoma, tumor, or chronic blood disorder (including sickle cell anemia)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7. In the past 5 years, has the Proposed Insured been incarcerated?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>8. Has the Proposed Insured <i>ever</i> been diagnosed with or treated for:</p> <p>(a) chronic kidney disease or disorder, or received kidney dialysis?</p> <p>(b) hepatitis (except Hepatitis A), or any liver or pancreas disease?</p> <p>(c) Congestive Heart Failure (CHF)?</p> <p>(d) Multiple sclerosis, lupus, or ALS (also known as Lou Gehrig's disease)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### 4. HEALTH QUESTIONS

(If "yes", please provide details – attach additional sheet if necessary)

<p>9. In the past 2 years, has the Proposed Insured had an application for life or health insurance or reinstatement declined, rated, or modified in any way?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>10. Has any Proposed Insured <i>ever</i> been diagnosed with, been treated by a member of the medical profession, taken medication for, or been advised to have diagnostic tests for: (check applicable conditions)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Internal cancer  <input type="checkbox"/> Leukemia  <input type="checkbox"/> Lymphoma  <input type="checkbox"/> Hodgkin's disease  <input type="checkbox"/> Malignant melanoma  <input type="checkbox"/> Dementia, Alzheimer's or Parkinson's disease  <input type="checkbox"/> Malignant or benign tumors of any kind  <input type="checkbox"/> Emphysema or other chronic lung disease  <input type="checkbox"/> Blood disorder </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Heart Attack  <input type="checkbox"/> Stroke  <input type="checkbox"/> Transient Ischemic Attack  <input type="checkbox"/> Heart Surgery  <input type="checkbox"/> Coronary Artery Surgery  <input type="checkbox"/> Heart or circulatory system disease  <input type="checkbox"/> Angioplasty  <input type="checkbox"/> Paralysis, epilepsy, or other nervous system disease  <input type="checkbox"/> Diabetes Mellitus </td> </tr> </table>		<input type="checkbox"/> Internal cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Hodgkin's disease <input type="checkbox"/> Malignant melanoma <input type="checkbox"/> Dementia, Alzheimer's or Parkinson's disease <input type="checkbox"/> Malignant or benign tumors of any kind <input type="checkbox"/> Emphysema or other chronic lung disease <input type="checkbox"/> Blood disorder	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Transient Ischemic Attack <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Coronary Artery Surgery <input type="checkbox"/> Heart or circulatory system disease <input type="checkbox"/> Angioplasty <input type="checkbox"/> Paralysis, epilepsy, or other nervous system disease <input type="checkbox"/> Diabetes Mellitus
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<p>11. Does the Proposed Insured require the use of a wheel chair due to chronic illness?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>12. In the last 2 years, has the Proposed Insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>13. In the past 3 years, has the Proposed Insured been treated for alcohol and/or drug abuse?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>14. In the past 3 years, has the Proposed Insured been convicted of or put on probation for: (1) a felony; (2) driving under the influence (DUI); or (3) driving while intoxicated (DWI)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Give details to any "Yes" answers to the Health Questions

Question #	Explanation (including Medications)	Dates / Duration	Name of Physician and/or Hospital

## 5. REPLACEMENT INFORMATION

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Does the Proposed Insured have any existing life insurance or annuities currently in force or pending with this or any other company? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Will this policy, if issued, replace or modify insurance or annuities with this or any other company?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "yes", provide the following information:

Name of Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Reason for replacement? \_\_\_\_\_

## 6. AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued.

**WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.**

**If not a current member of The Order of United Commercial Travelers of America (UCT), I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.**

Signed At: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

Dated: \_\_\_\_\_  
(Month/Day/Year)

## 7. AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

### TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

- List any other life insurance or annuity policies you have sold to the Applicant that are still in force.  
\_\_\_\_\_  
\_\_\_\_\_
- List any other life insurance or annuity policies you have sold to the Applicant in the past five (5) years that are no longer in force.  
\_\_\_\_\_
- Do you have any knowledge or reason to believe that the Applicant is intending to replace an existing insurance?  Yes  No

I certify that:

I have accurately recorded the information supplied by the Applicant; and I have given an outline of coverage for the policy applied for to the applicant.

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's Printed Name: \_\_\_\_\_ Agent License Number: \_\_\_\_\_

**HIPAA & MIB AUTHORIZATION & ACKNOWLEDGEMENT  
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA**

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization **EXCEPT** to reinsurance companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance or reinsuring company, MIB, Inc., or other organization, institution, or person, that has my records or knowledge of me or my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original. I understand that I or my authorized representative may request to receive a copy of this authorization.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the Information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I authorize The Order of United Commercial Travelers of America, or its reinsurers, to make a brief report of my protected health information to MIB, Inc. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

I also understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, or a request for change in policy benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

\_\_\_\_\_

**Applicant Name**

\_\_\_\_\_

**Social Security Number**

\_\_\_\_\_

**Date of Birth**

\_\_\_\_\_

**Signature of Applicant**

\_\_\_\_\_

**Date**

**AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK – Deposit Slips NOT Accepted**

<b>AUTHORIZATION</b>	<b>IN FAVOR</b>	<u>The Order of United Commercial Travelers of America</u>		<b>AUTHORIZATION</b>
	<b>OF:</b>	<u>1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.</u>		
		<b>Name of Bank Customer:</b> _____		
		<b>Insured's Name:</b> _____		
		<b>Account Number:</b> _____	<b>Routing Number:</b> _____	
	<b>To (Name of Bank):</b> _____			
	<b>Address of Bank:</b> _____			
	<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>			
	<b>Date</b>	<b>Signature of Bank Customer</b>		

**Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.**

**To: Bank above:**  
 In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.



**NOTICE TO APPLICANT**

In making this application for insurance to The Order of United Commercial Travelers of America, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated confidential. The Order of United Commercial Travelers of America, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Order of United Commercial Travelers of America, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at [www.mib.com](http://www.mib.com).