

SERFF Tracking Number: IASL-128225993 State: Arkansas
Filing Company: Sterling Investors Life Insurance Company State Tracking Number:
Company Tracking Number: SI AR CA APP
TOI: H07I Individual Health - Specified Disease - Limited Benefit Sub-TOI: H07I.002A Dread Disease - Cancer Only
Product Name: SI AR CA APP
Project Name/Number: SI AR CA APP/

Filing at a Glance

Company: Sterling Investors Life Insurance Company

Product Name: SI AR CA APP SERFF Tr Num: IASL-128225993 State: Arkansas

TOI: H07I Individual Health - Specified Disease - Limited Benefit SERFF Status: Closed-Approved State Tr Num:

Sub-TOI: H07I.002A Dread Disease - Cancer Only Co Tr Num: SI AR CA APP State Status: Approved-Closed

Filing Type: Form

Author: Lauren Perley

Date Submitted: 04/02/2012

Reviewer(s): Donna Lambert

Disposition Date: 04/03/2012

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 04/03/2012

State Filing Description:

General Information

Project Name: SI AR CA APP

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 04/03/2012

State Status Changed: 04/03/2012

Created By: Lauren Perley

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Lauren Perley

Filing Description:

Enclosed is a letter authorizing Insurance Administrative Solutions, L.L.C. to file the above-captioned forms on behalf of Sterling Investors Life Insurance Company. This is a new filing.

The revised applications will replace SICDDAPPGN and SICDDSUPPAPP approved by your Department on 04/19/2011 (STATE TR Number 48404).

The following changes were made to SICDDAPP2GN:

- PART 2 – BENEFITS AND PREMIUM INFORMATION SELECTION

*Draft Preference was revised to allow the applicant to select the bank draft day.

- PART 3 – MEDICAL QUESTIONS

The lookback period in health question #1 was changed from 10 years to 5 years.

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• PART 6 – AUTHORIZATION AND CERTIFICATION

Reference to Medical Information Bureau (MIB) was changed to MIB Group.

The following changes were made to SICDDSUPPAPP2:

• PAGE 1 – MEDICAL QUESTIONS

The lookback period in health question #1 was changed from 10 years to 5 years.

• PAGE 2 – AUTHORIZATION AND CERTIFICATION

Reference to Medical Information Bureau (MIB) was changed to MIB Group.

Thank you for your assistance with this filing. If you have any questions, please contact me at 1-877-777-2443, extension 2319 or by e-mail at lauren.perley@iasadmin.com.

State Narrative:

Company and Contact

Filing Contact Information

Lauren Perley, Lauren.Perley@iasadmin.com
 8545 126th Avenue North, Suite 200 727-584-0007 [Phone]
 Largo, FL 33773-1502 727-584-5613 [FAX]

Filing Company Information

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

Sterling Investors Life Insurance Company	CoCode: 89184	State of Domicile: Georgia
210 East Second Avenue, Suite 105	Group Code:	Company Type: Life and Health
Rome, GA 30161	Group Name:	State ID Number:
(706) 235-8706 ext. [Phone]	FEIN Number: 59-1838073	

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 2 Applications @ \$50.00 each = \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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Product Name: SI AR CA APP
Project Name/Number: SI AR CA APP/
Sterling Investors Life Insurance Company \$100.00 04/02/2012 57640165

SERFF Tracking Number: IASL-128225993 State: Arkansas
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Product Name: SI AR CA APP
Project Name/Number: SI AR CA APP/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	04/03/2012	04/03/2012

SERFF Tracking Number: IASL-128225993 *State:* Arkansas
Filing Company: Sterling Investors Life Insurance Company *State Tracking Number:*
Company Tracking Number: SI AR CA APP
TOI: H07I Individual Health - Specified Disease - *Sub-TOI:* H07I.002A Dread Disease - Cancer Only
Limited Benefit
Product Name: SI AR CA APP
Project Name/Number: SI AR CA APP/

Disposition

Disposition Date: 04/03/2012

Implementation Date: 04/03/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: IASL-128225993 State: Arkansas
 Filing Company: Sterling Investors Life Insurance Company State Tracking Number:
 Company Tracking Number: SI AR CA APP
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only
 Product Name: SI AR CA APP
 Project Name/Number: SI AR CA APP/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Third Party Authorization Letter	Approved	Yes
Form	Application	Approved	Yes
Form	Supplemental Application	Approved	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 04/03/2012	SICDDAPP 2GN	Application/ Enrollment Form	Application	Revised	Replaced Form #: SICSDDAPPGN Previous Filing #: 48404		SICDDAPP2 GN.pdf
Approved 04/03/2012	SICDDSUP PAPP2	Application/ Enrollment Form	Supplemental Application	Revised	Replaced Form #: SICDDSUPPAPP Previous Filing #: 48404		SICDDSUPP APP2.pdf

STERLING INVESTORS LIFE INSURANCE COMPANY
 Home Office: [Rome, Georgia]
 Administrative Office: [P.O. Box 10846, Clearwater, Florida 33757-8846]

APPLICATION FOR CANCER INDEMNITY INSURANCE POLICY

New Business Reinstatement Policy # _____ Conversion Policy

APPLICATION #:

PART 1 – PROPOSED INSURED INFORMATION

NAMED INSURED INFORMATION			SPOUSE NAME (IF APPLICABLE)		
Last Name	First Name	M.I.	Last Name	First Name	M.I.
Date of Birth (MM/DD/YYYY)	Social Security#		Date of Birth (MM/DD/YYYY)	Social Security#	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Age:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Age:	

Street Address:

City: _____ State: _____ Zip Code: _____

Home Phone#: _____ Email Address: _____

PART 2 – BENEFITS AND PREMIUM INFORMATION SELECTION

Is this Policy intended to replace any other health insurance now in force? Yes No

Requested Policy Effective Date _____

Indicate The Number Of Units For Each Of The Benefits Listed Below (Minimum 1 Unit; Maximum 5 Units)

Hospital Confinement	# Units	Radiation and Chemotherapy	# Units	Cancer Lump Sum	# Units
	_____		_____		_____

Type of Coverage: Individual Family

Optional Benefit Riders:

Return of Premium Rider OR Return of Premium Upon Death Rider NOTE: Only ONE of the Return of Premium Riders may be elected.

Dread Disease Rider # Units _____ (Minimum 1 Unit; Maximum 5 Units)

Payment Mode:

Annual Semi-Annual Quarterly Bank Draft Monthly (Bank Draft Only)

PREMIUM CALCULATION

Cancer Indemnity Policy Insurance Premium		\$
Hospital Confinement	# Units _____ x _____ =	\$
Radiation and Chemotherapy	# Units _____ x _____ =	\$
Cancer Lump Sum	# Units _____ x _____ =	\$
Dread Disease Rider (Optional)	# Units _____ x _____ =	\$
One Time Policy Fee		\$ 30.00
TOTAL PREMIUM FOR MODE SELECTED		\$

Premium \$ _____ Premium Collected _____ *Initial Bank Draft \$ _____

* Draft Preference: Select Bank Draft Day: _____ (Cannot be more than 10 days beyond effective day)

*****IF DRAFTING PREFERENCE IS UNANSWERED, WE WILL DRAFT ON ISSUE DATE*****

PART 6 - AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB Group (formerly Medical Information Bureau), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Cancer Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company *will* result in the rejection of the Cancer Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Administrative Office: [P.O. Box 10846, Clearwater, Florida 33757-8846]. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I, or my authorized representatives are entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to me; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. I certify that I have read, or had read to me, the completed application, and I realize that policy issuance is base upon statements and answers provided herein, and that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Cancer Indemnity Insurance Policy. I understand that the purchase of this policy is intended to supplement existing health coverage and is not intended to replace or be issued in lieu of that coverage. I acknowledge that all persons to be covered under this policy are not also covered by any Title XIX program (Medicaid, MediCal or any similar name). I acknowledge receipt of the following: (1) Outline of Coverage; (2) Replacement Notice (if applicable); and (3) the *Guide to Insurance for People with Medicare* (For applicants age 65 and older).

Signed At: _____
(City/State)

Date: _____
(Month/Day/Year)

Signature of Proposed Named Insured _____

Signature of Proposed Spouse (if applicable) _____

Agent's Signature _____

Date: _____
(Month/Day/Year)

Agent's Printed Name _____

Agent Writing Number _____

Policy Mailing Preference: Mail to Agent Mail to Named Insured If unanswered, the policy will be mailed to Agent

<p style="text-align: center;">IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
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Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

STERLING INVESTORS LIFE INSURANCE COMPANY

Home Office: [Rome, Georgia]

Administrative Office: [P.O. Box 10846, Clearwater, Florida 33757-8846]

SUPPLEMENTAL APPLICATION CANCER INDEMNITY INSURANCE

NAMED INSURED: _____ **POLICY #** _____

DEPENDENT INFORMATION

DEPENDENT #1:			DEPENDENT #2:		
Last Name	First Name	M.I.	Last Name	First Name	M.I.
Date of Birth (MM/DD/YYYY)	Social Security#		Date of Birth (MM/DD/YYYY)	Social Security#	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Age		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Age	
Relationship:			Relationship:		
DEPENDENT #3:			DEPENDENT #4:		
Last Name	First Name	M.I.	Last Name	First Name	M.I.
Date of Birth (MM/DD/YYYY)	Social Security#		Date of Birth (MM/DD/YYYY)	Social Security#	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Age		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Age	
Relationship:			Relationship:		

MEDICAL QUESTIONS

Please answer yes or no for each proposed insured applying for coverage.	Dependent #1		Dependent #2		Dependent #3		Dependent #4	
	YES	NO	YES	NO	YES	NO	YES	NO
1. In the past 5 years, has any person to be insured had, been diagnosed as having, been advised to seek treatment for, received medication for, or been treated by a medical practitioner for:								
a. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS or AIDS related conditions (ARC), or	<input type="checkbox"/>							
b. Leukemia, Hodgkins disease, malignant melanoma, sarcoma, lymphoma, or any internal cancer, or had radiation or chemotherapy for any of these conditions?	<input type="checkbox"/>							
2. In the past 24 months, has any person to be insured experienced any symptoms that would have caused a person to seek medical advice from a medical practitioner, or to have or schedule a diagnostic test for any of the conditions listed above?	<input type="checkbox"/>							

If yes to any of the above medical questions, please provide name of insured with details:

PLEASE ANSWER THE FOLLOWING QUESTION IF APPLYING FOR THE DREAD DISEASE BENEFIT RIDER

Have you or has anyone to be covered under this policy ever had Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Tetanus, Rabies, Tuberculosis, Osteomyelitis, Diphtheria, Epidemic Cerebrospinal Meningitis, Sickle Cell Anemia, Scarlet Fever, Undulant Fever, Rocky Mountain Spotted Fever, Smallpox, Addison's Disease, Hansen's Disease, Tularemia, Bubonic Plague, or Typhoid Fever?

Dependent #1 <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent #2 <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent #3 <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent #4 <input type="checkbox"/> Yes <input type="checkbox"/> No
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Any person(s) answering yes to the above medical question will not be covered under the Dread Disease Benefit Rider.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB Group (formerly Medical Information Bureau), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Cancer Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company *will* result in the rejection of the Cancer Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Administrative Office: [P.O. Box 10846, Clearwater, Florida 33757-8846]. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I, or my authorized representative are entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to me; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. I certify that I have read, or had read to me, the completed application, and I realize that policy issuance is base upon statements and answers provided herein, and that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for coverage under my Cancer Indemnity Insurance Policy for my dependent(s) listed on this application. I understand that the purchase of this policy is intended to supplement existing health coverage and is not intended to replace or be issued in lieu of that coverage. I acknowledge that all persons to be covered under this policy are not also covered by any Title XIX program (Medicaid, MediCal or any similar name).

Signed At: _____
(City/State)

Date: _____
(Month/Day/Year)

Dependent # 1 Signature
(Spouse or Dependent Child Age 18 or older)

Dependent # 2 Signature
(Spouse or Dependent Child Age 18 or older)

Dependent # 3 Signature
(Spouse or Dependent Child Age 18 or older)

Dependent # 4 Signature
(Spouse or Dependent Child Age 18 or older)

Signature of Named Insured (Required)

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved	04/03/2012
Comments:		
Attachment: Certification of Compliance.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved	04/03/2012
Comments: Applications are on the Forms Tab.		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved	04/03/2012
Bypass Reason: Not Applicable		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved	04/03/2012
Bypass Reason: Not Applicable		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Third Party Authorization Letter	Approved	04/03/2012
Comments:		
Attachment: 2012 01 SILIC IAS Authorization Letter.pdf		

CERTIFICATION OF COMPLIANCE

Name and Address of Insurer:

**Sterling Investors Life Insurance Company
210 East Second Avenue, Suite 105
Rome, Georgia 30161**

I hereby certify that the forms below meet all of the applicable requirements of Arkansas Rule and Regulation 19.

TYPE/TITLE OF FORM

Application
Supplemental Application

FORM NUMBERS

SICDDAPP2GN
SICDDSUPPAPP2



Signature

Elwood Whitacre

Name

Secretary and Treasurer

Title

April 2, 2012

Date

210 E. Second Avenue
Ste. 105
Rome, Georgia 30161
Tel (706) 235-8154
Fax (866) 889-4054

January 11, 2012

Ms. Darcey Shaffer, FLMI, ACS
Compliance Manager
Insurance Administrative Solutions, L.L.C.
8545 126th Avenue North, Suite 200
Largo, Florida 33773-1502

Re: Life and Health Filings for Rate Increases, Forms and Reporting Requirements
for Sterling Investors Life Insurance Company

Dear Ms. Shaffer:

This letter authorizes Insurance Administrative Solutions, L.L.C. to file on behalf of Sterling Investors Life Insurance Company, rate increases, forms and reporting requirements for the Company's Life and Health Insurance Policies with the State Insurance Departments.

Insurance Administrative Solutions, L.L.C. may correspond with the State Insurance Departments regarding any questions they may have concerning the filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,


Elwood Whitacre
Secretary and Treasurer