

SERFF Tracking Number: FDLF-128366730 State: Arkansas
Filing Company: Federal Life Insurance Company (Mutual) State Tracking Number:
Company Tracking Number: FLIC188AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Multiple Applications
Project Name/Number: Multiple Application MIB Filing/FLIC188

Filing at a Glance

Company: Federal Life Insurance Company (Mutual)

Product Name: Multiple Applications

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: FDLF-128366730 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num:

Co Tr Num: FLIC188AR

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Steve Mink, Matt Kindelin, PW Calfas
Disposition Date: 05/30/2012

Date Submitted: 05/24/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Multiple Application MIB Filing

Project Number: FLIC188

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Matt Kindelin

Filing Description:

This filing is for our applications with MIB, Inc. required language changes.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Illinois is Compact
State.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 05/30/2012

State Status Changed: 05/30/2012

Created By: Matt Kindelin

Corresponding Filing Tracking Number:

Form LA-8097 is our newest basic life application that will be used to market Term Life, Universal Life, and Interest Sensitive Whole Life products approved in AR. This includes L-8029 Level Term Life Insurance Policy: Closed - Approved 03/20/09 - FRCS-126062253, L-8031 Flexible Premium Adjustable Universal Life Insurance Policy: Closed - Approved 03/24/09 - FRCS-126071969, and L-8035 Interest Sensitive Whole Life Insurance Policy: Closed - Approved 03/23/09 - FRCS-126073033.

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Form L-8104 is our latest Reinstatement or Change of Contract Application. It will be used to reinstate and/or change endowment life, whole life, universal life, and term life contracts inforce already issued or to be issued in AR.

State Narrative:

Company and Contact

Filing Contact Information

Matthew Kindelin, Actuarial Student mkindelin@federallife.com
 Federal Life Insurance Company (Mutual) 847-850-3263 [Phone]
 3750 W. Deerfield Road
 Riverwoods, IL 60015

Filing Company Information

Federal Life Insurance Company (Mutual) CoCode: 63223 State of Domicile: Illinois
 3750 W. Deerfield Road Group Code: Company Type:
 Riverwoods, IL 60015 Group Name: State ID Number:
 (847) 520-1900 ext. [Phone] FEIN Number: 36-1063550

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federal Life Insurance Company (Mutual)	\$100.00	05/24/2012	59396309

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/30/2012	05/30/2012

SERFF Tracking Number: FDLF-128366730 *State:* Arkansas
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Disposition

Disposition Date: 05/30/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *FDLF-128366730* State: *Arkansas*
 Filing Company: *Federal Life Insurance Company (Mutual)* State Tracking Number:
 Company Tracking Number: *FLIC188AR*
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
 Product Name: *Multiple Applications*
 Project Name/Number: *Multiple Application MIB Filing/FLIC188*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Rule 19 Certification		Yes
Supporting Document	Rule 49 Compliance		Yes
Form	Application ("APP") for Individual Life Insurance		Yes
Form	Application for Reinstatement or Change of Contract		Yes

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Form Schedule

Lead Form Number: LA-8097

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LA-8097	Application/ Enrollment Form	Application ("APP") for Individual Life Insurance	Initial		43.000	LA-8097 Life App 20120516.pdf
	L-8104	Application/ Enrollment Form	Application for Reinstatement or Change of Contract	Initial		43.600	L-8104 Application For Reinstatement Or Change 20120516.pdf



Federal Life Insurance Company (Mutual) ("The Company")

3750 West Deerfield Road • Riverwoods, Illinois 60015 • 800-233-3750 • federallife.com

Application ("APP") for Individual Life Insurance

PART I

1. Proposed Insured(s) First Name Middle Last	Soc. Sec. No.	Phone Numbers	Birthplace	Birth Month Day Year	Age	Sex
a. Insured						
b. Joint or Additional Insured						

Proposed Insured's Driver's License Number: _____ State _____

Proposed Joint or Additional Insured's Driver's License Number: _____ State _____

2. Street Address, City, State and Zip (No P.O. Boxes)	County	How Long?
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3. Is every proposed insured a citizen or permanent resident of the United States? Yes No

4. Employer Name	Employer Address	Proposed Insured's Job Title and Duties	How Long?
Proposed Insured:			
Proposed Joint or Additional Insured:			

5. Owner - If other than Insured	Relationship	Soc. Sec. No.
Street Address	City, State and Zip	County

We invite you to provide us with the name and address of a second addressee in the space below. This is intended to provide additional assurance that you receive notice if your policy enters its grace period or lapses. Second Addressee Name and Address:

Name	Street Address	City	State	Zip

Insurance Requested:

6. Life Insurance Plan _____
 Face Amount \$ _____
 If Universal Life: Option: A B
 If Current Interest Tradition (CIT) Only: Automatic Premium
 Loan Requested? Yes No

7. Supplemental Benefits	Amount Applied For
<input type="checkbox"/> Waiver of Premium	<input type="checkbox"/> Accidental Death Benefit \$ _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Children's Term Rider \$ _____
	<input type="checkbox"/> Additional Insured Rider \$ _____

8. Payment Plan EFT (complete EFT form on page 7) Annual Semi-Annual Quarterly List Bill
 Visa, MasterCard, or Discover (Complete Form L-8015; imprinter required)

9. Beneficiary: Enter full names, Social Security numbers, and relationships to Insured.

Primary	Contingent	Print Full Name	Allocation	SSN	Relationship
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	_____	_____

(Allocations in whole percentages only; Allocations to all Primary must equal 100%; Allocations to all Contingents must also equal 100%)

Items 10 through 28 apply to all persons proposed for insurance in Question 1:

- | | Proposed Insured | | Proposed Joint or Additional Insured | |
|---|--------------------------|--------------------------|--------------------------------------|--------------------------|
| | Yes | No | Yes | No |
| 10. Does any proposed insured now have any life insurance or annuities: | | | | |
| a. In force with any company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Applications or enrollment forms pending with any company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Which will be replaced or changed because of this APP? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If **Yes** to **10a.**, **10b.**, or **10c.**, give details below and submit any needed replacement forms.

Person	Company Name	Life Face Amount	Disability Monthly Benefit	Date Applied or Issued

11. Will any of the policy premiums be paid through a premium financing loan or with funds borrowed, advanced or paid from another person or entity?
- If **Yes**, provide details: _____
- Payor if other than Owner: _____
12. Does any proposed insured intend now or in the future to sell, transfer or assign their legal or beneficial ownership of this policy in whole or in part to another person or entity?
- If **Yes**, provide details: _____
13. In the past 7 years has any proposed insured been declined, postponed, or offered a rated or modified life insurance policy, or been denied reinstatement?
14. **In the past 3 years has any proposed insured:** a. Flown other than as a scheduled airline passenger?
- b. Engaged in, or intend to engage in, motorized racing, hang gliding, ballooning, soaring, ultralight aviation, sky or scuba diving, mountain or rock climbing, base jumping, bungee jumping, or backcountry skiing?
- If **Yes** to either **14a.** or **14b.**, complete the appropriate questionnaire.
15. In the past 5 years has any proposed insured made claim for or received disability payment for an injury or sickness?
16. In the past 5 years has any proposed insured:
- a. been convicted of or pleaded guilty to any moving violation or been involved in any accident in which they were found at fault, or had their license suspended or revoked?
- b. been convicted of, or pleaded guilty to reckless driving or driving under the influence of alcohol or drugs?
- If **Yes** to **16a.** or **16b.**, please provide details:
- Person's Name _____ Date of Incident _____
17. Has any proposed insured ever been convicted of, or pleaded guilty to a felony or do they have any such charges pending against them?
18. Is any proposed insured serving a term of parole or probation assigned by a court of law?

For Office Use Only: Part I: No. _____ Is Corrected To Read: _____

Part II – APP Non-Medical Report

19. Present height and weight a. Proposed insured ___ ft. ___ in. ___ lbs. b. Proposed joint or additional insured ___ ft. ___ in. ___ lbs.
- c. Has any proposed insured lost more than 10 lbs. in the past 12 months?
- If **Yes** to **19c.**, please answer below:
- Proposed insured's** weight loss _____ lbs. **Proposed joint or additional insured's** weight loss _____ lbs.
- Reason for loss if known: _____
20. Has any proposed insured used any form of tobacco or nicotine products within the past 24 months?
21. In the past 10 years, has any proposed insured:
- a. Used illegal drugs or used restricted or controlled drugs except as prescribed for that person by a physician?
- If **Yes**, list all drugs, when used, how often, and by whom: _____
- b. Had treatment or been advised by a medical professional to have treatment for drug use?
- If **Yes**, Dates: _____ Details: _____
- c. Had treatment or been advised by a medical professional to limit the use of, seek treatment for or receive treatment for alcohol use?
- If **Yes**, Dates: _____ Details: _____
22. In the past 7 years, has any proposed insured, been diagnosed, treated, tested positive for, or been given medical advice by a medical professional for any disease or disorder of the organs below?
- a. High blood pressure?
- b. Heart attack, heart disease, angina, heart murmur, congestive heart failure, stroke, anemia or any other disease or disorder of the heart, blood vessels or circulatory system?
- c. Epilepsy, seizures, convulsions, multiple sclerosis, paralysis, or any other disease or disorder of the brain or nervous system?
- d. Depression, anxiety, eating disorder, dementia, Alzheimer's, or any psychiatric or mental health disease or disorder?
- e. Emphysema, chronic obstructive pulmonary disease (COPD), asthma, sleep apnea, or any other disease or disorder of the lungs or respiratory system?

Proposed Joint
or Additional
Insured
Yes No Yes No

- f. Cancer, tumor, cyst, polyps, melanoma or other malignancy?
- g. Ulcer, colitis, Crohn's disease, hepatitis, cirrhosis, pancreatitis or any other disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or abdominal organs?
- h. Diabetes, thyroid, pituitary or other gland?
- i. Breasts, prostate, male or female reproductive organs?
- j. Any sexually transmitted disease or disorder?
- k. Kidneys, bladder or urinary system?
- l. Eyes, ears, nose, throat or skin?
- m. Any disease of the lymph nodes, or diseases or disorders of the immune system unrelated to the Human Immunodeficiency Virus (AIDS virus)?
- n. Arthritis, rheumatism, myalgias, chronic pain syndrome or any other musculoskeletal disorder such as of the joints, knees, ankles or limbs?
- o. Spinal, neck or back disorder, including sprain, sciatica or disc disorder?

Other than as answered in Question 22:

- 23. In the past 5 years, has any proposed insured:
 - a. Been an inpatient or outpatient in a hospital, clinic or medical facility, or any similar entity?
 - b. Had any blood tests (other than genetic, HIV or AIDS test), x-ray, EKG, MRI, CT Scan, or other diagnostic test?
 - c. Been treated, examined or advised by a medical professional?
- 24. Does any proposed insured now:
 - a. Have, as diagnosed by a medical professional, any abnormality, deformity, disease or disorder?
 - b. Receive treatment or take medication of any kind?
- 25. In the past 5 years, has any proposed insured been advised, by a medical professional, to have, or are they currently awaiting the results of, medical tests or procedures unrelated to the Human Immunodeficiency Virus (AIDS virus)?
- 26. Has any proposed insured ever been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), or been tested positive by a medical professional for Human Immunodeficiency Virus (HIV)?
- 27. Does any proposed insured have a family history of a medical professional's diagnosis, of or treatment for, diabetes, cancer, heart disease or mental illness?

28. Details of all "Yes" answers to questions 11 through 27 – attach additional sheet if necessary [must be signed and dated by the proposed insured(s)].

Question Number	Name of Person Affected	Specify nature of condition; dates of treatment; complete names, addresses, and phone numbers of doctors and hospital

I declare that all answers written on this APP are full and correct, to the best of my knowledge and belief. Any statements made in this APP are representations and not warranties. The Company is not presumed to know any information not in this APP. I agree that:

- A. The Company has the right to require a medical exam of any person proposed for insurance.
- B. The Company may add to or correct the APP in the space "For Office Use Only." Any changes are agreed to if the Contract is accepted; but written agreement will be obtained from me for any change in insurance amount, plan, benefits or payment class.
- C. I understand that the **USA PATRIOT Act** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and social security number allows us to verify your identity.
- D. Prior to any Contract going into effect, insurance will be in effect only as provided in the Conditional Receipt issued in connection with this APP. If no such receipt is issued, no insurance will start by reason of this APP unless and until: a Contract is delivered; and the first payment for it is made while all persons to be covered under it are alive and their health remains as described in this APP. In that case, the insurance under the Contract will begin on the date it provides that such coverage becomes effective.
- E. Only an officer of the Company may change the APP or waive a right or requirement. No agent may do this.

Make checks payable only to Federal Life Insurance Company (Mutual). Do not make checks payable to the agent or leave payee blank.

Dated at _____ City _____ State _____ On ____/____/____ Mo. Day Yr.

Is there existing life insurance and/or annuity contract(s) on the life of the proposed insured or proposed joint or additional insured? Yes No

Is replacement of life insurance or annuity contracts included in this transaction? Yes No

If Yes, I presented and read the applicant any required notice regarding replacement. Yes No

Agent's Number _____ - _____

Proposed Insured (if under age 15, Parent or Legal Guardian must sign)

Proposed Joint or Additional Insured

Owner (if Company, Officer's signature and title)

Agent's Signature _____

Agent's Printed Name _____

CONDITIONAL RECEIPT (“APP” means Application)

Federal Life Insurance Company (Mutual) (“The Company”) has received from _____

- a payment of \$_____ for the insurance applied for with the APP.
- an authorization for payment of premiums by participation in the Electronic Funds Transfer Plan or the Credit Card Billing Plan for the insurance applied for with the APP.

This receipt is not valid unless it is signed by an agent of The Company. This receipt is not valid unless the amount paid with the APP, if paid by check or draft, is honored on first presentation for payment, or the authorization for payment of premium remains in effect until the first premium is transmitted to The Company.

IMPORTANT: The payment or authorization for payment of premiums is received subject to the following conditions:

- (A) 1. If the medical examinations required by The Company are completed; and
2. If The Company at its Home Office is satisfied that, at the time of completing Part I and Part II of the APP each person to be covered was insurable under The Company’s rules for insurance on the plan, in the amount, and at the class of risk to be applied for in Part I of the APP;

Then, and only after these conditions are met, the insurance applied for shall be effective from the date of Part II, or the date requested in the APP, whichever is the latest, regardless of any change of insurability of each person to be covered occurring after completion of both parts of the APP. If less than the full first premium has been paid for such insurance, it shall remain in effect only for the fraction of one year that the payment made for such insurance bears to the annual premium for such insurance.

The Company shall not be required to make insurance effective for an amount which, together with any amount effective in The Company on each person to be covered would exceed the following limits: (a) \$100,000 of life insurance if such person is age 30 – 65 and is insurable as a standard class of risk, or \$25,000 at all other ages and classes of risk; and (b) \$50,000 of benefits for death by accident. Any insurance applied for as alternate or additional to the plan and amount of insurance applied for in the APP shall not become effective under this conditional receipt.

- (B) If the conditions of (A) are met for the insurance applied for in the APP, except that if any person to be covered is not insurable under The Company’s rules for benefits for disability or accidental death as applied for, the life insurance, and any portion of such benefits for which the Proposed Insured is insurable under The Company’s rules, shall be effective as provided in (A).

- (C) If family insurance or children’s insurance is applied for and the conditions of (A) are met for such insurance except that one or more of the persons to be covered are not insurable under The Company’s rules for such insurance, the family insurance or children’s insurance for which the other persons to be covered are insurable under The Company’s rules shall be effective as provided in (A).

Except as provided in this conditional receipt, any Contract issued by The Company shall not take effect unless the full first premium is paid and such Contract is delivered to the Owner during the lifetime of each person to be covered by such Contract, and all the statements and answers given in the APP continue to be true and complete to the best of the Proposed Insured’s (Owner’s) knowledge and belief as of the date of delivery of such Contract.

Neither the agent nor the medical examiner is authorized to accept risks or pass upon insurability, to modify contracts, or to waive any of The Company’s rights or requirements.

IMPORTANT: The payment is received subject to the conditions of this receipt. This conditional receipt does not provide any insurance until after its conditions are met.

Agent Name _____ Agent Signature _____ Date _____

----- DETACH HERE -----

MIB, Inc.

Notice to Applicant: Information regarding your insurability will be treated as confidential. Federal Life Insurance Company (Mutual) or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in the 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, MA 02184-8734.

Federal Life Insurance Company (Mutual) or its reinsurers may also release information in 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 may be obtained at its website www.mib.com.

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading may be committing a crime which is subject to criminal and civil penalties.

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

DC: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.

----- DETACH HERE -----

Fair Credit Reporting Act

Notice to Applicant: Federal law requires that notice of investigation be given to persons applying for insurance.

In making this application for insurance to Federal Life Insurance Company (Mutual) ("The Company"), it is understood that an investigative consumer report may be prepared by an outside insurance reporting organization whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, health and mode of living except as may be related directly or indirectly to your sexual orientation. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request to the Home Office of The Company within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. (See MIB, Inc. Notice)

Notice Of Information Practices – To our Contractholders, Applicants and Insureds:

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on the information provided by you. We may also seek information from others, such as medical professionals who have treated you or family members covered under such insurance, pharmacy benefit managers, the DMV, employers and other insurance companies.

A personal history interview may also be conducted by phone to assure that the application information is complete. When done, you will be contacted by either a member of our underwriting department or an outside insurance reporting organization. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, or as permitted or required by law.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of The Company's and its agents' information practices. If you would like to receive a more detailed explanation of those practices, please contact: **Customer Service – Federal Life Insurance Company (Mutual)**

3750 West Deerfield Road – Riverwoods, Illinois 60015

Federal Life Insurance Company (Mutual) ("The Company")

Health Insurance Portability and Accountability Act (HIPAA) Compliant Authorization to Obtain and Disclose Information

- A.** I hereby authorize the release of any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but should not be limited to, the following: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKGs. Other information could include items such as: other insurance information, personal finances, habits, hazardous avocations, motor vehicle reports or court records.
- B.** This information will be used to determine my eligibility for insurance, underwrite my application for insurance, determine my eligibility for benefits under any temporary insurance, determine risk rating, obtain reinsurance if needed, and if the contract is issued, determine my eligibility and contestability of the contract.
- C.** Providers may not refuse or condition your treatment or other health care services if you refuse to sign the authorization.
- D.** I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager, or other medical, or medically related facility, the Veteran's Administration, insurance company, MIB, Inc. ("MIB"), employer, consumer reporting agency, DMV or other organization, institution or person, that has any records or knowledge of me or my health to give to The Company or its reinsurers, any such information when this authorization or a copy of it is shown. I further authorize the sources listed above, except for MIB, Inc., to give such information to a consumer reporting agency acting on behalf of Federal Life Insurance Company (Mutual).
- E.** I authorize Federal Life Insurance Company (Mutual), or its reinsurers, to make a brief report of my personal health information to MIB, Inc.
- F.** Data about mental illness, alcoholism, and the use of drugs is to be included.
- G.** The Company or its reinsurers may make a brief report about me or my children to other companies to which I have applied or may apply for coverage.
- H.** This authorization is good for 24 months after it is signed. A copy of this authorization will be as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.
- I.** The company may obtain an investigative consumer report on me. I want to be interviewed if such a report is obtained.
- J.** I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows The Company to contest a claim under the contract or to contest the contract itself, by sending a written request to:
Federal Life Insurance Company (Mutual) – 3750 W. Deerfield Rd. – Riverwoods, IL 60015
I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance and the administration of any contract issued as a result of that application.
- K.** I understand that the signing of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, information necessary to consider my application.
- L.** I hereby acknowledge that The Company is subject to federal privacy regulations. I understand that information released to The Company will be used and disclosed as described in The Company's privacy policy, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.
- M.** I have read this authorization. I also have read and have received the MIB, Inc. notice, and the FAIR CREDIT REPORTING ACT notice.

Name of Proposed Insured

Today's Date

Signature of Proposed Insured or Proposed Insured's
Personal Representative

Date of Birth

Last Four Digits of SSN

If signed by Personal Representative, describe authority to sign: _____

Please Print and Sign Clearly — Attach VOIDED CHECK to assure proper account information.

Request For Electronic Funds Transfer

Insured's Name(print) _____

I authorize Federal Life Insurance Company (Mutual) to initiate deductions from my bank account with the routing number listed below. I understand and agree that this authorization remains in effect until discontinued by the Company or me upon thirty (30) days written notice. If the Company is unable to deduct payments from my account, I (or the contract owner) must pay the premium directly when due to keep the insurance coverage in force. **If I do not specify a process date below, the Company will assign one. If this insurance coverage is issued, then I request the Company to immediately deduct all payments due.** I would like subsequent premiums deducted from my account according to the process date selected below:

Process Date (1st to the 28th) . Payments will be deducted one to three business days after the process date.

Bank Name _____ Bank Phone Number _____

9 Digit Transit/Routing # _____ Bank Account # _____ Checking Savings

Bank Account Holder's Name

Print Name Sign Name Date

Agent's Report – To be completed by Field Underwriter (“APP” means Application)

	Proposed Insured	Proposed Joint or Additional Insured
1. a. Prior residential addresses within 2 years		
b. Prior employers and addresses within 2 years		
2. Check requirements for exams or special tests.	<input type="checkbox"/> Med <input type="checkbox"/> Urine <input type="checkbox"/> EKG <input type="checkbox"/> Blood	<input type="checkbox"/> Med <input type="checkbox"/> Urine <input type="checkbox"/> EKG <input type="checkbox"/> Blood

- Yes No**
3. Has the name of any person in question No. 1. of the APP changed in the past 7 years? If **Yes**, complete below:
 Person _____ Former Name _____ Date Changed _____ Reason _____
4. How long have you known proposed insured(s)? _____ How known? _____
5. Who first suggested the purchase of this insurance? Agent Proposed Insured Owner Other _____
6. Purpose of insurance (Insurable Interest): _____
7. a. Did you personally see the proposed insured(s)?
 b. Was the APP signed by the proposed insured(s) in your presence after all questions were answered?
 If either **7a.** or **7b.** are answered **No**, explain: _____
8. Are you aware of anything about the health, habits, hobbies, or other factors which might affect the insurability of the proposed insured(s)?
 If **Yes**, explain: _____
9. Did you quote a special class extra premium for this contract?
 If **Yes**, Table Rating? _____ Why? _____
10. If proposed insured is age 0 through 14, answer questions below:
 a. Number of brothers _____ sisters _____ Do they all have same amount of insurance as proposed insured?
 b. If less than 1 year of age, what was birth weight? _____ lb. _____ oz. c. Did you see the child?
 If **No**, explain: _____
- d. Amount of life insurance in force and/or requested on father: \$ _____ mother: \$ _____
11. **Annual Earned Income:** Proposed Insured \$ _____ Proposed Joint or Additional Insured \$ _____

12. Your calculation of the annual premium:

a. Life Insurance		b. If Universal Life,	
Base Plan	\$ _____	indicate planned periodic premium	\$ _____
Policy/Certificate Fee	\$ _____		\$ _____
Waiver of Premium	\$ _____		
Accidental Death Benefit	\$ _____	TOTAL	\$ _____
Other Benefits and Riders	\$ _____		
Subtotal	\$ _____		
TOTAL	\$ _____		

c. Amount of money submitted with APP: \$ _____

13. Is this Keyman Insurance? Yes No

Remarks: _____

14. **Agent's Commission** to be shared with: Name _____ % _____ No. _____ Situation Code _____

- I certify that:**
- Statements By Agent:**
- I asked and carefully explained each question to the proposed insured(s) and owner/applicant before recording each answer prior to the APP being signed;
 - The answers in this APP and Agent's Report are complete and accurate to the best of my knowledge and belief;
 - The proposed insured(s) and agent know that any fraudulent statement of material misrepresentation in the application form may result in loss of coverage under the contract;
 - I have no personal knowledge of any other factors which may have an effect on the proposed insured's insurability;
 - If I become aware of a change in the health or habits of the proposed insured(s) occurring after the date of the application form and before I deliver the contract, I will inform the Company of the change and agree to withhold delivery of the contract until instructed by the Company to do so;
 - I have explained to the proposed insured(s) that if money is submitted with this APP, conditions of the Conditional Receipt must be met;
 - I have made no agreement whereby anyone has received or is to receive directly or indirectly, in settlement of the premium on the proposed insurance any concession or rebate from the full regular premium according to The Company's table of rates.
 - The owner, proposed insured(s), or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement, or any other secondary market.

Agent's Signature _____ Agent's Printed Name _____ Date _____



Federal Life Insurance Company (Mutual) ("The Company")

3750 West Deerfield Road • Riverwoods, Illinois 60015 • 800-233-3750 • federallife.com

APPLICATION FOR [] REINSTATEMENT OR [] CHANGE OF CONTRACT NO. _____

Table with 5 columns: Names of Persons Insured, Birth Date, Relationship, Feet / Inches, lbs. Rows a and b.

DECLARATION OF HEALTH

- 2. Has any person listed in question 1: YES NO
a. Used any form of tobacco or nicotine products within the past 24 months?
b. Had any weight loss in the past year?
3. In the past 5 years has any person listed in question 1:
a. Been postponed, or offered a rated or modified life insurance policy?
b. Been hospitalized or been given medical advice by a medical professional for a checkup, an injury, an operation, or a physical or mental disorder?
c. Used illegal drugs or used restricted or controlled drugs except as prescribed for that person by a physician?
d. Had treatment or been advised by a medical professional to have treatment for drug use or alcohol use?
4. In the past 5 years has any person listed in question 1 been diagnosed, treated, or been given medical advice by a medical professional:
a. For a disease or disorder of the lungs, nervous system, digestive system, kidneys, eyes, or ears?
b. For elevated blood pressure, chest pain, dizziness, diabetes, or immune system disorder?
5. In the past 5 years has any person listed in question 1 received treatment from or taken medication of any kind prescribed by a medical professional?
6. Has any person listed in question 1:
a. Ever been or, in the next two years, intend to become an Aviation Pilot? (If "Yes", complete Aviation supplement.)
b. Changed occupation? If "Yes", give new occupation and duties on page 3.
7. Has any person listed in question 1 ever been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), or been tested positive by a medical professional for Human Immunodeficiency Virus (HIV)?
8. Will any of the policy premiums be paid through a premium financing loan or with funds borrowed, advanced or paid from another person or entity?
9. Does any person listed in question 1 intend now or in the future to sell, transfer or assign their legal or beneficial ownership of this policy in whole or in part to another person or entity?
10. Explain "Yes" answers in full detail on page 3. Include dates, nature, severity and duration of all illnesses or injuries; provide names and addresses of physicians; give details on any other pertinent information. (Give question numbers and names of persons involved.)

I hereby declare and agree that I have read the questions and answers for questions 1-10 and they are complete and true to the best of my knowledge and may be relied on by The Company, and that no information acquired by any representative of The Company shall bind The Company unless it shall have been set out in writing above. I further agree that the reinstatement or change of this contract(s) shall in no event become effective unless and until this application is approved at the Home Office of The Company, and the full amount due is paid during the lifetime and good health of the insured.

I further agree that reinstatement of change of this contract(s), if granted by The Company upon this application, shall be contestable for fraud and misrepresentation of any material facts stated herein for the same period after reinstatement is approved as provided in the contract(s) with respect to original issue.

For Reinstatement Only: I have paid \$ _____ in connection with this application. The Company is authorized and directed to retain this amount depositing or cashing any check or draft without prejudice to its right to disapprove this application. If, however, this application is not approved, The Company shall return this payment in the form of its check for the amount received.

Signature of Insured Signature of Insured Spouse (If Family Coverage)
Signature of Owner (If other than Insured) Date State

Federal Life Insurance Company (Mutual) ("The Company")

Health Insurance Portability and Accountability Act (HIPAA) Compliant Authorization to Obtain and Disclose Information

- A. I hereby authorize the release of any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but should not be limited to, the following: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKGs. Other information could include items such as: other insurance information, personal finances, habits, hazardous avocations, motor vehicle reports or court records.
- B. This information will be used to determine my eligibility for insurance, underwrite my application for insurance, determine my eligibility for benefits under any temporary insurance, determine risk rating, obtain reinsurance if needed, and if the contract is issued, determine my eligibility and contestability of the contract.
- C. Providers may not refuse or condition your treatment or other health care services if you refuse to sign the authorization.
- D. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager, or other medical, or medically related facility, the Veteran's Administration, insurance company, MIB, Inc. ("MIB"), employer, consumer reporting agency, DMV or other organization, institution or person, that has any records or knowledge of me or my health to give to The Company or its reinsurers, any such information when this authorization or a copy of it is shown. I further authorize the sources listed above, except for MIB, Inc., to give such information to a consumer reporting agency acting on behalf of Federal Life Insurance Company (Mutual).
- E. I authorize Federal Life Insurance Company (Mutual), or its reinsurers, to make a brief report of my personal health information to MIB, Inc.
- F. Data about mental illness, alcoholism, and the use of drugs is to be included.
- G. The Company or its reinsurers may make a brief report about me or my children to other companies to which I have applied or may apply for coverage.
- H. This authorization is good for 24 months after it is signed. A copy of this authorization will be as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.
- I. The company may obtain an investigative consumer report on me. I want to be interviewed if such a report is obtained.
- J. I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows The Company to contest a claim under the contract or to contest the contract itself, by sending a written request to:

Federal Life Insurance Company (Mutual) – 3750 W. Deerfield Rd. – Riverwoods, IL 60015

I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance and the administration of any contract issued as a result of that application.

- K. I understand that the signing of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, information necessary to consider my application.
- L. I hereby acknowledge that The Company is subject to federal privacy regulations. I understand that information released to The Company will be used and disclosed as described in The Company's privacy policy, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.
- M. I have read this authorization. I also have read and have received the MIB, Inc. notice, and the FAIR CREDIT REPORTING ACT notice.

Name of Proposed Insured

Today's Date

Signature of Proposed Insured or Proposed Insured's
Personal Representative

Date of Birth

Last Four Digits of SSN

If signed by Personal Representative, describe authority to sign: _____

APPLICATION FOR REINSTATEMENT OR CHANGE OF CONTRACT NO. _____

Please use the space below if additional space is needed for details to questions 1 through 9 of page 1.
If additional details are provided, then please sign and date this page below.

Signature of Insured

Signature of Insured Spouse (If Family Coverage)

Signature of Owner (If other than Insured)

Date

State

FOR COMPANY USE ONLY

Approved }
Declined }

Underwriter

Date

L-8104

(3)

05-12

----- DETACH HERE -----

MIB, Inc.

Notice to Applicant: Information regarding your insurability will be treated as confidential. Federal Life Insurance Company (Mutual) or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in the 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, MA 02184-8734.

Federal Life Insurance Company (Mutual) or its reinsurers may also release information in 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 may be obtained at its website www.mib.com.

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading may be committing a crime which is subject to criminal and civil penalties.

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

DC: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.

L-8104

(4)

05-12

----- DETACH HERE -----

Fair Credit Reporting Act

Notice to Applicant: Federal law requires that notice of investigation be given to persons applying for insurance.

In making this application for insurance to Federal Life Insurance Company (Mutual) ("The Company"), it is understood that an investigative consumer report may be prepared by an outside insurance reporting organization whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, health and mode of living except as may be related directly or indirectly to your sexual orientation. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request to the Home Office of The Company within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. (See MIB, Inc. Notice)

Notice Of Information Practices – To our Contractholders, Applicants and Insureds:

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on the information provided by you. We may also seek information from others, such as medical professionals who have treated you or family members covered under such insurance, pharmacy benefit managers, the DMV, employers and other insurance companies.

A personal history interview may also be conducted by phone to assure that the application information is complete. When done, you will be contacted by either a member of our underwriting department or an outside insurance reporting organization. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, or as permitted or required by law.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of The Company's and its agents' information practices. If you would like to receive a more detailed explanation of those practices, please contact: **Customer Service – Federal Life Insurance Company (Mutual)**

3750 West Deerfield Road – Riverwoods, Illinois 60015

SERFF Tracking Number: FDLF-128366730 State: Arkansas
Filing Company: Federal Life Insurance Company (Mutual) State Tracking Number:
Company Tracking Number: FLIC188AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Multiple Applications
Project Name/Number: Multiple Application MIB Filing/FLIC188

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Readability Certification MIB Update (Arkansas) 20120523.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Forms being filed are applications.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Rule 19 Certification
Comments:
Attachment:
Rule 19 Certification LA-8097 & L-8104 (Arkansas) 20120518.pdf

Item Status: **Status Date:**

Satisfied - Item: Rule 49 Compliance
Comments:
Our company complies with the Guaranty Association Notice distribution requirement at time of issue or prospective issue.

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Federal Life Insurance Co. (Mutual)

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 A.C.A. § 23-80-206.

Form Number	Score
LA-8097	43.0
L-8104	43.6



PW Calfas, ASA MAAA
Associate Actuary
May 23, 2012

RULE 19 CERTIFICATION
for our
Application ("APP") for Individual Life Insurance (LA-8097)
and
Application for Reinstatement or Change of Contract (L-8104)

I, PW Calfas, Associate Actuary for Federal Life Insurance Company (Mutual), hereby certify that this submission meets the provisions of Rule 19, the Unfair Sex Discrimination in the Sale of Insurance regulation, and all applicable requirements.

I affirm that this certification is being made on behalf of Federal Life Insurance Company (Mutual) and that the company is bound hereby.



PW Calfas, ASA MAAA
May 18, 2012