

SERFF Tracking Number: GRAX-G128320822 State: Arkansas  
Filing Company: Manhattan National Life Insurance Company State Tracking Number:  
Company Tracking Number: A6121512NW  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Individual Combined  
Project Name/Number: Life Individual Combined/A6121512NW

## Filing at a Glance

Company: Manhattan National Life Insurance Company

Product Name: Life Individual Combined SERFF Tr Num: GRAX-G128320822 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved-Closed State Tr Num:

Sub-TOI: L08.000 Life - Other Co Tr Num: A6121512NW State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird

Author: SPI Disposition Date: 05/08/2012

GreatAmericanFinancialRes

Date Submitted: 05/01/2012 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Life Individual Combined

Status of Filing in Domicile: Pending

Project Number: A6121512NW

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: 05/08/2012

State Status Changed: 05/08/2012

Deemer Date:

Created By: SPI GreatAmericanFinancialRes

Submitted By: SPI GreatAmericanFinancialRes

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval, please find the form referenced above. This form will replace form A6121506NW approved by your Department on 10/19/2006, under file # 34019. This submission does not contain any provisions, conditions, or concepts that are uncommon, unusual or possibly controversial from the standpoint of normal company or industry standards. This form was filed in Illinois, our state of domicile, on 05/01/2012.

This form has been modified to reflect a new requirement from MIB, Inc., and an additional underwriting question was added.

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Form A6121512NW will be used by policyholders to make changes such as reinstatement, increases in face amount, the addition of rider, etc to existing life insurance policies only.

At this time we are not currently selling "Life" policies in your state. If our position should change, this application may be used with life insurance policies approved by your Department in the future.

Please note this application is being filed for Great American Life Insurance Company and Loyal American Life Insurance Company simultaneously under separate cover.

State Narrative:

## Company and Contact

### Filing Contact Information

Brenda Little, Senior Compliance Filing Analyst blittle@gafri.com  
 P. O. Box 5420 513-412-2725 [Phone] 12725 [Ext]  
 Cincinnati, OH 45201-5420 513-361-5967 [FAX]

### Filing Company Information

Manhattan National Life Insurance Company CoCode: 67083 State of Domicile: Illinois  
 P.O. Box 5420 Group Code: 84 Company Type:  
 Cincinnati, OH 45201 Group Name: Great American State ID Number:  
 Financial Resources, Inc.  
 (800) 854-3649 ext. [Phone] FEIN Number: 45-0252531

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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Manhattan National Life Insurance Company	\$50.00	05/01/2012	58820074

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/08/2012	05/08/2012

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## Disposition

Disposition Date: 05/08/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Cover Letter		No
Form	Policy Change Request, Part II		No

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## Form Schedule

**Lead Form Number: A6121512NW**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A6121512N	Application/	Policy Change	Initial		50.100	A6121512NW
	W	Enrollment	Request, Part II				.PDF
		Form					

- Great American Life Insurance Company®  
 Manhattan National Life Insurance Company®  
 Loyal American Life Insurance Company®

**POLICY CHANGE REQUEST, Part II**

Life Products: P.O. Box 5416, Cincinnati, OH 45201-5416

Name of Insured \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Name of Owner \_\_\_\_\_ Telephone No. of Owner \_\_\_\_\_  
 Address of Owner \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Reinstate Policy      Face Amount Increase \$ \_\_\_\_\_ Child(ren) \$ \_\_\_\_\_  
 Add Riders:       Children's Term Life Insurance Rider

**(Please Print – Complete Form in Full)**

Full Name of Insured:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Driver's License No.: \_\_\_\_\_ State Issued: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Address of Employer: \_\_\_\_\_

Occupation: (Describe and give active duties)

Do you contemplate changing your occupation?

**Please print full name of all persons proposed for coverage. Show spouse's maiden name in parentheses, if applicable.**

Spouse/Other:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Driver's License No.: \_\_\_\_\_ State Issued: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Address of Employer: \_\_\_\_\_

Occupation: (Describe and give active duties)

Do you contemplate changing your occupation?

Child 1:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Child 2:								\$
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Does anyone proposed for coverage have any past, present or expected aviation activities or hazardous sports avocation or hobbies?  Yes  No (If yes, please explain.)

Has anyone proposed for coverage ever applied for insurance that was declined, postponed, rated, modified, or had any such insurance cancelled or had a renewal premium refused?  Yes  No

Does anyone proposed for coverage have other life insurance?  Yes  No If yes, please provide the following details.

Company	Plan	Amount	ADB	Year Issued

Will this policy replace or change any life insurance that is currently in force?  Yes  No

<b>SMOKING HABITS:</b>  Smoked cigarettes during the last 12 months? Smoked cigarettes during the last 36 months? Use other form of tobacco? (If "yes", describe.)	<b>Proposed Insured</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Spouse/Additional Insured</b> (Complete for Spouse/ Additional Insured Term Rider) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other: _____		Other: _____	



**AUTHORIZATION TO OBTAIN INFORMATION**

I/we, the Proposed Insured(s), authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the MIB, Inc., consumer reporting agency, employer, or pharmacy benefit manager, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children, and any other nonmedical information of me or my minor children, to give to Great American Life Insurance Company/Manhattan National Life Insurance Company/Loyal American Life Insurance Company or its legal representative or its reinsurers any and all such information. I/we also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me or my minor children. The types of information may include my/our: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV); (10) drug and alcohol treatment; (11) other personal information; (12) Motor Vehicle record, and (13) pharmaceutical information. I/we also authorize Great American Life Insurance Company/Manhattan National Life Insurance Company/Loyal American Life Insurance Company or their reinsurers, to make a brief report of my protected health information to MIB, Inc.

I/we understand the information obtained by use of the Authorization will be used by Great American Life Insurance Company/Manhattan National Life Insurance Company/Loyal American Life Insurance Company and its reinsurers to determine eligibility or continued eligibility for insurance and eligibility for benefits under an existing policy or a policy applied for. The insurance agent, producer or broker may also use the information to help update my/our insurance program. Any information obtained will not be released by Great American Life Insurance Company/Manhattan National Life Insurance Company/Loyal American Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my/our application, claim, or as may be otherwise lawfully allowed or required or as I/we may further authorize.

I/we know I/we may request to receive a copy of this Authorization. I/we agree a photographic copy of this Authorization shall be as valid as the original. I/we agree this Authorization shall be valid for two and one-half years from the date shown below.

I ACKNOWLEDGE receipt of the Notice to Persons Applying for Insurance and Notice of Disclosure of Information/MIB, Inc. Disclosure and authorize preparation of an investigative consumer report.

**NOTICES**

**[Alaska Residents:** You have 20 days (30 for replacements) from the date you receive the policy to review it and cancel the policy, if you are not satisfied. Upon receipt of a written request, we will provide you with factual information regarding the benefits and provisions of this policy to aid you in your decision. We will respond to your request for additional information within ten (10) days of its receipt. If you cancel the policy, we will refund the premiums paid for it.]

**[Arkansas, Louisiana, and Rhode Island Residents:** 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.]

**[Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

**[District of Columbia Residents:** 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 a claim was provided by the applicant.]

**[Washington Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or guardian if Insured is under 18)

Signature of Spouse (If Applicable) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Additional Insured (If Applicable) \_\_\_\_\_ Date \_\_\_\_\_

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> NW Readability 043012.PDF		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Application is under the Forms Schedule tab. <b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Cover Letter <b>Comments:</b> <b>Attachment:</b> Cover Letter.PDF		

# MANHATTAN NATIONAL LIFE INSURANCE COMPANY

P.O. Box 5416, Cincinnati, Ohio 45201-5416

## READABILITY CERTIFICATION

I, John P. Gruber, an officer of Manhattan National Life Insurance Company, hereby certify that the following form(s) has (have) the following readability score(s) as calculated by the Flesch Reading Ease Test and that this (these) form(s) meet(s) the reading ease requirements of the laws and regulations of your state.

Form  
A6121512NW

Readability Score  
50.1

A handwritten signature in black ink, appearing to read "John P. Gruber", with a horizontal line extending to the right from the end of the signature.

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**John P. Gruber, Esq.**  
**Senior Vice President,**  
**General Counsel and Secretary**

April 30, 2012

# MANHATTAN NATIONAL LIFE INSURANCE COMPANY

P.O. Box 5420, Cincinnati, Ohio 45201-5420

May 1, 2012

NAIC No. 084-67083  
FEIN No. 45-0252531

Insurance Commissioner Jay Bradford  
Compliance - Life and Health  
Arkansas Department of Insurance  
1200 West Third Street  
Little Rock, AR 72201-1904

RE: Request For Approval - Manhattan National Life Insurance Company  
A6121512NW Policy Change Request, Part II

Dear Insurance Commissioner Bradford:

Enclosed for your review and approval, please find the form referenced above. This form will replace form A6121506NW approved by your Department on 10/19/2006, under file # 34019. This submission does not contain any provisions, conditions, or concepts that are uncommon, unusual or possibly controversial from the standpoint of normal company or industry standards. This form was filed in Illinois, our state of domicile, on 05/01/2012.

This form has been modified to reflect a new requirement from MIB, Inc., and an additional underwriting question was added.

Form A6121512NW will be used by policyholders to make changes such as reinstatement, increases in face amount, the addition of rider, etc to existing life insurance policies only.

At this time we are not currently selling "Life" policies in your state. If our position should change, this application may be used with life insurance policies approved by your Department in the future.

Please note this application is being filed for Great American Life Insurance Company and Loyal American Life Insurance Company simultaneously under separate cover.

With this information, I look forward to receiving a favorable response to this filing.

If you have any questions or require additional information regarding this submission, please feel free to contact me at either of the phone numbers indicated below or via e-mail at [blittle@gafri.com](mailto:blittle@gafri.com).

Sincerely,



Brenda Little  
Senior Compliance Filing Analyst

**BRENDA LITTLE , SENIOR COMPLIANCE FILING ANALYST**  
**(800) 854-3649 (TOLL FREE - EXT. 12725)**  
**(513) 412-2725 (DIRECT DIAL) \* (513) 361-5967 FAX**