

SERFF Tracking Number: LSVX-G128449874 State: Arkansas
 Filing Company: USAbLe Life State Tracking Number:
 Company Tracking Number: AR000210100007
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: Evidence of Insurability, EOI (5-09) - electronic
 Project Name/Number: Group Applications/AR000210100007

Filing at a Glance

Company: USAbLe Life
 Product Name: Evidence of Insurability, EOI (5- SERFF Tr Num: LSVX- State: Arkansas
 09) - electronic G128449874
 TOI: L04G Group Life - Term SERFF Status: Closed-Accepted State Tr Num:
 For Informational Purposes
 Sub-TOI: L04G.103 Renewable - Single Life - Co Tr Num: AR000210100007 State Status: Closed-Accepted for
 Fixed/Indeterminate Premium Informational Purposes
 Filing Type: Form Reviewer(s): Linda Bird
 Disposition Date: 06/08/2012
 Author: SPI Life and Specialty
 Ventures
 Date Submitted: 06/05/2012 Disposition Status: Accepted For
 Informational Purposes
 Implementation Date Requested: 06/05/2012 Implementation Date:
 State Filing Description:

General Information

Project Name: Group Applications Status of Filing in Domicile:
 Project Number: AR000210100007 Date Approved in Domicile:
 Requested Filing Mode: Informational Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Group Market Type: Employer Overall Rate Impact:
 Filing Status Changed: 06/08/2012
 State Status Changed: 06/08/2012 Deemer Date:
 Created By: SPI Life and Specialty Ventures Submitted By: SPI Life and Specialty Ventures
 Corresponding Filing Tracking Number:
 Filing Description:

We are enclosing, for informational purposes, the screen shots for an electronic version of our Evidence of Insurability application, EOI (5-09). The screen shots show the displayed content and data collected electronically during the online application process. This new online capability will be in addition to the paper format, which was approved on 2/18/2009 with Filing ID # 41419 (SERFF Filing ID # LSVX-126016440). Although the conversion of the paper format to an electronic version will slightly alter the appearance of the document, we assure that its content has not changed and its

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readability compliance has not been affected. A readability certification for the paper version is attached.

This electronic version of the Evidence of Insurability application can be used with all Group and Voluntary Life, AD&D, STD and LTD products that have been previously approved by your department.

State Narrative:

Company and Contact

Filing Contact Information

Rob Wittenburg, Compliance Supervisor rwittenburg@usablelife.com
 PO Box 1650 501-212-8877 [Phone] 8877 [Ext]
 Little Rock, AR 72203-1650 501-235-8484 [FAX]

Filing Company Information

USable Life CoCode: 94358 State of Domicile: Arkansas
 PO Box 1650 Group Code: 876 Company Type: Life & Health
 Little Rock, AR 72203-1650 Group Name: Life and Speciality State ID Number:
 Ventures (LSV)
 (501) 375-7200 ext. [Phone] FEIN Number: 71-0505232

Filing Fees

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

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|-------------|---------|----------------|---------------|
| USable Life | \$50.00 | 06/05/2012 | 59697230 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-------------------------------------------|------------|------------|----------------|
| Accepted For Informational Purposes | Linda Bird | 06/08/2012 | 06/08/2012 |

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Disposition

Disposition Date: 06/08/2012

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

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| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|-----------------------------------------------|----------------------|---------------|
| Supporting Document | Application | | No |
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | Evidence of Insurability - electronic version | | Yes |

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Supporting Document Schedules

| | Item Status: | Status Date: |
|-------------------------------------------------------------------------------------------------------|---------------------|-------------------------|
| Bypassed - Item: Application Bypass Reason: Not a policy filing. Comments: | | |

| | Item Status: | Status Date: |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------|
| Satisfied - Item: Flesch Certification Comments: Attachment: Readability Certification EOI (5-09) - electronic version.PDF | | |

| | Item Status: | Status Date: |
|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------|
| Satisfied - Item: Evidence of Insurability - electronic version Comments: Attachment: EOI Form Scen Shots.PDF | | |

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: USAble Life

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 Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

| Form Number | Score |
|--------------------|--------------|
| EOI (5-09) | 52.9 |



Signed: _____

Name: Sally A. Murphy
Senior Counsel, Chief Compliance Officer and
Title: Assistant Secretary

Date: 6/5/2012


Welcome!

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EOI & Medical Underwriting
Submit EOI Form

Step 1 - Personal Information

Member

Section 1

| | |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| Group Name: | GG JET ISSUE |
| Group Number: | 50006353 |
| Date of Hire: | 5/21/2012 |
| Group Administrator Telephone Number: | <input type="text" value="(904) 444-8787"/> |
| Employee's Annual Salary*: | \$89,000.00 |
| Amount of Insurance Applying for*: | |
| Employee Life: | Other: Voluntary Spouse Group Term Life \$100,000.00 Voluntary Child Group Term Life \$10,000.00 Voluntary Group Term Life \$100,000.00 |
| Disability Life: | Dependent Life: N/A Short Term Disability \$855.77 Long Term Disability \$3,708.33 N/A Dependent Life \$7,000.00 |

Section 2

Voluntary Group Term Life
 Amount Over Guarantee Issue
 Late Enrollee

| | | | |
|---------------|--------------------------------------|---------------------|----------------------|
| Name: | TEST MEMBER | SSN: | ***-**-3341 |
| Work Phone: * | <input type="text" value="() - -"/> | Date of Birth: * | 8/8/1975 |
| Home Phone: * | <input type="text" value="() - -"/> | Birth State: * | Select one... ▼ |
| Home Address | | Birth Country: * | Select one... ▼ |
| Line 1: * | 4545 TEST STREET | Gender: * | Male ▼ |
| Line 2: | <input type="text"/> | Weight (in lbs.): * | <input type="text"/> |
| City: * | JACKSONVILLE | Height: * | ▼ Feet ▼ Inches |
| State: * | Select one... ▼ | | |
| Zip: * | 32256 | | |
| County: * | <input type="text"/> | | |

Spouse and Children Information - Complete if Applying for Dependent Coverage

| | | | |
|-------------------|--------------------------------------|------------------|-----------------------|
| Name: | TEST SPOUSE | SSN: * | ***-**-3342 |
| Occupation: * | <input type="text"/> | Date of Birth: | 7/8/1975 |
| Telephone: * | <input type="text" value="() - -"/> | Birth State: * | Select one... ▼ |
| Marital Status: * | Married ▼ | Birth Country: * | Select one... ▼ |
| | | Gender: * | Male ▼ |
| | | Weight (lbs.): * | <input type="text"/> |
| | | Height: * | ▼ Feet and ▼ Inches |

Children

i Your benefit coverage(s) require Dependent(s). Please add Dependent(s) below. Complete once for each Dependent

Add Dependent(s)

Next Step >>

Step 2 - Insurability Questionnaire

Step 3 - Insurability Questionnaire Detail

Step 4 - Confirmation

Exit

Children

Dependent Information - Complete Once for Each Dependent

| First Name | Middle Name | Last Name | |
|------------|-------------|-----------|---|
| TEST | | CHILD | X |

First Name:* Date of Birth:*

Middle Name: Birth State:*

Last Name:* Birth Country:*

Occupation: Gender:*

Marital Status:* Weight (lbs.)*

Height*

[Add Dependent](#)

[Next Step >>](#)

Step 2 - Insurability Questionnaire

Step 3 - Insurability Questionnaire Detail

Step 4 - Confirmation

[Exit](#)


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Step 1 - Personal Information
▼

Step 2 - Insurability Questionnaire
▲

Questions

Section 3 - Insurability Questionnaire NOTE - Questions apply to all applicants listed on this form.

| Question | Answer * |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Has anyone to be covered used any tobacco products in the past year? <input checked="" type="radio"/> Yes <input type="radio"/> No Answer applies to: <input checked="" type="checkbox"/> TEST MEMBER <input checked="" type="checkbox"/> TEST SPOUSE <input type="checkbox"/> TEST CHILD |
| 2 | Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3 | Has anyone to be covered been hospitalized for any reason during the past five (5) years? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4 | Has anyone to be covered consulted a physician in the past one (1) year for any reason? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5 | Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: |
| 5.1 | Cancer, cancer related disease or benign tumor? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.2 | Disease of the heart or blood vessels, or had a stroke? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.3 | Kidney disease or diabetes? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.4 | Alcohol or drug abuse? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.5 | Lung, asthma, liver or blood disorder? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.6 | Lung, asthma, liver or blood disorder? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.7 | Emotional, nervous system, eating disorder, or mental health problems? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.8 | Ulcer, stomach or digestive disorder? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.9 | Arthritis, back, bones or joint disorder? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5.10 | Bladder, urinary system or reproductive organs disorder? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 6 | Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 7 | Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4 <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 8 | Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4. <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 9 | Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 10 | Are you now pregnant? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 10.1 | Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section? <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 11 | Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If No, give full details in Section 4. <input checked="" type="radio"/> Yes <input type="radio"/> No Answer applies to: <input type="checkbox"/> TEST MEMBER |

Next Step >>

Step 3 - Insurability Questionnaire Detail
▼

Step 4 - Confirmation
▼

Exit

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Welcome!

EDI & Medical Underwriting

Submit EOI Form

Step 1 - Personal Information

Step 2 - Insurability Questionnaire

Step 3 - Insurability Questionnaire Detail

Medical Detail

Section 4 - Give Details to "Yes" answers to questions 2 through 10 include dates of treatment.

Names, addresses (including City and State) and phone numbers of the personal physicians of all applicants: *

| Individual | Illness/Reason for Checkup or Medication and Dosage or Doctor's Treatment/Consultation * | Date and Duration * | Full Name, Complete Address and Telephone Number of Doctors and Hospitals * |
|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------|
| # 1.; Question: Has anyone to be covered used any tobacco products in the past year? | | | |
| TEST MEMBER | | | |
| TEST SPOUSE | | | |

Next Step >>

Step 4 - Confirmation

Exit

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EOI & Medical Underwriting

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Step 1 - Personal Information

Step 2 - Insurability Questionnaire

Step 3 - Insurability Questionnaire Detail

Step 4 - Confirmation

Disclaimers

i Please read the disclaimers and print this page for confirmation. Check "I agree" and press submit when complete.

NOTICE OF INSURANCE INFORMATION PRACTICES In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request. 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 our information practices. If you would like to receive a more detailed explanation of those practices, please send your request to the chief underwriter, P.O. Box 1650, Little Rock, AR 72203 FEDERAL FAIR CREDIT REPORTING ACT NOTICE In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer

I agree.

Edit Form

Print Form

Exit

Submit

report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company. NOTICE FOR PROPOSED INSURED IMPORTANT NOTICE FOR DISABILITY COVERAGE Acceptance of your application for disability income insurance will be based upon the information contained in the Evidence of Insurability, including the medical information disclosed and information obtained from your medical providers. Your insurance coverage may not be issued as applied for. If not, an "Exclusion of Coverage Amendment" will be attached to your certificate of coverage. PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT. IMPORTANT NOTICE CONCERNING YOUR EFFECTIVE DATE 1. Insurance will not be effective until the application is approved by USABLE Life. 2. Insurance will not be effective if there has been a change in the health of the proposed insured(s) after the date of the application and prior to the effective date. 3. For benefits sheltered under a Section 125 Cafeteria plan: To satisfy premium deduction requirements of your employer and dating requirements of the Section 125 Plan, your coverage will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) of the Section 125 agreement or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy. In signing below, I: (a) represent

I agree.

Edit Form

Print Form

Exit

Submit

that the statements and answers given in this application, are true, complete and correctly recorded; (b) understand that the insurance applied for is not effective until the application is approved by USABLE Life; (c) authorize any physician, medical practitioner, hospital, clinic, or other medical facility, insurance or reinsurance company, or MIB, Inc., formerly known as Medical Information Bureau, Inc., having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USABLE Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (d) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (e) agree that this authorization shall be valid for two (2) years from the date the authorization is signed; (f) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (g) acknowledge I have read and understand all disclosures on this form; and (h) acknowledge receipt of written notification describing the use of the MIB as required by the Fair Credit Reporting Act and the Notice of Information Practices. I have read and understand

I agree.

Edit Form

Print Form

Exit

Submit

the above statements and agreements. Insurance Fraud Warning – It is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. USable Life 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 life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

I agree.

Edit Form

Print Form

Exit

Submit

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 about you in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Braintree, Massachusetts 02184-8734.

USable Life or its reinsurers may also release information in its file to other life 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 on its website at www.mib.com.

PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT. Check to see if it includes an Exclusion of Coverage amendment.

I agree.

Edit Form

Print Form

Exit

Submit