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<b>SERFF Tracking #:</b>	BFLI-128578351	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	AR B 8722 (14/14)
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Bankers Fidelity Life Insurance Company		
<b>TOI/Sub-TOI:</b>	H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer or association groups				
<b>Product Name:</b>	Disability Income				
<b>Project Name/Number:</b>	/				

## Filing at a Glance

Company:	Bankers Fidelity Life Insurance Company
Product Name:	Disability Income
State:	Arkansas
TOI:	H111 Individual Health - Disability Income
Sub-TOI:	H111.002 Short Term - Unrelated to marketing with employer or association groups
Filing Type:	Form/Rate
Date Submitted:	07/19/2012
SERFF Tr Num:	BFLI-128578351
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	AR B 8722 (14/14)
Implementation	On Approval
Date Requested:	
Author(s):	Jill Jones, Bridgett Williams, Tina Cunningham, Lyn Ezell, Sharon White, Norma Christopher
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	07/20/2012
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

<b>SERFF Tracking #:</b>	BFLI-128578351	<b>State Tracking #:</b>	<b>Company Tracking #:</b> AR B 8722 (14/14)
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Bankers Fidelity Life Insurance Company
<b>TOI/Sub-TOI:</b>	H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer or association groups		
<b>Product Name:</b>	Disability Income		
<b>Project Name/Number:</b>	/		

## General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 06/22/2012
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: 07/20/2012
	State Status Changed: 07/20/2012
Deemer Date:	Created By: Tina Cunningham
Submitted By: Tina Cunningham	Corresponding Filing Tracking Number:

### Filing Description:

We are submitting an updated actuarial memorandum with rates to add two new elimination period options - 7/7 and 14/14 - to our previously approved Disability Income Policy, forms B 8722 AR and B 8722 DR AR. Policy forms B 8722 AR and B 8722 DR AR were both approved by the Arkansas Department of Insurance on 10-25-2006. Included under the Supporting Documentation tab are John Doe policy specification pages showing the new 7/7 and 14/14 options.

In addition to the new options and rates for the 7/7 and 14/14 elimination periods, some of the rates for the previously filed options have been adjusted to maintain actuarial consistency among all the options. This policy has not been solicited or marketed in your state therefore, there are no existing insureds.

We are also submitting revised applications which include these new options as well. Applications B 8722 AP2012 and B 8722 AP2012 DR will replace forms B 8722 AP2006-1 and B 8722 AP2006-1 DR, both of which were approved by the Arkansas Department of Insurance on 10-25-2006, respectively.

## Company and Contact

### Filing Contact Information

Tina Cunningham, Compliance Analyst L1 tcunningham@atlam.com  
 4370 Peachtree Road NE 404-266-5723 [Phone]  
 Atlanta, GA 30319 404-926-4092 [FAX]

### Filing Company Information

Bankers Fidelity Life Insurance Company	CoCode: 61239	State of Domicile: Georgia
4370 Peachtree Rd NE	Group Code: 587	Company Type: Life & Health
Atlanta, GA 30319	Group Name: 61239	State ID Number:
(404) 266-5600 ext. [Phone]	FEIN Number: 58-0658963	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	Yes
Fee Explanation:	\$25.00 X 2 = \$50.00
Per Company:	No

**SERFF Tracking #:** BFLI-128578351      **State Tracking #:**      **Company Tracking #:** AR B 8722 (14/14)

**State:** Arkansas      **Filing Company:** Bankers Fidelity Life Insurance Company

**TOI/Sub-TOI:** H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer  
or association groups

**Product Name:** Disability Income

**Project Name/Number:** /

<b>Company</b>	<b>Amount</b>	<b>Date Processed</b>	<b>Transaction #</b>
Bankers Fidelity Life Insurance Company	\$100.00	07/19/2012	61020702

<b>SERFF Tracking #:</b>	BFLI-128578351	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	AR B 8722 (14/14)
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Bankers Fidelity Life Insurance Company		
<b>TOI/Sub-TOI:</b>	H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer or association groups				
<b>Product Name:</b>	Disability Income				
<b>Project Name/Number:</b>	/				

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/20/2012	07/20/2012

<b>SERFF Tracking #:</b>	BFLI-128578351	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	AR B 8722 (14/14)
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Bankers Fidelity Life Insurance Company		
<b>TOI/Sub-TOI:</b>	H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer or association groups				
<b>Product Name:</b>	Disability Income				
<b>Project Name/Number:</b>	/				

## Disposition

Disposition Date: 07/20/2012

Implementation Date:

Status: Approved-Closed

Comment:

<b>Company Name:</b>	<b>Overall % Indicated Change:</b>	<b>Overall % Rate Impact:</b>	<b>Written Premium Change for this Program:</b>	<b># of Policy Holders Affected for this Program:</b>	<b>Written Premium for this Program:</b>	<b>Maximum % Change (where req'd):</b>	<b>Minimum % Change (where req'd):</b>
Bankers Fidelity Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	John Doe Policy Specifications Pages	Approved-Closed	Yes
<b>Supporting Document</b>	Statement of Variability	Approved-Closed	Yes
<b>Supporting Document</b>	Forms Use List	Approved-Closed	Yes
<b>Form</b>	Application (Agent Written)	Approved-Closed	Yes
<b>Form</b>	Application (Direct Response)	Approved-Closed	Yes

**State:** Arkansas  
**TOI/Sub-TOI:** H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer or association groups  
**Filing Company:** Bankers Fidelity Life Insurance Company  
**Product Name:** Disability Income  
**Project Name/Number:** /

## Form Schedule

Lead Form Number: B 8722 AP2012

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 07/20/2012	B 8722 AP2012	AEF	Application (Agent Written)	Initial:	51.300	B 8722 AP2012.pdf
2	Approved-Closed 07/20/2012	B 8722 AP2012 DR	AEF	Application (Direct Response)	Initial:	53.040	B 8722 AP2012 DR.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

# BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, GA 30348-5146

## APPLICATION FOR DISABILITY INCOME

PLEASE PRINT

Agent/Broker Name	Agent #

Proposed Insured	Social Security No.	Sex	Place (State) of Birth	Age	Born			Height & Weight		
					Mo.	Day	Yr.	Ft.	In.	Lbs.
Residence Address (Street or Route & Box No.)		City	County	State	Zip Code					
Telephone Number ( )	Best Time to Call: <input type="checkbox"/> AM <input type="checkbox"/> PM	Proposed Insured E-mail Address:			Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent					

**SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW**

<p><b>DISABILITY INCOME:</b>                  Monthly Benefit Requested.....\$ _____  <small>Minimum \$500</small></p> <p>Benefit Period (Months):  <input type="checkbox"/> 3   <input type="checkbox"/> 6   <input type="checkbox"/> 12   <input type="checkbox"/> 24</p> <p>Elimination Period (Days) (Accident/Sickness)  <input type="checkbox"/> 7/7   <input type="checkbox"/> 14/14   <input type="checkbox"/> 14/30   <input type="checkbox"/> 30/30</p> <p><b>The following elimination periods are only available with the 12 or 24 month benefit periods:</b>  <input type="checkbox"/> 60/60   <input type="checkbox"/> 90/90   <input type="checkbox"/> 180/180</p> <p>Optional Job-Related Accident-Only Disability Rider:  <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Occupational Class:  <input type="checkbox"/> A   <input type="checkbox"/> B   <input type="checkbox"/> C   <input type="checkbox"/> D   <input type="checkbox"/> E</p> <p>Requested Effective Date: _____</p>	<p><b>PREMIUM MODE:</b>  <input type="checkbox"/> Annual  <input type="checkbox"/> Semi-Annual  <input type="checkbox"/> Quarterly  <input type="checkbox"/> Payroll Deduction  <input type="checkbox"/> Monthly Bank Draft*  <input type="checkbox"/> Monthly Credit Card*                  *Requested Draft Date _____</p> <p><b>BILLING TYPE:</b>  <input type="checkbox"/> Individual   <input type="checkbox"/> Family*  <small>*Complete Family Billing Form B 0129 FB/LB</small></p>	<p><b>PREMIUM COMPUTATION:</b>                  Disability Income:..... \$ _____                  Rider: ..... \$ _____  <b>Total Amount Paid: ..... \$ _____</b></p> <p><input type="checkbox"/> Check/money order included.  <input type="checkbox"/> Charge credit card for initial premium.  <input type="checkbox"/> Draft initial premium*                  *Initial Draft Date _____</p>
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1. <b>Occupation(s) of Applicant:</b>	Duties:	Years Employed
Employers' Name(s) and Address(es):		

Employed full-time?  Yes  No   Average Monthly Earnings Last 12 Months for all income (after business expenses)? \$ \_\_\_\_\_

2. Is the Proposed Insured a legal citizen of the United States or its possessions? .....  Yes  No  
 If "No," is the Proposed Insured a Permanent Resident?  Yes  No   **If "No," coverage is not available.**  
 If "Yes," provide the following information as shown on the Permanent Resident Card:  
 I.N.S. # \_\_\_\_\_ CATEGORY \_\_\_\_\_ RESIDENT SINCE \_\_\_\_\_ CARD EXPIRES \_\_\_\_\_

3. (a) Does the Proposed Insured currently have any disability income policies in force or pending? .....  Yes  No  
 If "Yes," give Name of Company(s) or Other Insurer & Policy Number(s) \_\_\_\_\_  
 Amount of Monthly Benefit \$ \_\_\_\_\_  
 \$ \_\_\_\_\_

(b) Will any insurance be replaced with this policy? .....  Yes  No  
 If "Yes," which company? \_\_\_\_\_ Policy No \_\_\_\_\_

4. Name of Primary Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
Name of Contingent Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.

5. Has the Proposed Insured:
- (a) ever applied for or received a pension or disability benefit for a sickness or injury? .....  Yes  No
  - (b) ever received or is currently receiving benefits from a state welfare program, Medicaid or Social Security disability? .....  Yes  No
  - (c) ever had life, disability or hospital insurance issued other than as applied for, issued at a rate higher than applied for, modified, rejected, cancelled or not renewed? .....  Yes  No
  - (d) ever had or applied for and was issued any coverage with Bankers Fidelity Life®? .....  Yes  No
  - (e) ever applied for and was declined any coverage with Bankers Fidelity Life? .....  Yes  No

If "Yes," give details:

\_\_\_\_\_

\_\_\_\_\_

6. Has the Proposed Insured, within the last two years, engaged in: skydiving; hang-gliding; underwater diving; organized racing events; rodeo; mountaineering; professional sports; or piloting a plane; or are any such activities contemplated? .....  Yes  No
- If "Yes," state activity and average number of times per year. \_\_\_\_\_
- \_\_\_\_\_

7. Within the last 3 years, has the Proposed Insured:
- (a) had three or more moving violations? .....  Yes  No
  - (b) been charged with driving while intoxicated or under the influence? .....  Yes  No
  - (c) had their driver's license suspended or revoked? .....  Yes  No

If "Yes," provide your Driver's License Number and State of Issue:

Proposed Insured Driver's License # \_\_\_\_\_ Issue State \_\_\_\_\_

8. In the last 5 years, has the Proposed Insured been medically diagnosed with or treated for:
- (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? .....  Yes  No
  - (b) any lipidosis, including Gaucher's or Tay-Sachs or Wolman's? .....  Yes  No

9. In the last 10 years, has the Proposed Insured been medically diagnosed with or treated for:  
(Circle conditions to which "Yes" answer applies and give details below)

- (a) any disease of heart or circulatory system, high blood pressure, varicose veins, phlebitis, cancer or tumor? .....  Yes  No
- (b) any disease of kidney or urinary tract, reproductive organs or breasts, diabetes, or sugar in urine? .....  Yes  No
- (c) any disease of lungs, respiratory system, stomach or digestive tract, gall bladder, or hernia? .....  Yes  No
- (d) any disease of or injury to neck, back or spine, muscles, joints, sciatica, bodily deformity or arthritis? .....  Yes  No
- (e) any disease or impairment of the eyes or ears, treatment for nervous or mental disorder, alcoholism, drug dependency? .....  Yes  No

10. In the last 5 years, has the Proposed Insured had any tests performed, or any tests or treatment recommended or scheduled but not yet begun for any condition not listed in question 8 or 9 above? .....  Yes  No

11. In the last 5 years, has the Proposed Insured had or been medically diagnosed with or treated for any disease, disorder or condition not listed in questions 8 or 9 above? .....  Yes  No

If "Yes," list condition(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for Treatment or consultation (Please include type of treatment and degree of recovery)	Date	Name & Full Address of Physician/Clinic or Hospital

12. Please provide complete name, address and telephone number of the Proposed Insured's primary care physician:

Physician's name: \_\_\_\_\_ Telephone number \_\_\_\_\_

Physician's address: \_\_\_\_\_

13. I, the undersigned Proposed Insured, hereby apply to Bankers Fidelity Life Insurance Company® for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued, received by me and the first premium paid and honored upon first presentation, all during my lifetime and before any change in my health as stated herein. I have received an outline of coverage and a "Guide To Health Insurance For People With Medicare" (if age 65 or older).

The undersigned Proposed Insured and agent state that the Proposed Insured has read or had read to him the completed application and that the Proposed Insured realizes that any false statement or material misrepresentation in the application may result in loss of coverage under the policy, subject to the "Time Limit On Certain Defenses" provision of the policy.

**CAUTION:** If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company® may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy.

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

Dated at , on \_\_\_\_\_ (City and State) \_\_\_\_\_ (Month, Day, Year) X \_\_\_\_\_ Proposed Insured's signature. Please read item 13 before signing.

X \_\_\_\_\_ Agent's signature \_\_\_\_\_ Agent's number

Is any of this insurance being purchased to replace or change any existing insurance? .....  Yes  No  
Complete Replacement Notice(s) as required.

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare" (if age 65 or older).

Is the Proposed Insured related to you?  Yes  No If "Yes," explain relationship:  Self  \_\_\_\_\_  
If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identity as required by the USA Patriot Act (PL 107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:

Drivers License  Passport  Government-issued identification card  Other \_\_\_\_\_

Dated at \_\_\_\_\_ , on \_\_\_\_\_ X \_\_\_\_\_ Agent's signature \_\_\_\_\_ Agent's number

X \_\_\_\_\_ Co-signature (if required)

WRITING AGENT COMPLETE

# BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P.O. Box 105146, Atlanta, GA 30348-5146

## APPLICATION FOR DISABILITY INCOME

PLEASE PRINT

SECTION A: Please provide the following information about yourself:				
Name: (First Name, Middle Initial, Last Name)			Social Security Number	
Date of Birth: (Month/Day/Year)	Age	Place (State) of Birth	Sex (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	E-mail Address
Address: (No. & Street, City, County, State, Zip Code)			Daytime Phone #: (Include Area Code)	

SECTION B: Select Your Benefits:	
<b>DISABILITY INCOME:</b> Monthly Benefit Requested.....\$ _____ Benefit Period (Months): <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 24 Elimination Period Days (Accident/Sickness) <input type="checkbox"/> 7/7 <input type="checkbox"/> 14/14 <input type="checkbox"/> 14/30 <input type="checkbox"/> 30/30 <b>The following elimination periods are only available with the 12 or 24 month benefit periods:</b> <input type="checkbox"/> 60/60 <input type="checkbox"/> 90/90 <input type="checkbox"/> 180/180 Optional Job-Related Accident-Only Disability Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No Requested Effective Date: _____	<b>Payment Method:</b> <input type="checkbox"/> Bank Draft <input type="checkbox"/> Credit Card Premium Included with Application: \$ _____

SECTION C: Please answer the following questions about yourself:	
1. Occupation(s) of Applicant:	Duties: _____ Years Employed: _____
Employer's Name(s) and Address(es): _____	
Employed full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Monthly Earnings Last 12 Months for all income (after business expenses)? \$ _____
2. Are you a legal citizen of the United States or its possessions?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," are you a Permanent Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If "No," coverage is not available.</b> If "Yes," provide the following information as shown on your Permanent Resident Card: I.N.S. # _____ CATEGORY _____ RESIDENT SINCE _____ CARD EXPIRES _____	
3. Do you currently have any disability income policies in force or pending? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give Name of Company(s) or Other Insurer & Policy Number(s) _____ <div style="text-align: right; margin-right: 50px;">Amount of Monthly Benefit</div> \$ _____ \$ _____ Will any insurance be replaced with this policy? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," which company? _____ Policy No _____	

4. Who do you want to receive any remaining benefits if you should die prior to all benefits having been paid?				
Name of Primary Beneficiary(ies)	Relationship	Social Security No. (if known)	Address	Telephone No.
Name of Contingent Beneficiary(ies)	Relationship	Social Security No. (if known)	Address	Telephone No.

5. Have you:
- (a) ever applied for or received a pension or disability benefit for a sickness or injury? .....  Yes  No
  - (b) ever received or is currently receiving benefits from a state welfare program, Medicaid or Social Security disability? .....  Yes  No
  - (c) ever had life, disability or hospital insurance issued other than as applied for, issued at a rate higher than applied for, modified, rejected, cancelled or not renewed? .....  Yes  No
  - (d) ever had or applied for and was issued any coverage with Bankers Fidelity Life? .....  Yes  No
  - (e) ever applied for and was declined any coverage with Bankers Fidelity Life? .....  Yes  No
- If "Yes," give details: \_\_\_\_\_

6. Have you, within the last two years, engaged in: skydiving; hang-gliding; underwater diving; organized racing events; rodeo; mountaineering; professional sports; or piloting a plane; or are any such activities contemplated? .....  Yes  No
- If "Yes," state activity and average number of times per year. \_\_\_\_\_

7. Within the last 3 years, have you:
- (a) had three or more moving violations? .....  Yes  No
  - (b) been charged with driving while intoxicated or under the influence? .....  Yes  No
  - (c) had your driver's license suspended or revoked? .....  Yes  No
- If "Yes," provide your Driver's License Number and State of Issue:
- Driver's License # \_\_\_\_\_ Issue State \_\_\_\_\_

8. In the last 5 years, have you been medically diagnosed with or treated for:
- (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? .....  Yes  No
  - (b) any lipidosis, including Gaucher's or Tay-Sachs or Wolman's? .....  Yes  No

9. In the last 10 years, have you been medically diagnosed with or treated for:  
(Circle conditions to which "Yes" answer applies and give details below)
- (a) any disease of heart or circulatory system, high blood pressure, varicose veins, phlebitis, cancer or tumor? .....  Yes  No
  - (b) any disease of kidney or urinary tract, reproductive organs or breasts, diabetes, or sugar in urine? .....  Yes  No
  - (c) any disease of lungs, respiratory system, stomach or digestive tract, gall bladder, or hernia? .....  Yes  No
  - (d) any disease of or injury to neck, back or spine, muscles, joints, sciatica, bodily deformity or arthritis? .....  Yes  No
  - (e) any disease or impairment of the eyes or ears, treatment for nervous or mental disorder, alcoholism, drug dependency? .....  Yes  No

10. In the last 5 years, have you had any tests performed, or any tests or treatment recommended or scheduled but not yet begun for any condition not listed in question 4 or 5 above? .....  Yes  No

11. In the last 5 years, have you had or been medically diagnosed with or treated for any disease, disorder or condition not listed in questions 4 or 5 above? .....  Yes  No

If "Yes," list condition(s) \_\_\_\_\_

Reason for Treatment or consultation (Please include type of treatment and degree of recovery)	Date	Name & Full Address of Physician/Clinic or Hospital

12. Please provide complete name, address and telephone number of your primary care physician:
- Physician's name: \_\_\_\_\_ Telephone number \_\_\_\_\_
- Physician's address: \_\_\_\_\_

**SECTION D: Please read the following agreement and sign at the bottom:**

13. I, the undersigned, hereby apply to Bankers Fidelity Life Insurance Company® for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. **I agree the policy shall not be effective unless it has actually been issued, received by me and the first premium paid, all during my lifetime and before any change in my health as stated herein.**

**I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy, subject to the “Time Limit on Certain Defenses” provision of the policy.**

**CAUTION: If the answers on this application are incorrect or untrue, Bankers Fidelity Life Insurance Company® may have the right to deny benefits or rescind your policy, subject to the “Time Limit on Certain Defenses” provision of the Policy.**

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

Dated at \_\_\_\_\_, on \_\_\_\_\_ X \_\_\_\_\_  
(City and State) (Month, Day, Year) Signature. Please read item #9 before signing.

<b>SERFF Tracking #:</b>	BFLI-128578351	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	AR B 8722 (14/14)
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Bankers Fidelity Life Insurance Company		
<b>TOI/Sub-TOI:</b>	H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer or association groups				
<b>Product Name:</b>	Disability Income				
<b>Project Name/Number:</b>	/				

## Rate Information

Rate data applies to filing.

<b>Filing Method:</b>	SERFF
<b>Rate Change Type:</b>	Neutral
<b>Overall Percentage of Last Rate Revision:</b>	0.000%
<b>Effective Date of Last Rate Revision:</b>	06/29/2012
<b>Filing Method of Last Filing:</b>	N/A

## Company Rate Information

<b>Company Name:</b>	<b>Overall % Indicated Change:</b>	<b>Overall % Rate Impact:</b>	<b>Written Premium Change for this Program:</b>	<b># of Policy Holders Affected for this Program:</b>	<b>Written Premium for this Program:</b>	<b>Maximum % Change (where req'd):</b>	<b>Minimum % Change (where req'd):</b>
Bankers Fidelity Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

<b>SERFF Tracking #:</b>	BFLI-128578351	<b>State Tracking #:</b>	<b>Company Tracking #:</b>	AR B 8722 (14/14)
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Bankers Fidelity Life Insurance Company	
<b>TOI/Sub-TOI:</b>	H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer or association groups			
<b>Product Name:</b>	Disability Income			
<b>Project Name/Number:</b>	/			

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Flesch Certification	Approved-Closed	07/20/2012
Comments:			
Attachment(s):			
Guaranty Association Notice B 0076 AR.pdf			
Consumer Notice B 0034 AR.pdf			
B 8722 AP2012 Flesch cert.pdf			
Certificate of Compliance B 8722 AP2012.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Application	Approved-Closed	07/20/2012
Comments:	The applications are filed under the Form Schedule.		

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Outline of Coverage	Approved-Closed	07/20/2012
Bypass Reason:	N/A as this is an application filing.		
Comments:			

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	John Doe Policy Specifications Pages	Approved-Closed	07/20/2012
Comments:			
Attachment(s):			
B 8722 John Doe Page 3.pdf			
B 8722 DR John Doe Page 3.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Statement of Variability	Approved-Closed	07/20/2012
Comments:			
Attachment(s):			

<b>SERFF Tracking #:</b>	BFLI-128578351	<b>State Tracking #:</b>	<b>Company Tracking #:</b>	AR B 8722 (14/14)
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Bankers Fidelity Life Insurance Company	
<b>TOI/Sub-TOI:</b>	H111 Individual Health - Disability Income/H111.002 Short Term - Unrelated to marketing with employer or association groups			
<b>Product Name:</b>	Disability Income			
<b>Project Name/Number:</b>	/			

B 8722 Statement of Variability.pdf

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Forms Use List	Approved-Closed	07/20/2012
Comments:			
Attachment(s):			
AR B 8722 Forms Use List.pdf			

## **LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are member of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting the insurance companies that are well managed and financially stable.

### **DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

The Arkansas Life and Health Insurance Guaranty Association  
C/o The Liquidation Division  
1023 West Capitol, Suite 2  
Little Rock, Arkansas 72202

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

### **COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

## LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different type of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

# **BANKERS FIDELITY LIFE INSURANCE COMPANY**

Atlanta, Georgia

The following information is being provided to you in accordance with Act 197 of the Arkansas Department of Insurance Regulations:

## **Bankers Fidelity Life Insurance Company**

Policyholder Service Department

4370 Peachtree Road, N.E.

Atlanta, Georgia 30319

Toll-Free: 866-458-7500

Fax: (404) 926-4033

[bflphs@atlam.com](mailto:bflphs@atlam.com)

If we at Bankers Fidelity Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

## **Arkansas Department of Insurance**

Consumer Service Division

1200 West Third Street

Little Rock, Arkansas 72201-1904

(510) 371-2640, (800) 852-5494

Fax: (501) 371-2749

[insurance.consumers@arkansas.gov](mailto:insurance.consumers@arkansas.gov)

### **Your Agent:**

{FId0240}

{FId0241} {FId0242}

{FId0243} {FId0244}

{FId0245}

This notice is for information only and does not become a part or condition of your policy.

**BANKERS FIDELITY LIFE INSURANCE COMPANY**

4370 Peachtree Road, N.E., Atlanta, Georgia 30319

(404) 266-5657

**READABILITY CERTIFICATION**

B 8722 AP2012 - Application for Disability Income

Words: 525

Sentences: 34

Syllables: 868

Score: 51.3

B 8722 AP2012 DR - Application for Income

Words: 501

Sentences: 34

Syllables: 820

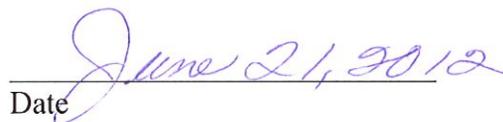
Score: 53.4

I hereby certify that the captioned filing meets the minimum reading ease score of the Flesch Readability Test.



Sharon A. White

Vice-President, Legal/Compliance



Date

**CERTIFICATE OF COMPLIANCE**

**ARKANSAS**

The Bankers Fidelity Life Insurance Company certifies that the form filing for:

B 8722 AP2012 – Level Term Life Insurance Policy

meets the provisions of the Rule 19, as well as all other requirements of the Arkansas Department of Insurance.



Sharon A. White  
Vice President, Legal/Compliance

July 19, 2012 \_\_\_\_\_  
Date

# BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P.O. Box 105185, Atlanta, Georgia 30348-5185

For inquiries or to make a complaint, please contact the Policyholder Service Department at:  
Direct (404) 266-5730; Toll-free (866) 458-7500; email bfphs@atlam.com

## POLICY SPECIFICATIONS PAGE

### Disability Income Policy

Policy Form B 8722

#### Covered Person

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<u>Name:</u> JOHN D DOE	<u>Issue Age:</u> 35	<u>Sex:</u> M	<u>Effective Date:</u> 09-01-2006
			<u>Expiry Date:</u> 01-01-2041

#### Benefits

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Base Plan Benefits:

MONTHLY DISABILITY INCOME BENEFIT:	[\$100 units]
MAXIMUM DISABILITY BENEFIT PERIOD:	[3, 6, 12, 24] MONTHS

Elimination Period:

COVERED ACCIDENT:	[7, 14, 30, 60, 90, 180] DAYS
COVERED SICKNESS:	[7, 14, 30, 60, 90, 180] DAYS

Waiver of Premium Elimination Period:

[7, 14, 30, 60, 90, 180] DAYS

Optional Benefit Riders (if any):

JOB-RELATED ACCIDENT ONLY DISABILITY RIDER

#### Premiums

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Initial Premium: \$[XXX.XX]

<u>Renewal Premium:</u>	<u>Annual:</u>	<u>Semi-Annual:</u>	<u>Quarterly:</u>	<u>Monthly:</u>
	[\$[XXX.XX]]	[\$[XXX.XX]]	[\$[XXX.XX]]	[\$[XXX.XX]]

#### Policy Identification

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Policy Number: 005-[2060950001]

Issue State: [GA]

Industry Class: [A]

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# BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P.O. Box 105185, Atlanta, Georgia 30348-5185

For inquiries or to make a complaint, please contact the Policyholder Service Department at:  
Direct (404) 266-5730; Toll-free (866) 458-7500; email bfphs@atlam.com

## POLICY SPECIFICATIONS PAGE

### Disability Income Policy

Policy Form B 8722 DR

#### Covered Person

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<u>Name:</u> JOHN D DOE	<u>Issue Age:</u> 35	<u>Sex:</u> M	<u>Effective Date:</u> 09-01-2006
			<u>Expiry Date:</u> 01-01-2041

#### Benefits

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Base Plan Benefits:

MONTHLY DISABILITY INCOME BENEFIT:	[\$100 units]
MAXIMUM DISABILITY BENEFIT PERIOD:	[3, 6, 12, 24] MONTHS

Elimination Period:

COVERED ACCIDENT:	[14, 30, 60, 90, 180] DAYS
COVERED SICKNESS:	[30, 60, 90, 180] DAYS

Waiver of Premium Elimination Period:

[14, 30, 60, 90, 180] DAYS

Optional Benefit Riders (if any):

JOB-RELATED ACCIDENT ONLY DISABILITY RIDER

#### Premiums

---

Initial Premium: \$[XXX.XX]

<u>Renewal Premium:</u>	<u>Annual:</u> \$[XXX.XX]	<u>Semi-Annual:</u> \$[XXX.XX]	<u>Quarterly:</u> \$[XXX.XX]	<u>Monthly:</u> \$[XXX.XX]
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#### Policy Identification

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Policy Number: 005-[2060950001]

Issue State: [GA]

Industry Class: [A]

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## STATEMENT OF VARIABILITY

### Disability Income Policy B 8722 & B 8722 DR

#### Policy Specifications Pages

<u>Item</u>	<u>Variableness Based On:</u>
Name	individual insured personal information
Issue Age	individual insured personal information
Sex	individual insured personal information
Effective Date	selected by insured
Expiry Date	type of plan issued as selected by insured
Monthly Disability Income Benefit	selected by insured
Maximum Disability Income Benefit Period	selected by insured
Covered Accident Elimination Period	selected by insured
Covered Sickness Elimination Period	selected by insured
Waiver of Premium Elimination Period	determined by type of plan selected by insured
Optional Benefit Riders (if any)	optional rider will be listed if selected by insured
Initial Premium	Initial Premium due for policy based on options selected
Renewal Premium: Annual	current annual renewal premium for policy
Renewal Premium: Semi-Annual	current semi-annual renewal premium for policy
Renewal Premium: Quarterly	current quarterly renewal premium for policy
Renewal Premium: Monthly	current monthly renewal premium for policy
Policy Number	unique identifying number assigned by company to each policy
Issue State	where application is signed
Industry Class	based on occupation of insured

#### Applications – Coverage Selection Area

Benefit Period	3, 6, 12 & 24 months; may delete option if company decides to no longer offer; may add options if filed and approved at a later date
Elimination Period	7/7, 14/14/, 14/30, 30/30, 60/60, 90/90, 180/180 days; may delete option if company decides to no longer offer; may add options if filed and approved at a later date
Occupational Class:	A, B, C, D, E, F; may delete class if company decides to no longer offer; may add classes if filed and approved at a later date
Optional Rider	may delete option if company decides to no longer offer; may add options if filed and approved at a later date

## FORMS USE LIST

### Disability Income Policy B 8722 AR

#### Arkansas

In addition to the forms included in the product filing; policy form B 8722 AR may be underwritten from the following previously approved applications:

<u>Form Number</u>	<u>Approval Date</u>	<u>SERFF Tracking #</u>
B 0093 AP2006	09-27-2006	n/a
B 0093 AP2007 GA	03-27-2007	n/a
B 0093 AP2011 GA	04-11-2011	BFLI-127102700