

State: Arkansas Filing Company: State Farm Life Insurance Company  
TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life  
Product Name: FCB Supplemental Application Informational Filing  
Project Name/Number: FCB Supplemental Application Informational Filing/SFL-AR-1001565 b

## Filing at a Glance

Company: State Farm Life Insurance Company  
Product Name: FCB Supplemental Application Informational Filing  
State: Arkansas  
TOI: L09I Individual Life - Flexible Premium Adjustable Life  
Sub-TOI: L09I.001 Single Life  
Filing Type: Form  
Date Submitted: 07/12/2012  
SERFF Tr Num: STFL-128171138  
SERFF Status: Closed-Accepted For Informational Purposes  
State Tr Num:  
State Status: Closed-Accepted for Informational Purposes  
Co Tr Num: SFL-AR-1001565 B  
  
Implementation: 03/13/2013  
Date Requested:  
Author(s): Rachel Lighthall, Maureen Macak  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 07/18/2012  
Disposition Status: Accepted For Informational Purposes  
Implementation Date:  
  
State Filing Description:

State: Arkansas Filing Company: State Farm Life Insurance Company

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### General Information

|   |  |
|---|--|
| Project Name: FCB Supplemental Application Informational Filing | Status of Filing in Domicile: Authorized   |
| Project Number: SFL-AR-1001565 b                                | Date Approved in Domicile: 06/27/2012  |
| Requested Filing Mode: Informational                            | Domicile Status Comments: A filing of a similar form has been approved by Illinois, our state of domicile. |
| Explanation for Combination/Other:                              | Market Type: Individual  |
| Submission Type: New Submission                                 | Individual Market Type:  |
| Overall Rate Impact:  | Filing Status Changed: 07/18/2012  |
|   | State Status Changed: 07/18/2012   |
| Deemer Date:  | Created By: Maureen Macak  |
| Submitted By: Maureen Macak                                     | Corresponding Filing Tracking Number:  |

Filing Description:  
NAIC # 69108  
FEIN #37-0533090

RE: Informational Filing – Expanded Use of Form 1001565 b

Enclosed for your information is a description of the expanded use of the following individual life insurance form.

|            |   |
|------------|---|
| Form #,    | Form Name   |
| 1001565 b, | Supplemental Application for Accelerated Death Benefit for Long-Term Care Rider |

Form 1001565 b is the supplemental application that is used to apply for benefit rider form 10220-04. Form 1001565 b was approved by your Department on March 29, 2010 under SERFF tracking number STFL-126451532 and is used in connection with the approved base policy’s application form 1004522 AR, which was approved by your Department on May 8, 2012 under SERFF tracking number STFL-128169578.

Supplemental application form 1001565 b is used with benefit rider form 10220-04, Accelerated Death Benefit for Long-Term Care Rider, which was approved by your Department on March 29, 2010 under SERFF tracking number STFL-126451532. The benefit rider form is attached to base policy form 11030-04 which was approved by your Department on April 5, 2011 under SERFF tracking number STFL-126971519.

The expanded use of application form 1001565 b includes completion through the following distribution channels:

- Customer visiting an Agent’s office;
- Customer completing the online application through www.Statefarm.com; or
- Customer completing the application by telephoning a State Farm Call Center agent or licensed insurance producer.

In all cases, a copy of the completed life application and supplemental application (when applicable) are included in the policy.

#### COMPLETING AN APPLICATION THROUGH AN AGENT

Application form 1001565 b can be completed on paper or electronically in an agent’s office. The application must be completed by a licensed State Farm agent or a licensed member of the agent’s staff. The electronic application is accessed through our internal State Farm system. Information included in the electronic application is identical to the questions and information requested on the paper application. Responses to those questions will be printed on the paper application.

|                             |  |                          |   |
|-----------------------------|--|--------------------------|---|
| <b>SERFF Tracking #:</b>    | STFL-128171138   | <b>State Tracking #:</b> | <b>Company Tracking #:</b> SFL-AR-1001565 B |
| <b>State:</b>               | Arkansas   | <b>Filing Company:</b>   | State Farm Life Insurance Company           |
| <b>TOI/Sub-TOI:</b>         | L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life |                          |   |
| <b>Product Name:</b>        | FCB Supplemental Application Informational Filing                            |                          |   |
| <b>Project Name/Number:</b> | FCB Supplemental Application Informational Filing/SFL-AR-1001565 b           |                          |   |

## CUSTOMER COMPLETING APPLICATION ONLINE

Application 1001565 b can also be completed online by the customer. If the customer is interested in applying for coverage they may do so by applying through our company website, [www.statefarm.com](http://www.statefarm.com).

The customer will complete a Quote through our company website. Before proceeding, the customer will be asked if they agree to completing the application and transacting with the company electronically. If they do not agree, they will be instructed to visit a State Farm agent's office. If they agree to continue electronically, they can continue with the online application. If the person completing the online application is a current State Farm customer, then some demographic information will be retrieved. If the person completing the online application is not a current State Farm customer, they may complete a quote anonymously. If at any time they want to save that Quote, we will ask them to establish an account. We will ask a series of unique questions to authenticate the identity of the customer. Once customer identification has been verified, the customer will be asked if the policy being applied for will replace an existing policy. If a replacement is indicated, the customer will be instructed to visit an agent's office to complete the application and the required replacement forms. If the application does not involve a replacement, the customer can continue through the online submission process.

The customer will be given the option to electronically sign the application using a digital signature solution or they can print the application, physically sign it, and mail the completed application to the Company.

The following explanation addresses the electronic handling of the application when applied for through [www.statefarm.com](http://www.statefarm.com):

- Information included in the electronic application is identical to the questions and information requested on the paper application. Responses to those questions will be printed on the paper application.
- The customer will be provided with the appropriate disclosure and will be asked if they consent to electronically sign the application. If the customer agrees, they will be asked to review the application. A tab will appear in the signature area(s) of an electronic version (PDF) of the application to indicate where signatures are needed and to navigate the customer through the signature ceremony.
- When the customer indicates they are ready to sign, they will be asked to type in their name and choose a style that will convert their name to a handwritten signature or if device type allows, the customer will be able to choose to write/draw their signature instead of using a chosen stylized signature.
- The customer will then apply the signature in each required location.
- Once all signatures are applied the customer will be presented with a confirmation message. When the customer confirms, the signature is permanently associated with the application, which completes the signature ceremony.
- When the confirm signature step is completed, the signature software will capture signature data such as date signed, time signed (timestamp), and Internet Protocol (IP) address to uniquely identify the signature and the form and ensure that the application can no longer be altered.
- The completed application will then be stored electronically by State Farm and an electronic copy of the signed application will be made available to the customer that they can store electronically or print a paper copy.
- Once the electronic signature is applied, the signature is no longer accessible. The signature ceremony relies on the identity authentication and will only allow that individual to apply a signature to the application.

If the customer electronically signs the application, they will be asked if they wish to apply a payment at time of application. If they wish to pay later, the application will be submitted and payment will be collected after the application is underwritten but prior to the policy being issued. All documents will be available for viewing by the customer through their online account once the application has been submitted.

## APPLICATION COMPLETED BY AN AGENT OR LICENSED INSURANCE PRODUCER AT A STATE FARM CALL CENTER

State: Arkansas Filing Company: State Farm Life Insurance Company  
 TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life  
 Product Name: FCB Supplemental Application Informational Filing  
 Project Name/Number: FCB Supplemental Application Informational Filing/SFL-AR-1001565 b

The customer can call a State Farm Call Center to have an agent or licensed insurance producer complete Application form 1001565 b. The agent or licensed insurance producer will ask the customer if he or she agrees to transact with the Company electronically. The response to this question will determine if the company can electronically communicate with the customer or will need to use traditional mail. If the customer agrees to electronic transactions with the Company, then the call center application process will continue. If the customer is a current State Farm customer, then some demographic information will be retrieved. If the customer is not a current State Farm customer, then an account will be established.

As part of the application call center process, we will ask a series of unique questions to authenticate the identity of the customer. Once identification has been verified, the licensed insurance producer will provide the customer with product information by means of a quote or an illustration. The customer will then be asked underwriting and beneficiary information questions. Once the application is complete, the agent or licensed insurance producer will print and sign the application and any supporting documents and mail the application and supporting documents to the customer for their review and signatures. After signing all required documents, the customer will mail the signed documents back to the Company.

Replacement situations are identified by the replacement question found in the application. If the replacement question is answered "yes", a state mandated replacement form (Important Notice: Replacement of Life Insurance or Annuities) must be completed by the applicant and submitted with the application. A separate signed statement as to whether or not an agent knows a replacement is or may be involved in the transaction is accomplished in the Agent's Statement.

The expanded use of this form will be marketed to the general public and will be effective March 13, 2013.

## Company and Contact

### Filing Contact Information

Maureen Macak, Tech - Contracts & Compliance  
 maureen.macak.ljrd@statefarm.com  
 1 State Farm Plaza  
 Bloomington, IL 61710-0001  
 309-763-2341 [Phone]  
 309-766-8483 [FAX]

### Filing Company Information

State Farm Life Insurance Company  
 1 State Farm Plaza  
 Bloomington, IL 61710-0001  
 (309) 766-4541 ext. [Phone]  
 CoCode: 69108  
 Group Code: 176  
 Group Name: 69108  
 FEIN Number: 37-0533090  
 State of Domicile: Illinois  
 Company Type:  
 State ID Number:

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50.00 per informational filing x 1 informational filing = \$50.00  
 Per Company: No

| Company                           | Amount  | Date Processed | Transaction # |
|-----------------------------------|---------|----------------|---------------|
| State Farm Life Insurance Company | \$50.00 | 07/12/2012     | 60828203      |

|                             |  |                          |                                   |                            |                  |
|-----------------------------|--|--------------------------|-----------------------------------|----------------------------|------------------|
| <b>SERFF Tracking #:</b>    | STFL-128171138   | <b>State Tracking #:</b> |                                   | <b>Company Tracking #:</b> | SFL-AR-1001565 B |
| <b>State:</b>               | Arkansas   | <b>Filing Company:</b>   | State Farm Life Insurance Company |                            |                  |
| <b>TOI/Sub-TOI:</b>         | L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life |                          |                                   |                            |                  |
| <b>Product Name:</b>        | FCB Supplemental Application Informational Filing                            |                          |                                   |                            |                  |
| <b>Project Name/Number:</b> | FCB Supplemental Application Informational Filing/SFL-AR-1001565 b           |                          |                                   |                            |                  |

## Correspondence Summary

### Dispositions

| Status                              | Created By | Created On | Date Submitted |
|-------------------------------------|------------|------------|----------------|
| Accepted For Informational Purposes | Linda Bird | 07/18/2012 | 07/18/2012     |

|                             |  |                          |                                   |                            |                  |
|-----------------------------|--|--------------------------|-----------------------------------|----------------------------|------------------|
| <b>SERFF Tracking #:</b>    | STFL-128171138   | <b>State Tracking #:</b> |                                   | <b>Company Tracking #:</b> | SFL-AR-1001565 B |
| <b>State:</b>               | Arkansas   | <b>Filing Company:</b>   | State Farm Life Insurance Company |                            |                  |
| <b>TOI/Sub-TOI:</b>         | L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life |                          |                                   |                            |                  |
| <b>Product Name:</b>        | FCB Supplemental Application Informational Filing                            |                          |                                   |                            |                  |
| <b>Project Name/Number:</b> | FCB Supplemental Application Informational Filing/SFL-AR-1001565 b           |                          |                                   |                            |                  |

## Disposition

Disposition Date: 07/18/2012

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

| Schedule            | Schedule Item   | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification  |                      | Yes           |
| Supporting Document | Application   |                      | Yes           |
| Supporting Document | Health - Actuarial Justification  |                      | No            |
| Supporting Document | Outline of Coverage   |                      | Yes           |
| Supporting Document | Information Only - Expanded Use of Form 1001565 b - Supplemental Application for Accelerated Death Benefit For Long-Term Care Rider |                      | Yes           |

|                             |  |                          |                                   |                            |                  |
|-----------------------------|--|--------------------------|-----------------------------------|----------------------------|------------------|
| <b>SERFF Tracking #:</b>    | STFL-128171138   | <b>State Tracking #:</b> |                                   | <b>Company Tracking #:</b> | SFL-AR-1001565 B |
| <b>State:</b>               | Arkansas   | <b>Filing Company:</b>   | State Farm Life Insurance Company |                            |                  |
| <b>TOI/Sub-TOI:</b>         | L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life |                          |                                   |                            |                  |
| <b>Product Name:</b>        | FCB Supplemental Application Informational Filing                            |                          |                                   |                            |                  |
| <b>Project Name/Number:</b> | FCB Supplemental Application Informational Filing/SFL-AR-1001565 b           |                          |                                   |                            |                  |

## Supporting Document Schedules

|  |   | Item Status: | Status Date: |
|--|---|--------------|--------------|
| Satisfied - Item:                            | Flesch Certification  |              |              |
| Comments:                                    | Please see the attached Readability Certification. This is the same Readability Certification that was submitted when form 1001565 b was originally approved by your Department. This Certification is being submitted for informational purposes to show that no changes have been made to form 1001565 b. |              |              |
| Attachment(s):                               |   |              |              |
| 1001565 b - AR Readability Certification.pdf |   |              |              |

|                   |                                | Item Status: | Status Date: |
|-------------------|--------------------------------|--------------|--------------|
| Satisfied - Item: | Application                    |              |              |
| Comments:         | Not applicable to this filing. |              |              |

|                   |                                | Item Status: | Status Date: |
|-------------------|--------------------------------|--------------|--------------|
| Satisfied - Item: | Outline of Coverage            |              |              |
| Comments:         | Not applicable to this filing. |              |              |

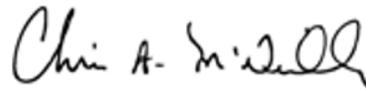
|   |   | Item Status: | Status Date: |
|---|---|--------------|--------------|
| Satisfied - Item:   | Information Only - Expanded Use of Form 1001565 b - Supplemental Application for Accelerated Death Benefit For Long-Term Care Rider   |              |              |
| Comments:   | Please see the attached form 1001565 b (Supplemental Application for Accelerated Death Benefit for Long-Term Care Rider) which was approved by your Department on March 29, 2010 under SERFF tracking number STFL-126451532.<br><br>Please note that NO changes have been made to this form – the purpose of this filing is to expand the use of this form. |              |              |
| Attachment(s):  |   |              |              |
| 1001565 b - Supplemental Application for Accelerated Death Benefit for Long-Term Care Rider.pdf |   |              |              |

**STATE FARM LIFE INSURANCE COMPANY**

**READABILITY CERTIFICATION**

This is to certify that the attached forms listed below have achieved the minimum Flesch Reading Ease Score required by your state.

| <u>TITLE</u>  | <u>FORM NUMBER</u> | <u>FLESCH SCORE</u> |
|---|--------------------|---------------------|
| Accelerated Death Benefit for Long-Term Care Rider                              | 10220-04           | 50                  |
| Supplemental Application for Accelerated Death Benefit for Long-Term Care Rider | 1001565 b          | 50                  |
| Binding Receipt   | 1002483            | 52                  |
| Children's Term Life Insurance Benefit Rider                                    | 10141              | 59                  |
| Guaranteed Insurability Option Benefit Rider                                    | 10251              | 52                  |



Signature: \_\_\_\_\_

Chris A. McNeilly  
Assistant Secretary

Date: March 18, 2010



## Supplemental Application for Accelerated Death Benefit for Long-Term Care Rider

(Questions are for Proposed Insured 1)

**NOTE: Any monthly benefit paid under this Rider will reduce the total death benefit payable under the Policy. The Monthly Benefit is determined at the time of claim and will not exceed the lesser of 2% of the death benefit or the amount determined by application of the per diem limit in effect under the Internal Revenue Code.**

**Rider Benefits may be taxable. You should consult your personal tax advisor. This Rider is not approved for Medicaid asset protection under state Long-Term Care Partnership Programs.**

**SECTION ONE** If any question in Section One is answered "Yes," Proposed Insured 1 is ineligible for this Rider and this Supplemental Application should not be submitted.

- |   | Yes                       | No                                   |
|---|---------------------------|--------------------------------------|
| 1. Due to any present or past mental or physical disability, is any person or institution currently authorized to act on your behalf?                                     | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| 2. Are you bedridden at home or confined in a hospital, nursing home, or long term care facility?   | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| 3. For any "Yes" answers to the questions below, check all that apply:  |                           |                                      |
| a. Do you use a: <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> motorized cart <input type="checkbox"/> quad (4-prong) cane | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| b. Do you use any medical appliance such as: <input type="checkbox"/> catheter <input type="checkbox"/> oxygen equipment <input type="checkbox"/> dialysis machine        | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| c. Do you require help or supervision, or are you limited in any way in performing the following daily activities:  | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| <input type="checkbox"/> bathing <input type="checkbox"/> mobility <input type="checkbox"/> managing medications  |                           |                                      |
| <input type="checkbox"/> dressing <input type="checkbox"/> toileting <input type="checkbox"/> eating  |                           |                                      |
| d. Have you ever been diagnosed as having or have you received medical advice or treatment for:   | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> ALS (Lou Gehrig's disease)                              |                           |                                      |
| <input type="checkbox"/> dementia <input type="checkbox"/> muscular dystrophy <input type="checkbox"/> Huntington's disease   |                           |                                      |
| <input type="checkbox"/> recurrent memory loss <input type="checkbox"/> Parkinson's disease   |                           |                                      |
| 4. Are you receiving any type of disability benefits?   | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |

**SECTION TWO** Explain any "Yes" answers.

- |   | Yes                       | No                                   |
|---|---------------------------|--------------------------------------|
| 5. Within the past 12 months have you been hospitalized; or have you had, been scheduled for, or discussed with a medical practitioner the possible need for surgery? | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| 6. Do you have any family history (parent or grandparent) of Alzheimer's disease diagnosed prior to age 70?   | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| 7. Have you ever taken or been recommended to take a cognitive screening test?  | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |
| 8. Have you received Medicare benefits prior to age 65?   | [ <input type="radio"/> ] | [ <input checked="" type="radio"/> ] |

**Explanations** (include appropriate question number and date of occurrence):

If space below is insufficient, use additional sheets which will be part of this Supplemental Application. Sheets must be signed & dated by Proposed Insured 1 and/or Applicant, and witnessed by Agent.

**SECTION THREE Other Insurance**

- Yes No
9. Do you now have in force or are you applying for any traditional long-term care, nursing home, or home health care policy, rider, or certificate (including a health care service contract or a health maintenance organization contract)? [   ]
10. Other than above, did you have a traditional long-term care policy, rider, or certificate in force during the last 12 months? [   ]
11. Are you covered by Medicaid? [   ]
12. If the answer to question 9 is “**Yes**”, do you intend to replace that policy, rider, or certificate with this policy? [   ]

**Agent: If yes, and the other coverage is in force, complete the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance.**

List details below for any “**Yes**” answers in questions 9, 10 and 11:

| Name and address of company(ies) | Lapsed                   | When?<br>(mm-dd-yyyy) | Applied<br>For           | In<br>Force              | Policy Number, Type and Amount of Benefits |
|----------------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--|
|                                  | <input type="checkbox"/> |                       | <input type="checkbox"/> | <input type="checkbox"/> |  |
|                                  | <input type="checkbox"/> |                       | <input type="checkbox"/> | <input type="checkbox"/> |  |

13. **Agent: List any other health insurance policies you have sold to the applicant:**

a. List policies sold that are still in force. (If none, indicate none.)

b. List policies sold in the last (5) years that are no longer in force. (If none, indicate none.)

**SECTION FOUR Protection Against Unintended Lapse**

**THIS SECTION IS TO BE COMPLETED BY PROPOSED INSURED 1 OR THE APPLICANT, IF OTHER THAN PROPOSED INSURED 1. YOU HAVE THE RIGHT TO DESIGNATE A THIRD PARTY TO RECEIVE NOTICE OF OUR INTENT TO TERMINATE THE POLICY FOR NONPAYMENT OF PREMIUM.**

I understand that I have the right to designate others to receive notice of lapse or termination of the life insurance policy with an accelerated death benefit for long term care rider for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

I elect **NOT** to designate another person to receive such notice.

I designate Proposed Insured 1 to receive notice prior to cancellation of the policy for nonpayment of premium.

I designate the following person or entity, other than Proposed Insured 1, to receive notice prior to cancellation of the policy for nonpayment of premium.

Full Name

Address

|      |       |     |                  |
|------|-------|-----|------------------|
| City | State | ZIP | Telephone Number |
|------|-------|-----|------------------|

To add, remove, or change the person designated, please contact your State Farm® agent.

**SECTION FIVE Supplemental Agreements**

Proposed Insured 1 or Applicant, if other than Proposed Insured 1, states that information in the Supplemental Application and any medical history is true and complete.

**CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind the Policy or this Rider.**

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

I certify that I have received the Outline of Coverage, Long-Term Care Insurance Potential Rate Increase Disclosure, and Replacement Notice (if applicable).

Date Signed [October 15, 2010] Signature of Proposed Insured 1  [ John J. Doe ]  
(month/day/year)

at [Bloomington, MD]  
(City) (State)

**SAMPLE**

Signature of Agent as Witness to all Signatures  [ Mark Smith ]

Signature of Applicant  [ Jane A. Doe ]

*Not required unless applicant is other than the Proposed Insured 1.*