

**State:** Arkansas      **Filing Company:** United Home Life Insurance Company

**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other

**Product Name:** 200-724

**Project Name/Number:** /

## Filing at a Glance

Company: United Home Life Insurance Company

Product Name: 200-724

State: Arkansas

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

Date Submitted: 07/12/2012

SERFF Tr Num: UFFL-128562618

SERFF Status: Closed-Approved-Closed

State Tr Num:

State Status: Approved-Closed

Co Tr Num: 200-724

Implementation: 12/01/2012

Date Requested:

Author(s): Karen Hynes

Reviewer(s): Linda Bird (primary)

Disposition Date: 07/16/2012

Disposition Status: Approved-Closed

Implementation Date:

State Filing Description:

State: Arkansas Filing Company: United Home Life Insurance Company  
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
Product Name: 200-724  
Project Name/Number: /

## General Information

Project Name: Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments: Filed concurrently with Indiana, our state of domicile.  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 07/16/2012  
State Status Changed: 07/16/2012  
Deemer Date: Created By: Karen Hynes  
Submitted By: Karen Hynes Corresponding Filing Tracking Number:

### Filing Description:

Attached please find the form referenced below for your review and approval. The requested implementation date of the form included in this submission is the later of your approval or December 1, 2012.

Form 200-724 12-12 (AR) is an application for reinstatement that will be used to apply for reinstatement of coverage for products and riders currently on file with your department and those that may be filed at a later date. The application is new and replaces form 200-638 3-09 (AR) previously approved by your department April 12, 2010.

The main differences between the form enclosed and that previously approved are, as required by MIB, Inc., we added language to the Authorizations on page 2 to obtain the applicant's consent to report personal health information to MIB. Additionally, we removed "or formerly known as Medical Information Bureau," from the second paragraph of the notice on page 4.

We reserve the right to make any typographical corrections or make minor revisions to the appearance of the form due to printing constraints.

If you have any questions or need any additional information, please feel free to contact me via SERFF, at 317-692-7465 or by email at Karen.Hynes@infarmbureau.com.

## Company and Contact

### Filing Contact Information

Karen Hynes, karen.hynes@infarmbureau.com  
225 S East 317-692-7465 [Phone]  
Indianapolis, IN 46202

### Filing Company Information

United Home Life Insurance CoCode: 69922 State of Domicile: Indiana  
Company Group Code: Company Type: LAH  
225 S. East St. Group Name: State ID Number:  
Indianapolis, IN 46202 FEIN Number: 35-0841899  
(317) 692-7465 ext. [Phone]

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**State:** Arkansas      **Filing Company:** United Home Life Insurance Company

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## Filing Fees

Fee Required?                      Yes  
Fee Amount:                        \$50.00  
Retaliatory?                        No  
Fee Explanation:                  AR imposes a filing fee of \$50 per form.  
Per Company:                        No

<b>Company</b>	<b>Amount</b>	<b>Date Processed</b>	<b>Transaction #</b>
United Home Life Insurance Company	\$50.00	07/12/2012	60842497

<b>SERFF Tracking #:</b>	UFFL-128562618	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	200-724
<b>State:</b>	Arkansas	<b>Filing Company:</b>	United Home Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other				
<b>Product Name:</b>	200-724				
<b>Project Name/Number:</b>	/				

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/16/2012	07/16/2012

<b>SERFF Tracking #:</b>	UFFL-128562618	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	200-724
<b>State:</b>	Arkansas	<b>Filing Company:</b>	United Home Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other				
<b>Product Name:</b>	200-724				
<b>Project Name/Number:</b>	/				

## Disposition

Disposition Date: 07/16/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Application for Reinstatement		Yes

<b>SERFF Tracking #:</b>	UFFL-128562618	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	200-724
<b>State:</b>	Arkansas	<b>Filing Company:</b>	United Home Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other				
<b>Product Name:</b>	200-724				
<b>Project Name/Number:</b>	/				

## Form Schedule

Lead Form Number: 200-724 12-12 (AR)							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1		200-724 12-12 (AR)	AEF	Application for Reinstatement	Initial:	50.100	200-724 - AR - 12-12.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

# Application for Reinstatement

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

Policy Number	Proposed Insured	Spouse (If spouse coverage)
Premium Collected	Mode/Method of Payment	Home Office Use Only

I hereby apply for Reinstatement.

As an inducement to the Company to approve this application, I agree that:

- a. The statements and answers in this application are true and complete.
- b. No insurance will be in force until this application is approved:
  1. during the lifetime and sound health of the proposed insured; and
  2. also during the lifetime and sound health of the spouse and the children, if they are covered under the policy or any rider being reinstated.
- c. Approval of this application will be void if at any time within two years from the approval date any of the statements or answers are found to be untrue.
- d. If approved:
  1. this application, along with the original application, will become part of the policy described above; and
  2. a copy will be returned to the policyowner to attach to the policy.

**If Spouse coverage, complete 1a and 2a.**

1. Proposed Insured's Occupation	2. Exact Height - Weight Ft. In. Lbs.	Has weight changed more than 10 lbs. in past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount of increase _____ decrease _____	Date of Birth
1. a. Spouse's Occupation	2. a. Exact Height - Weight Ft. In. Lbs.	Has weight changed more than 10 lbs. in past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount of increase _____ decrease _____	Date of Birth

The representations made below apply to **EACH PERSON** who would be insured under the policy, including any riders, if reinstated. These individuals include: the insured; any person other than the insured on whose death the premiums would be waived; the insured's spouse or children; and any other individual covered by the stated policy.

3. Since the date of the original application has any proposed insured:	
a. Had any consultation or treatment by a member of the medical profession, physician or practitioner, examination in a clinic, hospital, dispensary, or sanitarium; any surgical operation, x-ray, electrocardiogram, or other tests, or been told there is a need for them?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Had or been told they have any disease, illness, impairment or injury, either physical or mental, by a member of the medical profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Been exempted or discharged as unfit from military service; applied for any kind of disability compensation; or had an application for life or health insurance: declined; postponed; limited; or issued other than as applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Engaged in or contemplate engaging in scuba or sky diving, racing, or other hazardous sports; or made or contemplate making flights as a pilot or student pilot?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Had a driver's license revoked or suspended or been convicted of a felony; sought or received advice, counseling or treatment by a member of the medical profession for the abuse of alcohol or drugs; used (other than as prescribed by a member of the medical profession) narcotics, cocaine, heroin, amphetamines, barbiturates, hallucinogens, or marijuana; used alcohol to the point of intoxication on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Used any nicotine products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details of "Yes" answers to any questions:

**\*\*\*WARNING\*\*\***

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.

Dated at _____	this				
		Month	Day	Year	
<b>X</b>		<b>X</b>			
Signature of Agent			Signature of Proposed Insured		
<b>X</b>		<b>X</b>			
Signature of Witness, if Agent not Present			Signature of Spouse		
		<b>X</b>			
Current Address of Payor			Signature of Owner – If Other Than Proposed Insured		
		<b>X</b>			
City/State/Zip of Payor			Signature of Owner – If Other Than Proposed Insured		
Social Security Number of Insured/Owner					

**AUTHORIZATION**

I hereby authorize any: licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; insurance company; MIB, Inc. ("MIB"); or other organization, institution or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I further authorize United Home Life Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that I am giving permission to release medical information which may include treatment of: physical and/or emotional illness; communicable diseases; alcohol or drug abuse treatment; and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is reinstated.

	<b>X</b>	
Date		Signature of Proposed Insured (Required on proposed insureds age 15 and up)

**AUTHORIZATION**

I hereby authorize any: licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; insurance company; MIB, Inc. ("MIB"); or other organization, institution or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I further authorize United Home Life Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that I am giving permission to release medical information which may include treatment of: physical and/or emotional illness; communicable diseases; alcohol or drug abuse treatment; and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is reinstated.

	<b>X</b>	
Date		Signature of Owner

**AUTHORIZATION**

I hereby authorize any: licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; insurance company; MIB, Inc. ("MIB"); or other organization, institution or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I further authorize United Home Life Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that I am giving permission to release medical information which may include treatment of: physical and/or emotional illness; communicable diseases; alcohol or drug abuse treatment; and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is reinstated.

	<b>X</b>	
Date		Signature of Spouse



**FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE**

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., a non-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.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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 Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) 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](http://www.mib.com).

I declare that I have read and understand the above notice.

Dated at _____	X	
this _____		<b>Signature of Proposed Insured</b>
Month                    Day                    Year	X	(Required on proposed insureds age 15 and up.)
X		<b>Signature of Spouse</b>
	X	<b>Signature of Owner – If Other than Proposed Insured</b>
		<b>Signature of Agent</b>

**IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION**

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

<b>SERFF Tracking #:</b>	UFFL-128562618	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	200-724
<b>State:</b>	Arkansas	<b>Filing Company:</b>	United Home Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other				
<b>Product Name:</b>	200-724				
<b>Project Name/Number:</b>	/				

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability - Signed.pdf			



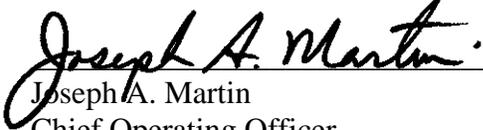
## CERTIFICATION

I hereby certify the following score(s) on the Flesch Reading Ease Test.

Form 200-724 12-12

50.1

Date: 7/11/2012

  
\_\_\_\_\_  
Joseph A. Martin  
Chief Operating Officer  
Senior Vice President, Life Operations  
United Home Life Insurance Company