

SERFF Tracking Number: ZUUG-128531271 State: Arkansas
Filing Company: Zurich American Life Insurance Company State Tracking Number:
Company Tracking Number: MULTI-STATE EE APP
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: Employee Application & EOI Form
Project Name/Number: Multi-State EE App & EOI Filing /Multi-State EE App

Filing at a Glance

Company: Zurich American Life Insurance Company

Product Name: Employee Application & EOI Form SERFF Tr Num: ZUUG-128531271 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: H11G.005 Combined Short Term and Long Term Co Tr Num: MULTI-STATE EE APP State Status: Approved-Closed

Filing Type: Form

Author: Jean Moriarity

Date Submitted: 06/29/2012

Reviewer(s): Rosalind Minor

Disposition Date: 07/02/2012

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Multi-State EE App & EOI Filing

Project Number: Multi-State EE App

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 07/02/2012

State Status Changed: 07/02/2012

Created By: Jean Moriarity

Corresponding Filing Tracking Number:

Filing Description:

Zurich American Life Insurance Company hereby submits for review and approval an Employee Application and Evidence of Insurability Form, ZALIC-EMAP-0001. This application will be used with the Group Insurance Policy, Group Term Life and Accidental Death and Dismemberment Certificate of Coverage and Benefits Schedule, and Group Long and Short Term Disability Certificates of Coverage and Benefits Schedules which were previously approved by your Department.

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 09/30/2012

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Jean Moriarity

Employees of Policyholders applying for our Group Term Life, Accidental Death and Dismemberment, and Group

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 Disability products will complete this application.

An explanation of variable material for the application is in the Supplemental Documentation tab of SERFF.

Please contact me at (215) 861-6812 if you have any questions or concerns or email me at jean.moriarity@zurichna.com.

Sincerely,

Jean M. Moriarity
 State Narrative:

Company and Contact

Filing Contact Information

Jean Moriarity, Director of Contract Development
 105 East 17TH Street
 New York, NY 10003
 jean.moriarity@zurichna.com
 917-534-4707 [Phone]

Filing Company Information

Zurich American Life Insurance Company
 1400 American Lane
 Schaumburg, IL 60196
 (847) 605-6000 ext. [Phone]
 CoCode: 90557
 Group Code: 212
 Group Name: Zurich North America
 State of Domicile: Illinois
 Company Type: Life and Annuity
 State ID Number:
 FEIN Number: 36-3050975

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50 / per form x 1 form = \$50
 The Retaliatory fee was also \$50.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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Zurich American Life Insurance Company \$50.00 06/29/2012 60581821

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/02/2012	07/02/2012

SERFF Tracking Number: *ZUUG-128531271* *State:* *Arkansas*
Filing Company: *Zurich American Life Insurance Company* *State Tracking Number:*
Company Tracking Number: *MULTI-STATE EE APP*
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.005 Combined Short Term and Long Term*
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Disposition

Disposition Date: 07/02/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanation of Variable Language	Approved-Closed	Yes
Form	Employee Application and Evidence of Insurability Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: ZALIC-EMAP-0001

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/02/2012	ZALIC-EMAP-0001	Application/Employee Enrollment Form	Application and Evidence of Insurability Form	Initial		50.000	ZALIC EMAP-0001_EE Application and EOI.pdf

[Zurich American Life Insurance Company]

[1400 American Lane

Schaumburg, Illinois 60196]

[Customer Service Toll Free Number: 1-XXX-XXX-XXXX

[Fax: 1-XXX-XXX-XXXX]

1[[Employee] Application For Group Insurance]

Completing Your Group Enrollment Form: Complete all information, and sign and date the form. All applications missing information be returned.

2

Application Type: New Hire Newly Eligible [Employee] Open Enrollment
 Annual Enrollment Life Status Change Increase not over the Guarantee Issue Amount]

3

Type of Insurance Requested: Term Life Insurance Long Term Disability Short Term Disability
 Accidental Death and Dismemberment]

Employer/Subsidiary _____ Billing Location _____

Address _____
Street City State Zip Code

Group Policy Number _____ Division _____ Class(es) _____

SECTION I: [EMPLOYEE] (APPLICANT) INFORMATION – Always Complete

Please print or type all information requested.

Employee Name (First, Middle, Last) _____

Home Address (Street/PO Box) Apt # _____ City/State _____ Zip Code _____

Home Phone Number _____ Basic Life Coverage _____ Date of Birth (mm/dd/yyyy) _____

Gender M F

Is [Employee] Actively at Work? Yes No Does [Employee] in the U.S.? Yes No

Job Title _____ Hire Date mm/dd/yyyy _____

\$ _____
Salary Annual Monthly Weekly Hourly

Scheduled Number of Work Hours per Week _____ Work Phone Number _____

SECTION II: Applicant Information – Complete only if applying for [employee] [,spouse*] [,or Domestic Partner**] [and dependents] requesting coverage.

	Names	Date of Birth Mm/dd/yyyy	Sex	Place of Birth
[EE]				
[SP*]4				
[DP**]4				
[CH]				
[CH]				
EE-Employee, [SP- Spouse*] [DP-Domestic Partner**][CH-Child]				

[SECTION III: Supplemental Life Insurance Amounts

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	Current Life Amount	Additional Life Amount Requested, Guaranteed Issue	Additional Life Amount Requested, Requiring Evidence of Insurability	Total Amount
[EE]	\$			
[SP*]	\$			
[DP**]	\$			
[CH 1]	\$			
[CH 2]	\$			

6 [Guaranteed Coverage Amount is only available for newly eligible [employees] (usually a new hire) and at such other times as identified and outlined in offering materials. Amount of insurance may be limited by state law.]

[SECTION IV: Accident Insurance

7

Supplemental Accidental Death [and Dismemberment] Benefits'

[I select the following insurance amount(s): [Employee] Benefit Amount Requested \$ _____]

Spouse] Domestic Partner] 100% of my benefit] 50% of my benefit] Children at [10%] of my benefit]]

[SECTION V: Beneficiary Designation

8

Term Life [and Accidental Death] Insurance Beneficiary Designation

To specify a beneficiary, complete the section below. [You will be your spouse's* beneficiary unless you specify otherwise.] When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

9

[Life [and Accidental Death] Insurance

Insured [Employee] Primary Beneficiary(ies)	Percentage	Date of Birth	Relationship
Insured [Employee] Contingent Beneficiary			

10

[Life [and Accidental Death] Insurance

Insured Spouse [or Domestic Partner] Primary Beneficiary(ies)	Percentage	Date of Birth	Relationship
Insured Spouse [or Domestic Partner] Contingent Beneficiary			

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Accidental Death Insurance Beneficiary Designation

Insured [Employee]	Primary Beneficiary	Percentage	Date of Birth	Relationship
Insured Spouse [or Domestic Partner]				

[SECTION VI: [Short Term] [and] [Long Term] Disability Insurance [(Employee Only)]

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To accept or waive coverage check the appropriate box and sign below.

[Voluntary Employee-Paid Coverage		Yes	No	Benefit Amount (% of Salary)	Employee Paid Coverage Amount
	Applicant	<input type="checkbox"/>	<input type="checkbox"/>		

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Applicant Agreement and Authorizations

- I accept the insurance coverage(s) chosen above.
- If I have declined coverage for Life Disability coverage. I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.
- [If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contribution in advance from wages due me, for remittance to the Company.]
- [I designate the beneficiary(ies) named on this form to receive the proceeds, if any, payable upon my death.] I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give the Company information about me. Such information will pertain to my employment or other insurance coverage.
- I understand that my insurance will not go into effect unless I am actively at work on the effective date. [I also understand that coverage for each of my eligible dependents, if any, will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment.] The conditions for the requested insurance to be effective are described in the [Group Insurance Policy] and Certificate of [Coverage]]. The approval of this request by the Insurance Company is one of those conditions.
- I hereby certify that to the best of my knowledge and belief, all written statements I have given are true and complete.

Applicant's Signature **Date**

IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM]

[Health Questionnaire/Evidence of Insurability Form]

[IMPORTANT]

Complete each section that follows if it is needed for the coverage you selected. Each section states when it is needed. Read the Agreements and Authorization. Sign and date the form in the space provided and retain a copy for your records.]

[Section VII [This section is needed when applying for [Life] [and] [Disability] Insurance.]

[Complete the Employee information in this section if you are:

- Applying for Life insurance for yourself that is greater than the guaranteed amount, or if
- Applying for Life and/or Disability Insurance for you [more than [31-180] days after you were eligible for the insurance.]

Complete the spouse [domestic partner] and child(ren) information in this section if:

- Applying for Life Insurance for your spouse [or domestic partner,] and/or child(ren) that is greater than the guaranteed amount, or if
- Applying for Life Insurance for them more than [31-180] days after the spouse [or domestic partner,] or child is eligible for the Life Insurance.]

[You must also answer the questions in Sections VII if you are also applying for Disability Insurance.]

Within the last [1-10 years] have you (or any person applying for coverage) [ever] been:

- a) Diagnosed with any of the conditions shown in this Section.
- b) Told by a medical professional you have or may have any of the condition shown [in 1-20] below,] or
- c) Been treated by a medical professional for any of the conditions shown [in 1-20] below]?

	Complete as required for all underwritten coverage	EE	SP[DP]	Child
[1.]	High blood pressure(unless under control with a single medication), stroke, heart attack, chest pain, heart or valve surgery, coronary artery disease or other heart related problems??	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[2]	Atrial fibrillation, angina, heart murmur, congestive heart failure, cardiomyopathy, anemia, blood or circulatory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[3]	Cancer or Tumor (except basal cell carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[4]	Cirrhosis, hepatitis B or C, Crohn's disease or ulcerative colitis, gastrointestinal disorder (digestive or intestinal), ulcer or digestive problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[5]	Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[6]	Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease or any respiratory disease or lung problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[7]	Epilepsy, fainting, seizures, or chronic headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[8]	Arthritis, systemic lupus or other connective tissue disease, chronic fatigue syndrome, disc disease or joint replacements?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[9]	Diabetes [(excluding gestational or diet controlled)], kidney or urinary problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[10]	Brain Disorder or Nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[11]	Have you ever been treated or counseled for or been advised to seek treatment or counseling for the use of alcohol, drugs, or other substance or joined an organization for alcohol or drug dependence or abuse.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[12]	Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or its antibodies, AIDS Related Complex (ARC) or tested positive on an AIDS/HIV-related test?]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[13]	Alzheimer's Disease, Multiple Sclerosis, Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's disease, Huntington's Disease or Parkinson's Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

[14]	In the past [5-10] years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician.]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[15]	Have you had an injury or illness, received medical treatment or advice for an injury or illness not indicated above, or been hospitalized or had surgery within the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[16]	Have you ever filed for, received or been refused disability benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[17]	Have you ever had an application for life insurance declined, withdrawn, rated or modified in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[18]	Have you ever had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating under the Influence (OUI) conviction?]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[19]	Have you ever used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system within the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[20]	Indicate height and weight for each applicant. For additional applicants add below.	____ht ____wt	____ht ____wt	____ht ____wt

[Provide details to "Yes" answers below: (provide any additional details on separate page.

[Section VIII [Additional] [Q][q]uestions when applying for Disability Insurance.]

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Complete this section by checking the Yes or No box for each question if you [the employee] are applying for Disability Insurance [more than 31-60] days [after you are eligible for it].]

Within the last [1-10 years] have you (or any person applying for coverage) [ever] been:

- Told by a medical professional you have or may have any of the condition shown [in 1-9] below,] or
- Been treated by a medical professional for any of the conditions shown [in 1-9] below]?

		EE
[1.]	Any condition affecting hearing or vision, including any loss of sight or hearing or dizziness or vertigo?	<input type="checkbox"/> Yes <input type="checkbox"/> No
[2.]	Carpel Tunnel Syndrome; neck, back, knee or joint condition, strain, sprain or other type of injury	
[3]	Fibromyalgia, chronic pain, Chronic Fatigue, Irritable Bowel Syndrome (IBS), Multiple Sclerosis, or "Temporomandibular Joint (TMJ) Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
[4]	Received any form of physical therapy; been seen by a chiropractor or other non-MD medical practitioner or therapist for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
[5]	Seizure, convulsion, fainting, loss of consciousness, tremor, MS, MD, ALS, or any other nervous system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
[6]	Arthritis, gout, back, knee, joint pain, bone fracture, muscle disorder, Systemic lupus or other connective tissue disease or joint replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
[7]	Anxiety, mental or nervous disorder, depression, stress, Schizophrenia, psychosis, bipolar disorder or any psychological or emotional condition or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
[8]	In the past 12 months, other than colds, flu, normal pregnancy or vacation, have you taken off of work or taken vacation time due to an accident, sickness, back, knee, neck, shoulder, joint or muscular disorder.]	<input type="checkbox"/> Yes <input type="checkbox"/> No
[9]	Have you been diagnosed as pregnant within the past 10 months, or are you being treated for pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

[Provide details to "Yes" answers below: (provide any additional details on separate page.

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[Applicant's Name _____]

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Applicant Authorizations and Agreements

I have applied for insurance under a Group Life and/or Disability Policy issued by [Zurich American Life Insurance Company] (the Company). To assess whether I am eligible for this insurance, the Company may require that I authorize disclosure of a copy of my health information. This authorization is intended to comply with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand and agree that:

- ❖ [This request will be part of the [Group Insurance Policy] that provides the insurance.]
- ❖ [I may need to provide more medical information directly or through my medical providers.]
- ❖ [I may need to take medical tests and report the results to the Company.]
- ❖ [My eligible dependent may need to take medical tests. The results of those tests must be reported to the Company.]
- ❖ [I must report any change to my health that happens before the insurance is effective.]
- ❖ [I must report any change in the health of my eligible dependent for whom coverage is requested that happens before the insurance is effective.] [and]
- ❖ [Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.]

I hereby authorize and permit any [hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, reinsurers, the Medical Information Bureau (MIB), RXcheck, or any other person or organization (collectively "Releasers")] having information about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, [motor vehicle driving record,] of me [or my eligible dependents requesting coverage] within the last [5-10] years to disclose to the Company, its reinsurers, affiliates or its authorized agent, any such information for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. I accept that a copy of this Authorization is as valid as the original.

By signing this Authorization, I acknowledge that I understand and agree to the following:

1. That any agreements I have made to restrict disclosure of my health information do not apply to this Authorization;
2. That I am authorizing the Releasers to release and disclose my entire medical file, as described above without restriction.
3. That I and/or my authorized agent have the right to receive a copy of this authorization upon request.
4. That the information will be used to determine eligibility for insurance.
5. That my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.
6. This authorization is valid for [12-24] months from the date below, if not revoked sooner. I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Company's right to use the Authorization for contest of a claim, benefit or Policy in accordance with applicable law.
7. That if 1) the Company denies my request for coverage; and 2) the denial is based, in whole or in part, on health information obtained in connection with this Authorization, the Company will not release this information to me unless otherwise authorized by the Releasers, including my physician or other medical professionals that disclosed such information to the Company unless required by law.
8. That information provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Company is subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protect information except as permitted by those laws.)

To the best of my knowledge and belief, all written[, telephonic and electronic] information I gave is true and complete. I understand that my insurance will not go into effect unless [I am actively at work on the effective date.] [I also understand that coverage for each of my eligible dependents, if any, will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment.] The conditions for the requested insurance to be effective are described in the [Group Insurance Policy] and the Certificate of [Coverage]. The approval of this [request] by the Insurance Company is one of those conditions. I understand and agree that:

[Pre-Existing Condition Limitation] applies disability insurance only: I understand if I become insured, I will not receive benefits for a Pre-existing Condition, until I have been insured for [5 days -24 months][the Pre-existing Condition period as defined in the [enrollment materials] and Certificate, for my Disability coverage. A "Pre-existing Condition" means any Injury or Sickness for which expenses were incurred, medical treatment, care or services, including diagnostic measures, was received, prescription drugs or medicines were taken, within [5 day 12 months] before his or her most recent effective date of insurance.]

[Zurich American Life Insurance Company] will rely on the information provided in order to evaluate this application. If the answers provided are incorrect or untrue, the Company may deny benefits or rescind insurance.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I hereby certify that the above statements and answers are complete and true to the best of my knowledge and belief concerning the past and present state of the health and medical history of the person to whom the statement and answers relate.]

Sign Here _____ Date _____
Employee Signature

[Spouse [or Domestic Partner] Signature] Date _____

[* Residents of Indiana authorize within the last 5 years]

The Company may disclose the health information to their agents; employees and their representatives (collectively "Zurich American Life Insurance Company"; my entire Health Information. Health Information means the entire medical file. This includes, but is not limited to x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, medications and treatment notes, that relate to: 1) Pre-existing or current illnesses, sickness, disease, disabilities, disorders, accidents, injuries, or any other health conditions. 2) Confinements in hospitals, medical facilities, or medical clinics, 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners, 4) Drug use, alcohol use, or mental health information protected by Federal Law, 5)** Counseling or therapy. Health information also means information on the diagnosis and treatment of mental illness. But it excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose health information to the Company. The Company will use this information to underwrite my request for coverage: make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to any coverage I have applied for with Zurich American Life Insurance Company.

**** Residents of Virginia**, review this additional text: Authorization signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits remain valid no longer than 30 months from the date the authorization is signed in Authorizations signed for the purpose of collecting information in connection with a claim for accident and sickness benefits under an insurance policy remain valid for the entire term of the coverage of the policy. Authorizations signed for the purpose of collecting information in connection with a claim for any other benefits under an insurance policy remains valid for the duration of the claim.]

***** Residents of West Virginia**, item 5) above reads as follows: Counseling or therapy, except that no adverse underwriting decision shall be made because I have demonstrated AIDS-related concerns or have sought AIDS-related counseling (this does not apply to my seeking treatment and diagnosis for Acquired Immune Deficiency Syndrome).]

State Fraud Notice

21 [All states, except as listed below:

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 may be guilty of a crime and may be subject to fines and confinement in prison.]

[Maryland Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection, California law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

DC: 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.

Florida, Minnesota: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

Missouri: Suicide is no defense to payment of life insurance benefits, nor is suicide while insane a defense to payment of accidental death benefits, if any, under this policy where the policy is issued to a Missouri citizen, unless the insurer can show that the insured intended suicide when s/he applied for the policy, regardless of any language to the contrary in this policy.

New Mexico: Any person who knowing presents a false or fraudulent claim for a 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 civil fines and criminal penalties.

New Jersey: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

Ohio and Texas: : Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Pennsylvania and Kentucky: 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, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

SERFF Tracking Number: ZUUG-128531271 State: Arkansas
 Filing Company: Zurich American Life Insurance Company State Tracking Number:
 Company Tracking Number: MULTI-STATE EE APP
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
 Product Name: Employee Application & EOI Form
 Project Name/Number: Multi-State EE App & EOI Filing /Multi-State EE App

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	07/02/2012
Comments: Attached please find the Flesch Certification for the Employee Application and Evidence of Insurability Form included with this submission.		
Attachment: EE App & EOI Readability Cert_6-29-12.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	07/02/2012
Bypass Reason: The Employee Application and Evidence of Insurability Form is in the Form Schedule tab of this submission.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Explanation of Variable Language	Approved-Closed	07/02/2012
Comments: Attached please find the Explanation of Variability for the Employee Application and Evidence of Insurability Form.		
Attachment: ZALIC-EMAP-0001_EE Application & EOI EO.V.pdf		

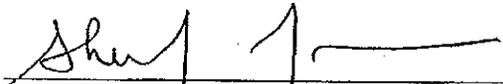
Zurich American Life Insurance Company

READABILITY CERTIFICATION

June 29, 2012

I hereby certify on behalf of Zurich American Life Insurance that the accuracy of the Flesch reading ease *test score for the following policy forms*. The forms are at least 10 (ten) point type, 2 (two) point leaded.

TITLE	FORM NUMBER	FLESCH SCORE
Employee Application and Evidence of Insurability Form	ZALIC-EMAP-0001	50.0



Sherif Zakhary
Vice President

**Zurich American Life Insurance Company
(Previously Kemper Investors Life Insurance Company)**

**Employee Application and Evidence of Insurability
Explanation of Variability**

Form ZALIC-EMAP-0001

Form ZALIC EMAP-0001 is submitted for approval and use with all state approved group term life, accidental death and dismemberment, and long and short term disability policies issued by Zurich American Life Insurance Company (ZALICO), previously Kemper Investors Life Insurance Company.

The application and EOI will be used with the following policy forms, certificates and benefits schedules:

Form Name	Description
1000 ZAGP-01-01, et al	Group Insurance Policy
2000 ZACERT-LTD-01-01, et al	Group Long Term Disability Certificate of Coverage
2000 ZASCH-LTD-01-01	Group Long Term Disability Benefits Schedule
3000 ZACERT-STD-01-01, et al	Group Short Term Disability Certificate of Coverage
3000 ZASCH-STD-01-01	Group Short Term Disability Benefits Schedule
4000 ZACERT-LF-01-01, et al	Group Term Life Insurance Plan with Accidental Death and Dismemberment Certificate of Coverage
4000 ZASCH-LF-01-01, et al	Group Term Life Insurance Plan with Accidental Death and Dismemberment Benefits Schedule

The application is intended to support:

- Initial requests for becoming insured for group life and/or group disability insurance;
- Requests for amounts of life insurance in excess of the guaranteed amount of insurance;
- Requests for changes in life or disability insurance that are subject to satisfaction of a medical evidence requirement; and
- Reinstatement of insurance.

The coverages subject to medical evidence questions via this application are Group Term Life and group Disability Income coverage.

This employee application was developed in a modular design to permit print- on-demand type applications, which will contain only the information relevant to the coverages purchased by the policyholder. The form may be used as an enrollment form, an evidence of insurability form only, or a combined enrollment form and evidence of insurability form.

The format of the enrollment section may be changed to accommodate a specific need of the group plan sponsor (e.g. the purpose of accommodating the plan sponsor's benefits system or payroll system.) The employee application will be used for basic life coverage, supplemental plans and disability plans. The application is a combined form, which includes:

1. An Employee Application/Enrollment Form for Group Life, Accident and Disability Plans;
2. A Beneficiary Designation Form for Life and Accidental Death benefits;
3. An Evidence of Insurability for Life and Disability Plans; and
4. Employee authorizations and agreements.

Example 1: if a life insurance only plan is purchased, only a life insurance application will print. If evidence of insurability (EOI) is required, only those questions relevant to life insurance coverage will be included on the EOI section of the application.

Example 2: if life and disability coverage is purchased, the application will contain the sections relevant to these plans. If evidence is not required, the Evidence of Insurability Section will not be included.

Each application will be completed to reflect the specific names of the policyholder and employee, the group policy number and the contract effective date applicable to each issued policy.

Standard Variable Material

Standard variable material identified in brackets consists of any items such as addresses, phone numbers, website addresses, eligible benefit amounts, percentages or time periods that will be revised to reflect the specific details of a policyholder's plan.

In addition, the common terms listed below are variable. They may not be relevant to all sections/subsections in the application. The terms do not have a corresponding EOV number or explanation other than what appears below. However, the terms do appear in variable brackets throughout the relevant sections/subsections. These general comments apply to the entire document.

Each variable and bracketed item listed in this section is subject to inclusion, omission or substitution as described in the specific variable explanations below. The application content will correspond to the particular coverage provided by the policyholder's plan of insurance, and will vary depending on the plan design.

For appearance purposes placement of material may vary to avoid gaps. Section numbers will be sequential and will change when a specific section is omitted. Connective words and phrases which serve the grammatical purpose of meaningful continuity may vary as sense may demand. Such connective wording will not be ambiguous or deceptive.

- The specific ZALICO corporate information included may be changed to reflect current addresses and contact numbers.
- References to 'class' may be changed to 'eligible groups', 'covered groups', 'covered classes' or any similar industry term.
- References to 'employee' may be changed to 'subscriber', 'enrollee', 'member', 'the insured', 'covered person', 'you', 'your', 'participant' or other appropriate term describing a member of the group insured.
- References to 'employer' may be changed to 'policyholder', 'plan sponsor', 'contract holder', 'member group', 'participant', 'Employer', or 'participating employer'. They may be used interchangeably when appropriate. We may also change the term to reflect the client's name.
- The term 'supplemental benefits' may be changed to 'Optional benefits', 'core buy-up benefits', 'voluntary benefits' or other similar industry terms.

- References to spouse, domestic partner or dependents will be omitted when such coverage is not provided.
- The term 'domestic partner' may be added alongside the 'spouse' option when domestic partners are also eligible for coverage.
- References to the 'Group Insurance Policy' may be changed to 'policy', 'group policy', 'group contract', 'group insurance contract' or other similar term to describe the policy.
- References to the 'Certificate of Coverage' may be changed to the 'Certificate' or 'Certificate of Insurance'.
- The term "division" may be changed to "unit" or another term to describe an internal department or a subsidiary/affiliate of the policyholder.

Specific Variable Material

Specific variable material is noted by subscripted numbers by variable text. Specific variable material will be changed only as indicated in the explanations shown below.

1. The title of this form may be any of the following or a title similar to any of the following: Evidence of Insurability Form, Evidence of Good Health, Application for Insurance, Request for insurance, Request for Change in Insurance, Request for Reinstatement, Reinstatement Application, Request for Reinstatement, the [ABC Company's Benefit Plan] Application for Insurance, Request for Increased Life Insurance, Request for Disability Insurance, Application for Disability Insurance, Application for Portability of Life Insurance, Change in Health Form, Proof of Insurability Form, Enrollment Application, Group Disability Evidence, Statement of Medical History, Continuation Form. When the policyholder's name is included on the form, it will not appear more prominently than the insurer's name.
2. The following applicant types may be included or omitted as relevant to the policyholder's eligibility options: Life Status Change, Annual Enrollment, Open Enrollment, and Increase over the Guarantee Issue Amount.
3. The application may include all types of insurance or only those coverages available for a specific policyholder. For example: a specific form may be created for late enrollees only which includes evidence of insurability, while a new hire or open enrollment form may not include evidence of insurability.

Section II - Applicant Information

4. References to spouse, domestic partner or dependents will be omitted when such coverage is not provided.

Section III - Life Insurance Coverage Amounts

5. This section will be included when the policyholder offers Life Insurance. It will be omitted if life insurance is not offered.
6. The bracketed statement regarding the Guarantee Coverage Amount may be omitted.

Section IV - Accident Insurance

7. This section will be included when supplemental accidental death and dismemberment benefits are available to the employee otherwise it will be omitted.

Section V - Beneficiary Designations

8. This Section will be omitted when only disability coverage is offered through this application.
9. Three beneficiary designation tables are shown. The first table will be included for 1) employee term life only plans; or 2) term life with accidental death employee plan.
10. The second table will be included when a spouse or domestic partner is eligible to elect life or life and accidental death benefits. This table will be omitted if spouse or domestic partner coverage is not provided by the plan.
11. The third table will included for 1) accidental death only plans; or 2) when the option to select separate beneficiaries for life benefits and accidental death benefits is offered to the employee or spouse; otherwise it will be omitted. When separate beneficiary charts are included, the Term Life Beneficiary Designation table 1 and the Accident Beneficiary Designation table 3 will be included of the application form.

Section VI - Short/Long Term Disability Insurance

12. This section will be included when Short and and/or Long Term Disability Insurance is offered by the policyholder. It will be omitted if disability insurance is not offered.

Applicant Agreements and Authorizations

13. Any bracketed statement is variable and is subject to inclusion or omission as relevant to the policyholder's plan and group insurance policy. For example, if contributions are not required, the authorization to deduct contributions will be omitted.

Health Questionnaire/Evidence of Insurability

14. This section will be included when evidence of insurability (EOI) is required as outlined in the certificate of coverage. Only the parts of the EOI relevant to the policyholder's plan will be included. Each of the health questions in sections VII and VIII are subject to inclusion or omission.

Section VII

15. This section may be omitted if life coverage is not provided or EOI questions 1-19 are not required. Reference to dependents will be omitted if dependent coverage is not provided. Reference to the disability questions in section VIII may be omitted.

The EOI will be utilized in multiple ways:

- 1) Any of the 19 questions may be included or omitted on the EOI for specific employer types, or classes of employees as determined by underwriting.
- 2) A simplified form will often be a standard EOI which will include a limited number of health questions, without use of the "provide details" section. A simplified form will generally include health questions 1, 3, 4, 6, 9, 11, 12, and 18 however, other questions may be included.

- 3) The "Provide Details" section on "yes" answers may be included or omitted.
- 4) The full list of questions will be included when required.
- 5) The questions in Section VII will be included when supplemental disability insurance is part of the plan

Section VIII - Disability Insurance Questions

16. Section VIII will be included when EOI is required for Disability Insurance. This section may be used for short term and/or long term disability.

This section may be omitted if disability coverage is not provided. The word "Additional" in the title will be omitted if a life plan is not offered and the questions in Section VII are omitted.

Reference to Section VII and late enrollment may be omitted.

Any bracketed question may be included or omitted.

17. The "Provide Details on "yes" answers may be included or omitted.

Applicant Authorizations and Agreements

18. Any of the authorizations may be included or omitted.
19. The life insurance pre-existing condition limitation will not be used for US employees. It is also non-standard for expatriate employees and will only be included in rare circumstances. The pre-existing condition limitation will be included if a pre-existing condition limitation applies to the plan. The look back period will reflect the Zurich standard of 3 months unless the policyholder's plan includes a longer or shorter look back period within the ranges shown and filed and approved in the state where the policy is issued.
20. The paragraphs for Virginia, Indiana and West Virginia will be included when policyholder is located in, or the policyholder employees are residents of these states.

State Fraud Notices

21. Each of the state specific state fraud notices may be included or omitted as appropriate for the employer and employee locations.