
State: Arkansas **Filing Company:** Woman's Life Insurance Society
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: AR - Applications - MIB
Project Name/Number: AR - Applications - MIB/

Filing at a Glance

Company: Woman's Life Insurance Society
Product Name: AR - Applications - MIB
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 07/30/2012
SERFF Tr Num: WLIC-128606203
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: On Approval
Date Requested:
Author(s): Deborah Bunch, Debra Matthews, Paul Bolek
Reviewer(s): Linda Bird (primary)
Disposition Date: 08/03/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas

Filing Company: Woman's Life Insurance Society

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

Product Name: AR - Applications - MIB

Project Name/Number: AR - Applications - MIB/

General Information

Project Name: AR - Applications - MIB

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 04/27/2012

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 08/03/2012

State Status Changed: 08/03/2012

Deemer Date:

Created By: Deborah Bunch

Submitted By: Deborah Bunch

Corresponding Filing Tracking Number:

Filing Description:

As you may be aware, MIB, Inc. (MIB) is requiring its members to include language in the authorization in their life applications specifically authorizing the insurer, or its reinsurers, to make a brief report regarding personal health information to MIB. An Explanation for Insurance Regulators prepared by MIB is included with this submission.

As a result of the MIB requirement, we are modifying the authorization in the following application forms to include the required MIB language and to update the reference to MIB (MIB Inc. & MIB rather than Medical Information Bureau). The added authorization language is one of the following, depending upon the application form:

- I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.
- I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information to MIB.
- I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of the health information of the Child proposed for insurance to MIB.

The above changes were accepted on 4-27-2012 by our state of domicile, Michigan, on an informational filing basis.

The application forms impacted are the following:

A1-91 Adult Application approved on 2/28/92

A18-91 Junior Application approved on 2/28/92

A100-96 Adult Application approved on 7/02/96

A180-96 Junior Application approved on 7/02/96

A210-00 AR Application for Certificate Changes approved on 9/09/04

I have included the authorization pages from the above applications with the new MIB language. I have also included a cross out/underlined version of the pages for your convenience. The form numbers for the impacted pages will be changed as follows:

Current Form Number Revised Form Number

A1-91 (pages 8 & 10) A1-91 5/12 (pages 8 & 10)

A18-91 (pages 8 & 10) A18-91 5/12 (pages 8 & 10)

A100-96 (back page) A100-96 5/12 (back page)

A180-96 (back page) A180-96 5/12 (back page)

A210-00 AR (page 9) A210-00 5/12 AR (page 9)

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: AR - Applications - MIB
Project Name/Number: AR - Applications - MIB/

Filing Company: Woman's Life Insurance Society

No other changes have been made to submitted pages.

Approval of this submission is respectfully requested. If, due to the nature of the change, submission of the pages for approval is not required, please consider this filing informational.

Company and Contact

Filing Contact Information

Paul Bolek, General Counsel
 1338 Military Street
 Port Huron, MI 48060
 pbolek@womanslife.org
 800-521-9292 [Phone] 156 [Ext]
 810-985-4137 [FAX]

Filing Company Information

Woman's Life Insurance Society	CoCode: 56170	State of Domicile: Michigan
1338 Military Street	Group Code:	Company Type: Fraternal
Port Huron, MI 48060	Group Name:	Benefit Society
(800) 521-9292 ext. 156[Phone]	FEIN Number: 38-1185570	State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

Company	Amount	Date Processed	Transaction #
Woman's Life Insurance Society	\$250.00	07/30/2012	61269931

SERFF Tracking #:

WLIC-128606203

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Woman's Life Insurance Society

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

AR - Applications - MIB

Project Name/Number:

AR - Applications - MIB/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/03/2012	08/03/2012

SERFF Tracking #:

WLIC-128606203

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Woman's Life Insurance Society

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

AR - Applications - MIB

Project Name/Number:

AR - Applications - MIB/

Disposition

Disposition Date: 08/03/2012

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		No
Supporting Document	Application		No
Supporting Document	Mark-ups		Yes
Supporting Document	Explanation For Insurance Regulators Regarding MIB's 2013 Authorization Change		Yes
Form	Adult Application		Yes
Form	Junior Application		Yes
Form	Adult Application		Yes
Form	Junior Application		Yes
Form	Application for Certificate Changes		Yes

State: Arkansas

Filing Company:

Woman's Life Insurance Society

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

Product Name: AR - Applications - MIB

Project Name/Number: AR - Applications - MIB/

Form Schedule

Lead Form Number: A1-91 5/12							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		A1-91 5/12	POLA	Adult Application	Initial:		A1-91 (5-12).pdf
2		A18-91 5/12	POLA	Junior Application	Initial:		A18-91 (5-12).pdf
3		A100-96 5/12	POLA	Adult Application	Initial:		A100-96 (5-12) (brackets).pdf
4		A180-96 5/12	POLA	Junior Application	Initial:		A180-96 (5-12) (brackets).pdf
5		A210-00 AR	POLA	Application for Certificate Changes	Initial:		AR A210-00 (5-12) (brackets).pdf

Form Type Legend:

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Woman's Life Insurance Society, its reinsurers and legal representatives may get medical and other information about me and any child listed on the application. This includes the right to get an investigative consumer report.

I authorize any:

physician; medical practitioner; hospital, clinic, or other medical or medically-related facility; Veterans Administration; insurer or reinsurer; the MIB, Inc. (MIB); consumer reporting agency or other insurance support organization; employer; or other person or entity,

that has knowledge or records of me, or any child listed on the application, as to:

age; character; finances; occupation and employment; other insurance; hazardous activities; physical or mental condition; or the medical care, advice, or treatment furnished with respect to any physical or mental condition,

to give such information to Woman's Life Insurance Society, its reinsurers and legal representatives. This includes any information as to use of and treatment for drugs or alcohol.

I know that this information will be used by Woman's Life Insurance Society to determine whether or not I or any such child is eligible for the insurance coverage applied for.

I know I can have a copy of this form. Anyone authorized to act for me can have one. This form will be valid for 2 years and 6 months. As to alcohol and drug information covered by federal regulation, this form may be revoked at any time by written notice to Woman's Life Insurance Society. But, any action taken before such notice is received by Woman's Life Insurance Society will be valid. A photocopy of this form shall have the same force as the original one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.

I have received the Fair Credit Reporting Act and MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Signed this _____ day of _____, 20_____

Signature of Proposed Insured

Signature of Payor (if Payor Benefit Requested)

Signature of Spouse (if Spouse Rider Requested)

AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS OR ACCOUNT DEBITS

Name of Depositor _____ (Print as it appears on Banking Institution records) _____ (Account or Code Number)

To _____ (Name of Banking Institution) _____ (Branch) _____ (Transit No.)

(Address of Banking Institution or Branch where account is maintained)

As a convenience to me, I authorize you to charge to my account (a) checks, (b) share drafts, (c) electronic fund transfer debits or (d) other account debits made by and payable to the order of, the Woman's Life Insurance Society, Port Huron, Michigan, provided there are sufficient funds in the account.

I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason, whether with or without cause, intentionally or inadvertently, you will not be under any liability even though dishonor results in the forfeiture of insurance.

I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation. You may end it earlier.

Request and Authorization Signatures

Date

Signature of Applicant

Date

Signature of Depositor
(If Joint Account, other Depositor must also sign)

To: The Bank named above. So that you may comply with the depositor's request as specified on the reverse side hereof this Society agrees in connection therewith:

- 1. To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, or electronic debit, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- 2. In the event that any such check, draft or order, or electronic debit shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
- 3. To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

The above is in accordance with Board of Trustees action dated August 1, 1989.

{ Christopher J. Martin }
NATIONAL PRESIDENT

Agreement:

As used in this Agreement and, if issued, the Conditional Receipt: "Society" means Woman's Life Insurance Society.

This application includes Part I and Part II.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application, are true and complete. They are correctly recorded. It is understood and agreed that:

(a) Any certificate issued as a result of this application, together with this application and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the [National President] or the [National Secretary] of the Society may make a contract on its behalf. No waiver or modification of a contract provision or any of the Society's rights or requirements shall be binding on it unless in writing signed by one of such officers. NEITHER THE REPRESENTATIVE (AGENT) WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER REPRESENTATIVE (AGENT), NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS ON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE SOCIETY'S RIGHTS OR REQUIREMENTS.

(b) The statements and answers in this application are made as the basis for any certificate issued on this application.

(c) Except as provided in the conditional receipt, if issued, with the same number as this application, no insurance shall take effect unless the certificate is delivered to and accepted by the Proposed Insured and the full first premium is paid and then only if my health and that of any other person to be covered by such certificate, as well as any other factor affecting insurability, is the same as set forth in this application.

(d) If the Society issues a certificate other than the one applied for, this application will be the application for the certificate thus issued. However, any change as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Proposed Insured.

(e) Any person accepted as a member shall be governed by the Society's Laws. This includes all later amendments to the Laws. Such person will seek to advance the welfare and progress of the Society.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Woman's Life Insurance Society, its reinsurers and legal representatives may get medical and other information about me and any child listed on the application. This includes the right to get an investigative consumer report.

I authorize any:

physician; medical practitioner; hospital, clinic, or other medical or medically-related facility; Veterans Administration; insurer or reinsurer; the MIB, Inc. (MIB); consumer reporting agency or other insurance support organization; employer; or other person or entity,

that has knowledge or records of me, or any child listed on the application, as to:

age; character; finances; occupation and employment; other insurance; hazardous activities; physical or mental condition; or the medical care, advice, or treatment furnished with respect to any physical or mental condition,

to give such information to Woman's Life Insurance Society, its reinsurers and legal representatives. This includes any information as to use of and treatment for drugs or alcohol.

I know that this information will be used by Woman's Life Insurance Society to determine whether or not I or any such child is eligible for the insurance coverage applied for.

I know I can have a copy of this form. Anyone authorized to act for me can have one. This form will be valid for 2 years and 6 months. As to alcohol and drug information covered by federal regulation, this form may be revoked at any time by written notice to Woman's Life Insurance Society. But, any action taken before such notice is received by Woman's Life Insurance Society will be valid. A photocopy of this form shall have the same force as the original one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.

I have received the Fair Credit Reporting Act and MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Woman's Life Insurance Society, its reinsurers and legal representatives may get medical and other information about me and the Child proposed for insurance. This includes the right to get an investigative consumer report.

I authorize any:

physician; medical practitioner; hospital, clinic, or other medical or medically-related facility; Veterans Administration; insurer or reinsurer; the MIB, Inc. (MIB); consumer reporting agency or other insurance support organization; employer; or other person or entity,

that has knowledge or records of me, or the Child proposed for insurance, as to:

age; character; finances; occupation and employment; other insurance; hazardous activities; physical or mental condition; or the medical care, advice, or treatment furnished with respect to any physical or mental condition,

to give such information to Woman's Life Insurance Society, its reinsurers and legal representatives. This includes any information as to use of and treatment for drugs or alcohol.

I know that this information will be used by Woman's Life Insurance Society in order to determine eligibility for the insurance coverage applied for.

I know I can have a copy of this form. Anyone authorized to act for me can have one. This form will be valid for 2 years and 6 months. As to alcohol and drug information covered by federal regulation, this form may be revoked at any time by written notice to Woman's Life Insurance Society. But, any action taken before such notice is received by Woman's Life Insurance Society will be valid. A photocopy of this form shall have the same force as the original one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of the health information of the Child proposed for insurance to MIB.

I have received the Fair Credit Reporting Act and MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Signed this _____ day of _____, 20_____

Signature of Parent

Signature of Payor (if Payor Benefit Requested)

AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS OR ACCOUNT DEBITS

Name of Depositor _____ (Print as it appears on Banking Institution records) _____ (Account or Code Number)

To _____ (Name of Banking Institution) _____ (Branch) _____ (Transit No.)

(Address of Banking Institution or Branch where account is maintained)

As a convenience to me, I authorize you to charge to my account (a) checks, (b) share drafts, (c) electronic fund transfer debits or (d) other account debits made by and payable to the order of, the Woman's Life Insurance Society, Port Huron, Michigan, provided there are sufficient funds in the account.

I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason, whether with or without cause, intentionally or inadvertently, you will not be under any liability even though dishonor results in the forfeiture of insurance.

I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation. You may end it earlier.

Request and Authorization Signatures

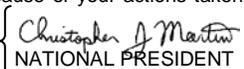
Date Signature of Applicant

Date Signature of Depositor

Date Signature of Parent
(Who signed Application)

Date Signature of other Depositor
(If Joint Account)

To: The Bank named above. So that you *may* comply with the depositor's request as specified on the reverse side hereof this Society agrees in connection therewith:
 1. To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, or electronic debit, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
 2. In the event that any such check, draft or order, or electronic debit shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
 3. To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.


 { Christopher J. Martin }
 NATIONAL PRESIDENT

The above is in accordance with Board of Trustees action dated August 1, 1989.

Agreement:

As used in this Agreement and, if issued, the Conditional Receipt: "Society" means Woman's Life Insurance Society.

This application includes Part I and Part II.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application, are true and complete. They are correctly recorded. It is understood and agreed that:

(a) Any certificate issued as a result of this application, together with this application and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the National President or the National Secretary of the Society may make a contract on its behalf. No waiver or modification of a contract provision or any of the Society's rights or requirements shall be binding on it unless in writing signed by one of such officers. NEITHER THE REPRESENTATIVE (AGENT) WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER REPRESENTATIVE (AGENT), NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS ON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE SOCIETY'S RIGHTS OR REQUIREMENTS.

(b) The statements and answers in this application are made as the basis for any certificate issued on this application.

(c) Except as provided in the conditional receipt, if issued, with the same number as this application, no insurance shall take effect unless the certificate is delivered and accepted and the full first premium is paid and then only if the Child's health and that of the Proposed Payor (if the Payor Benefit is requested), as well as any other factor affecting insurability, is the same as set forth in this application.

(d) If the Society issues a certificate other than the one applied for, this application will be the application for the certificate thus issued. However, any change as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Parent who signed this application.

(e) Any person accepted as a member shall be governed by the Society's Laws. This includes all later amendments to the Laws. Such person will seek to advance the welfare and progress of the Society.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Woman's Life Insurance Society, its reinsurers and legal representatives may get medical and other information about me and the Child proposed for insurance. This includes the right to get an investigative consumer report.

I authorize any:

physician; medical practitioner; hospital, clinic, or other medical or medically-related facility; Veterans Administration; insurer or reinsurer; the MIB, Inc. (MIB); consumer reporting agency or other insurance support organization; employer; or other person or entity,

that has knowledge or records of me, or the Child proposed for insurance, as to:

age; character; finances; occupation and employment; other insurance; hazardous activities; physical or mental condition; or the medical care, advice, or treatment furnished with respect to any physical or mental condition,

to give such information to Woman's Life Insurance Society, its reinsurers and legal representatives. This includes any information as to use of and treatment for drugs or alcohol.

I know that this information will be used by Woman's Life Insurance Society in order to determine eligibility for the insurance coverage applied for.

I know I can have a copy of this form. Anyone authorized to act for me can have one. This form will be valid for 2 years and 6 months. As to alcohol and drug information covered by federal regulation, this form may be revoked at any time by written notice to Woman's Life Insurance Society. But, any action taken before such notice is received by Woman's Life Insurance Society will be valid. A photocopy of this form shall have the same force as the original one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of the health information of the Child proposed for insurance to MIB.

I have received the Fair Credit Reporting Act and MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Agreement: As used in this Agreement, "Society" means Woman's Life Insurance Society.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application are true and complete. They are correctly recorded. It is understood and agreed that:

(a) Any certificate that is issued as a result of this application, together with this application and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the {National President} or the {National Secretary} of the Society may make a contract on its behalf. No waiver or change of a contract provision or any of the Society's rights or requirements shall be binding on the Society unless such waiver or change is in writing signed by one of such officers. **Neither the Representative (Agent) whose signature appears below, nor any other Representative (Agent), nor any medical examiner is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Society's rights or requirements.**

(b) The statements and answers in this application are made as the basis for any certificate issued on this application.

(c) **No insurance will take effect unless and until the Society approves this application and the certificate is delivered to and accepted by the Proposed Insured and the full first premium is paid and then only if my health and that of any other person to be covered by such certificate, as well as any other factor affecting insurability, is the same as set forth in this application.**

(d) If the Society issues a certificate other than the one applied for, this application will be the application for the certificate thus issued. However, any change as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Proposed Insured.

Authorization for the Release of Information: To any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurer, or the MIB, Inc. (MIB) or other organization, institution or person: So that eligibility for life insurance can be determined, I authorize you to give Woman's Life Insurance Society any medical or other information or records you may have about me or any child listed on the application. This authorization is valid for two and one half years. A photocopy shall have the same force as the original one. I know I can have a copy of this authorization. Anyone authorized to act for me can have one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.

I have received the Fair Credit Reporting Act and MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Under penalty of perjury, I certify that:

1. The social security number given in Section 1 is my correct social security number; and
2. I am not subject to backup withholding because: (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding. (Please draw a line through statement 2 if it is not true.)

Signed at _____ this _____ day of _____, 20 _____.

Phone Interview Information:
 Home Phone No. _____
 Best Time to Call _____
 Business Phone No. _____
 Best Time to Call _____

Signature of Proposed Insured

Signature of Spouse (If Spouse Rider Requested)

I certify that to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify that to the best of my knowledge any certificate issued on this application will will not replace or change any existing life insurance or annuity policy now in force.

Signature of Representative (Witness)

Agreement: As used in this Agreement, "Society" means Woman's Life Insurance Society.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application are true and complete. They are correctly recorded. It is understood and agreed that:

(a) Any certificate that is issued as a result of this application, together with this application and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the {National President} or the {National Secretary} of the Society may make a contract on its behalf. No waiver or change of a contract provision or any of the Society's rights or requirements shall be binding on the Society unless such waiver or change is in writing signed by one of such officers. **Neither the Representative (Agent) whose signature appears below, nor any other Representative (Agent), nor any medical examiner is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Society's rights or requirements.**

(b) The statements and answers in this application are made as the basis for any certificate issued on this application.

(c) **No insurance will take effect unless and until the Society approves this application and the certificate is delivered to and accepted and the full first premium is paid and then only if the Child's health and that of the Proposed Payor (if the Payor Benefit is requested), as well as any other factor affecting insurability, is the same as set forth in this application.**

(d) If the Society issues a certificate other than the one applied for, this application will be the application for the certificate thus issued. However, any change as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Parent who signed the application.

Authorization for the Release of Information: To any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurer, or the MIB, Inc. (MIB) or other organization, institution or person: So that eligibility for life insurance can be determined, I authorize you to give Woman's Life Insurance Society any medical or other information or records you may have about me or the child proposed for insurance. This authorization is valid for two and one half years. A photocopy shall have the same force as the original one. I know I can have a copy of this authorization. Anyone authorized to act for me can have one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of the health information of the Child proposed for insurance to MIB.

I have received the Fair Credit Reporting Act and MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Under penalty of perjury, I certify that:

1. The social security number given for the Child in Section 1 is the Child's correct social security number, and the social security number given for me in Section 2 is my correct social security number; and
2. I am not subject to backup withholding because: (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding. (Please draw a line through statement 2 if it is not true.)

Signed at _____ this _____ day of _____, 20 _____.

Signature of Applicant

Signature of Parent (If Applicant is not Parent)

Phone Home Phone No. _____
Interview Best Time to Call _____
Information: Business Phone No. _____
 Best Time to Call _____

Signature of Payor (If Payor Rider Requested)

I certify that to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify that to the best of my knowledge any certificate issued on this application will will not replace or change any existing life insurance or annuity policy now in force.

Signature of Representative (Witness)

Agreement: As used in this Agreement, "Society" Means Woman's Life Insurance Society.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application are true and complete. They are correctly recorded. It is understood and agreed that:

(a) This application and the application for the original certificate shall form the basis for any change requested herein and approved by the Society as well as for any new certificate issued on this application. The changed or new certificate, this application together with the application for the original certificate, any application for a previous change and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the National President or the National Secretary of the Society may make a contract on its behalf. No waiver or change of a contract provision or any of the Society's rights or requirements shall be binding on the Society unless such waiver or change is in writing signed by one of such officers. **Neither the Representative (Agent) who signs below, nor any other Representative (Agent), nor any medical examiner is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Society's rights or requirements.**

(b) Any requested addition to or increase in coverage shall not take effect until it is approved by the Society, the changed certificate is delivered to and accepted by the certificate owner and any required additional premium has been paid and then only if the health of the person whose life is covered by the additional or increased coverage is the same as set forth in this application. Any requested cancellation of or decrease in coverage shall become effective on the monthly anniversary on or next following the date this application is signed.

Issue of a certificate pursuant to a guaranteed issue provision of a rider or certificate or pursuant to conversion not requiring insurability shall take effect on the date specified in the original certificate or rider. If no such date is specified in the original certificate or rider, then the new certificate shall take effect on the monthly anniversary on or next following the date the application is signed. **(Society receives this application and the full first premium for the new certificate.)** Upon the effective date of a conversion, all coverage under the portion of the certificate or rider being converted or canceled shall end.

(c) If the Society changes or issues a certificate other than as applied for, this application will be the application for such change or new certificate. However, any variation as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Proposed Insured.

(d) A copy (including, but not limited to: any facsimile, photostatic or electronic copy) of my signature below is as valid as the original.

Authorization for the Release of Information: To any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurer, or the MIB, Inc. (MIB) or other organization, institution or person: So that eligibility for life insurance can be determined, I authorize you to give Woman's Life Insurance Society any medical or other information or records you may have about me or any child listed on the application. This authorization is valid for two and one half years. A photocopy shall have the same force as the original one. I know I can have a copy of this authorization. Anyone authorized to act for me can have one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.

I have received the Fair Credit Reporting Act and MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Under penalty of perjury, I certify that:

1. The social security number given is my correct social security number; and
2. I am not subject to backup withholding because: (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (b) the IRS has notified me that I am not subject to backup withholding. (Please draw a line through statement 2 if it is not true.)

Signed at _____ this _____ day of _____, 20____.
(City, State)

Signature of Proposed Insured/Applicant

Signature of Spouse (If Spouse Rider Requested)

Signature of Payor (If Payor Benefit Requested)

Signature of Child Representative (Parent or Guardian)

I certify that to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify that to the best of my knowledge any certificate issued on this application will will not replace or change any existing life insurance or annuity policy now in force.

Signature of Representative (Witness)

Printed or Typed Name of Representative

SERFF Tracking #:

WLIC-128606203

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Woman's Life Insurance Society

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

AR - Applications - MIB

Project Name/Number:

AR - Applications - MIB/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Mark-ups		
Comments:			
Attachment(s):			
A1-91 (5-12) (markup).pdf			
A18-91 5-12 (markup).pdf			
A100-96 (5-12) (markup).pdf			
A180-96 (5-12) (markup).pdf			
AR A210-00 (5-12) (markup).pdf			

		Item Status:	Status Date:
Satisfied - Item:	Explanation For Insurance Regulators Regarding MIB's 2013 Authorization Change		
Comments:			
Attachment(s):			
MIB Explanation 2012.pdf			

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Woman's Life Insurance Society, its reinsurers and legal representatives may get medical and other information about me and any child listed on the application. This includes the right to get an investigative consumer report.

I authorize any:

physician; medical practitioner; hospital, clinic, or other medical or medically-related facility; Veterans Administration; insurer or reinsurer; the MIB, Medical Information Bureau Inc. (MIB); consumer reporting agency or other insurance support organization; employer; or other person or entity,

that has knowledge or records of me, or any child listed on the application, as to:

age; character; finances; occupation and employment; other insurance; hazardous activities; physical or mental condition; or the medical care, advice, or treatment furnished with respect to any physical or mental condition,

to give such information to Woman's Life Insurance Society, its reinsurers and legal representatives. This includes any information as to use of and treatment for drugs or alcohol.

I know that this information will be used by Woman's Life Insurance Society to determine whether or not I or any such child is eligible for the insurance coverage applied for.

I know I can have a copy of this form. Anyone authorized to act for me can have one. This form will be valid for 2 years and 6 months. As to alcohol and drug information covered by federal regulation, this form may be revoked at any time by written notice to Woman's Life Insurance Society. But, any action taken before such notice is received by Woman's Life Insurance Society will be valid. A photocopy of this form shall have the same force as the original one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.

I have received the Fair Credit Reporting Act and M.I.B.-MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Signed this _____ day of _____, 20_____

Signature of Proposed Insured

Signature of Payor (if Payor Benefit Requested)

Signature of Spouse (if Spouse Rider Requested)

AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS OR ACCOUNT DEBITS

Name of Depositor _____ (Print as it appears on Banking Institution records) _____ (Account or Code Number)

To _____ (Name of Banking Institution) _____ (Branch) _____ (Transit No.)

(Address of Banking Institution or Branch where account is maintained)

As a convenience to me, I authorize you to charge to my account (a) checks, (b) share drafts, (c) electronic fund transfer debits or (d) other account debits made by and payable to the order of, the Woman's Life Insurance Society, Port Huron, Michigan, provided there are sufficient funds in the account.

I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason, whether with or without cause, intentionally or inadvertently, you will not be under any liability even though dishonor results in the forfeiture of insurance.

I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation. You may end it earlier.

Request and Authorization Signatures

Date

Signature of Applicant

Date

Signature of Depositor
(If Joint Account, other Depositor must also sign)

To: The Bank named above. So that you may comply with the depositor's request as specified on the reverse side hereof this Society agrees in connection therewith:

- 1. To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, or electronic debit, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- 2. In the event that any such check, draft or order, or electronic debit shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
- 3. To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

The above is in accordance with Board of Trustees action dated August 1, 1989.

{ Christopher J. Martin }
NATIONAL PRESIDENT

Agreement:

As used in this Agreement and, if issued, the Conditional Receipt: "Society" means Woman's Life Insurance Society.

This application includes Part I and Part II.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application, are true and complete. They are correctly recorded. It is understood and agreed that:

(a) Any certificate issued as a result of this application, together with this application and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the National President or the National Secretary of the Society may make a contract on its behalf. No waiver or modification of a contract provision or any of the Society's rights or requirements shall be binding on it unless in writing signed by one of such officers. **NEITHER THE REPRESENTATIVE (AGENT) WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER REPRESENTATIVE (AGENT), NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS ON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE SOCIETY'S RIGHTS OR REQUIREMENTS.**

(b) The statements and answers in this application are made as the basis for any certificate issued on this application.

(c) Except as provided in the conditional receipt, if issued, with the same number as this application, no insurance shall take effect unless the certificate is delivered to and accepted by the Proposed Insured and the full first premium is paid and then only if my health and that of any other person to be covered by such certificate, as well as any other factor affecting insurability, is the same as set forth in this application.

(d) If the Society issues a certificate other than the one applied for, this application will be the application for the certificate thus issued. However, any change as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Proposed Insured.

(e) Any person accepted as a member shall be governed by the Society's Laws. This includes all later amendments to the Laws. Such person will seek to advance the welfare and progress of the Society.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Woman's Life Insurance Society, its reinsurers and legal representatives may get medical and other information about me and any child listed on the application. This includes the right to get an investigative consumer report.

I authorize any:

physician; medical practitioner; hospital, clinic, or other medical or medically-related facility; Veterans Administration; insurer or reinsurer; the ~~Medical Information Bureau~~ M.I.B.-MIB, Inc. (MIB); consumer reporting agency or other insurance support organization; employer; or other person or entity,

that has knowledge or records of me, or any child listed on the application, as to:

age; character; finances; occupation and employment; other insurance; hazardous activities; physical or mental condition; or the medical care, advice, or treatment furnished with respect to any physical or mental condition,

to give such information to Woman's Life Insurance Society, its reinsurers and legal representatives. This includes any information as to use of and treatment for drugs or alcohol.

I know that this information will be used by Woman's Life Insurance Society to determine whether or not I or any such child is eligible for the insurance coverage applied for.

I know I can have a copy of this form. Anyone authorized to act for me can have one. This form will be valid for 2 years and 6 months. As to alcohol and drug information covered by federal regulation, this form may be revoked at any time by written notice to Woman's Life Insurance Society. But, any action taken before such notice is received by Woman's Life Insurance Society will be valid. A photocopy of this form shall have the same force as the original one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.

I have received the Fair Credit Reporting Act and ~~M.I.B.-MIB~~ Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Woman's Life Insurance Society, its reinsurers and legal representatives may get medical and other information about me and the Child proposed for insurance. This includes the right to get an investigative consumer report.

I authorize any:

physician; medical practitioner; hospital, clinic, or other medical or medically-related facility; Veterans Administration; insurer or reinsurer; the ~~Medical Information Bureau MIB, Inc. (MIB)~~; consumer reporting agency or other insurance support organization; employer; or other person or entity,

that has knowledge or records of me, or the Child proposed for insurance, as to:

age; character; finances; occupation and employment; other insurance; hazardous activities; physical or mental condition; or the medical care, advice, or treatment furnished with respect to any physical or mental condition,

to give such information to Woman's Life Insurance Society, its reinsurers and legal representatives. This includes any information as to use of and treatment for drugs or alcohol.

I know that this information will be used by Woman's Life Insurance Society in order to determine eligibility for the insurance coverage applied for.

I know I can have a copy of this form. Anyone authorized to act for me can have one. This form will be valid for 2 years and 6 months. As to alcohol and drug information covered by federal regulation, this form may be revoked at any time by written notice to Woman's Life Insurance Society. But, any action taken before such notice is received by Woman's Life Insurance Society will be valid. A photocopy of this form shall have the same force as the original one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of the health information of the Child proposed for insurance to MIB.

I have received the Fair Credit Reporting Act and ~~M.I.B.~~ MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Signed this _____ day of _____, 20_____

Signature of Parent

Signature of Payor (if Payor Benefit Requested)

AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS OR ACCOUNT DEBITS

Name of Depositor _____ (Print as it appears on Banking Institution records) _____ (Account or Code Number)

To _____ (Name of Banking Institution) _____ (Branch) _____ (Transit No.)

(Address of Banking Institution or Branch where account is maintained)

As a convenience to me, I authorize you to charge to my account (a) checks, (b) share drafts, (c) electronic fund transfer debits or (d) other account debits made by and payable to the order of, the Woman's Life Insurance Society, Port Huron, Michigan, provided there are sufficient funds in the account.

I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason, whether with or without cause, intentionally or inadvertently, you will not be under any liability even though dishonor results in the forfeiture of insurance.

I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation. You may end it earlier.

Request and Authorization Signatures

Date Signature of Applicant

Date Signature of Depositor

Date Signature of Parent
(Who signed Application)

Date Signature of other Depositor
(If Joint Account)

To: The Bank named above. So that you may comply with the depositor's request as specified on the reverse side hereof this Society agrees in connection therewith:
1. To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, or electronic debit, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, draft or order, or electronic debit shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

Christopher J. Martin
NATIONAL PRESIDENT

The above is in accordance with Board of Trustees action dated August 1, 1989.

Agreement:

As used in this Agreement and, if issued, the Conditional Receipt: "Society" means Woman's Life Insurance Society.

This application includes Part I and Part II.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application, are true and complete. They are correctly recorded. It is understood and agreed that:

(a) Any certificate issued as a result of this application, together with this application and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the [National President] or the [National Secretary] of the Society may make a contract on its behalf. No waiver or modification of a contract provision or any of the Society's rights or requirements shall be binding on it unless in writing signed by one of such officers. NEITHER THE REPRESENTATIVE (AGENT) WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER REPRESENTATIVE (AGENT), NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS ON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE SOCIETY'S RIGHTS OR REQUIREMENTS.

(b) The statements and answers in this application are made as the basis for any certificate issued on this application.

(c) Except as provided in the conditional receipt, if issued, with the same number as this application, no insurance shall take effect unless the certificate is delivered and accepted and the full first premium is paid and then only if the Child's health and that of the Proposed Payor (if the Payor Benefit is requested), as well as any other factor affecting insurability, is the same as set forth in this application.

(d) If the Society issues a certificate other than the one applied for, this application will be the application for the certificate thus issued. However, any change as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Parent who signed this application.

(e) Any person accepted as a member shall be governed by the Society's Laws. This includes all later amendments to the Laws. Such person will seek to advance the welfare and progress of the Society.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Woman's Life Insurance Society, its reinsurers and legal representatives may get medical and other information about me and the Child proposed for insurance. This includes the right to get an investigative consumer report.

I authorize any:

physician; medical practitioner; hospital, clinic, or other medical or medically-related facility; Veterans Administration; insurer or reinsurer; the ~~Medical Information Bureau MIB, Inc. (MIB)~~; consumer reporting agency or other insurance support organization; employer; or other person or entity,

that has knowledge or records of me, or the Child proposed for insurance, as to:

age; character; finances; occupation and employment; other insurance; hazardous activities; physical or mental condition; or the medical care, advice, or treatment furnished with respect to any physical or mental condition,

to give such information to Woman's Life Insurance Society, its reinsurers and legal representatives. This includes any information as to use of and treatment for drugs or alcohol.

I know that this information will be used by Woman's Life Insurance Society in order to determine eligibility for the insurance coverage applied for.

I know I can have a copy of this form. Anyone authorized to act for me can have one. This form will be valid for 2 years and 6 months. As to alcohol and drug information covered by federal regulation, this form may be revoked at any time by written notice to Woman's Life Insurance Society. But, any action taken before such notice is received by Woman's Life Insurance Society will be valid. A photocopy of this form shall have the same force as the original one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of the health information of the Child proposed for insurance to MIB.

I have received the Fair Credit Reporting Act and ~~M.I.B.~~ MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Agreement: As used in this Agreement, "Society" means Woman's Life Insurance Society.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application are true and complete. They are correctly recorded. It is understood and agreed that:

(a) Any certificate that is issued as a result of this application, together with this application and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the National President or the National Secretary of the Society may make a contract on its behalf. No waiver or change of a contract provision or any of the Society's rights or requirements shall be binding on the Society unless such waiver or change is in writing signed by one of such officers. **Neither the Representative (Agent) whose signature appears below, nor any other Representative (Agent), nor any medical examiner is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Society's rights or requirements.**

(b) The statements and answers in this application are made as the basis for any certificate issued on this application.

(c) **No insurance will take effect unless and until the Society approves this application and the certificate is delivered to and accepted by the Proposed Insured and the full first premium is paid and then only if my health and that of any other person to be covered by such certificate, as well as any other factor affecting insurability, is the same as set forth in this application.**

(d) If the Society issues a certificate other than the one applied for, this application will be the application for the certificate thus issued. However, any change as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Proposed Insured.

Authorization for the Release of Information: To any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurer, or the ~~Medical Information Bureau-MIB, Inc. (MIB)~~ or other organization, institution or person: So that eligibility for life insurance can be determined, I authorize you to give Woman's Life Insurance Society ~~and the Medical Information Bureau Inc.~~ any medical or other information or records you may have about me or any child listed on the application. This authorization is valid for two and one half years. A photocopy shall have the same force as the original one. I know I can have a copy of this authorization. Anyone authorized to act for me can have one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.

I have received the Fair Credit Reporting Act and ~~M.I.B.-MIB~~ Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Under penalty of perjury, I certify that:

1. The social security number given in Section 1 is my correct social security number; and
2. I am not subject to backup withholding because: (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding. (Please draw a line through statement 2 if it is not true.)

Signed at _____ this _____ day of _____, 20 _____.

Phone Interview Information:

Home Phone No. _____

Best Time to Call _____

Business Phone No. _____

Best Time to Call _____

Signature of Proposed Insured

Signature of Spouse (If Spouse Rider Requested)

I certify that to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify that to the best of my knowledge any certificate issued on this application will will not replace or change any existing life insurance or annuity policy now in force.

Signature of Representative (Witness)

Agreement: As used in this Agreement, "Society" means Woman's Life Insurance Society.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application are true and complete. They are correctly recorded. It is understood and agreed that:

(a) Any certificate that is issued as a result of this application, together with this application and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the National President or the National Secretary of the Society may make a contract on its behalf. No waiver or change of a contract provision or any of the Society's rights or requirements shall be binding on the Society unless such waiver or change is in writing signed by one of such officers. **Neither the Representative (Agent) whose signature appears below, nor any other Representative (Agent), nor any medical examiner is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Society's rights or requirements.**

(b) The statements and answers in this application are made as the basis for any certificate issued on this application.

(c) **No insurance will take effect unless and until the Society approves this application and the certificate is delivered to and accepted and the full first premium is paid and then only if the Child's health and that of the Proposed Payor (if the Payor Benefit is requested), as well as any other factor affecting insurability, is the same as set forth in this application.**

(d) If the Society issues a certificate other than the one applied for, this application will be the application for the certificate thus issued. However, any change as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Parent who signed the application.

Authorization for the Release of Information: To any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurer, or the ~~Medical Information Bureau~~ MIB, Inc. (MIB) or other organization, institution or person: So that eligibility for life insurance can be determined, I authorize you to give Woman's Life Insurance Society ~~and the Medical Information Bureau Inc.~~ any medical or other information or records you may have about me or the child proposed for insurance. This authorization is valid for two and one half years. A photocopy shall have the same force as the original one. I know I can have a copy of this authorization. Anyone authorized to act for me can have one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of the health information of the Child proposed for insurance to MIB.

I have received the Fair Credit Reporting Act and ~~M.I.B.~~ MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Under penalty of perjury, I certify that:

1. The social security number given for the Child in Section 1 is the Child's correct social security number, and the social security number given for me in Section 2 is my correct social security number; and
2. I am not subject to backup withholding because: (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding. (Please draw a line through statement 2 if it is not true.)

Signed at _____ this _____ day of _____, 20 _____.

Signature of Applicant

Signature of Parent (If Applicant is not Parent)

Phone Home Phone No. _____
Interview Best Time to Call _____
Information: Business Phone No. _____
 Best Time to Call _____

Signature of Payor (If Payor Rider Requested)

I certify that to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify that to the best of my knowledge any certificate issued on this application will will not replace or change any existing life insurance or annuity policy now in force.

Signature of Representative (Witness)

Agreement: As used in this Agreement, "Society" Means Woman's Life Insurance Society.

I have read this application. To the best of my knowledge and belief, the statements and answers given in this application are true and complete. They are correctly recorded. It is understood and agreed that:

(a) This application and the application for the original certificate shall form the basis for any change requested herein and approved by the Society as well as for any new certificate issued on this application. The changed or new certificate, this application together with the application for the original certificate, any application for a previous change and the Society's Articles of Incorporation and Laws (as amended), shall constitute a single and entire contract. Only the National President or the National Secretary of the Society may make a contract on its behalf. No waiver or change of a contract provision or any of the Society's rights or requirements shall be binding on the Society unless such waiver or change is in writing signed by one of such officers. **Neither the Representative (Agent) who signs below, nor any other Representative (Agent), nor any medical examiner is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Society's rights or requirements.**

(b) Any requested addition to or increase in coverage shall not take effect until it is approved by the Society, the changed certificate is delivered to and accepted by the certificate owner and any required additional premium has been paid and then only if the health of the person whose life is covered by the additional or increased coverage is the same as set forth in this application. Any requested cancellation of or decrease in coverage shall become effective on the monthly anniversary on or next following the date this application is signed.

Issue of a certificate pursuant to a guaranteed issue provision of a rider or certificate or pursuant to conversion not requiring insurability shall take effect on the date specified in the original certificate or rider. If no such date is specified in the original certificate or rider, then the new certificate shall take effect on the monthly anniversary on or next following the date the application is signed. **(Society receives this application and the full first premium for the new certificate.)** Upon the effective date of a conversion, all coverage under the portion of the certificate or rider being converted or canceled shall end.

(c) If the Society changes or issues a certificate other than as applied for, this application will be the application for such change or new certificate. However, any variation as to amount, rate, class, plan of insurance or benefits shall require a written consent signed by the Proposed Insured.

(d) A copy (including, but not limited to: any facsimile, photostatic or electronic copy) of my signature below is as valid as the original.

Authorization for the Release of Information: To any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurer, or the ~~Medical Information Bureau-MIB, Inc. (MIB)~~ or other organization, institution or person: So that eligibility for life insurance can be determined, I authorize you to give Woman's Life Insurance Society ~~and the Medical Information Bureau Inc.~~ any medical or other information or records you may have about me or any child listed on the application. This authorization is valid for two and one half years. A photocopy shall have the same force as the original one. I know I can have a copy of this authorization. Anyone authorized to act for me can have one.

I authorize Woman's Life Insurance Society, or its reinsurers, to make a brief report of my personal health information and that of any child listed on the application to MIB.

I have received the Fair Credit Reporting Act and ~~M.I.B.~~ MIB Notices and Notice of Information Practices.

As to any investigative consumer report which may be obtained: I do do not want to be interviewed.

Under penalty of perjury, I certify that:

1. The social security number given is my correct social security number; and
2. I am not subject to backup withholding because: (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding. (Please draw a line through statement 2 if it is not true.)

Signed at _____ this _____ day of _____, 20____.
(City, State)

Signature of Proposed Insured/Applicant

Signature of Spouse (If Spouse Rider Requested)

Signature of Payor (If Payor Benefit Requested)

Signature of Child Representative (Parent or Guardian)

I certify that to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify that to the best of my knowledge any certificate issued on this application will will not replace or change any existing life insurance or annuity policy now in force.

Signature of Representative (Witness)

Printed or Typed Name of Representative



EXPLANATION FOR INSURANCE REGULATORS REGARDING MIB'S 2013 AUTHORIZATION CHANGE

We are pleased to provide you with some background information on MIB's initiative to modify its Authorization, along with the attached Fact Sheet on MIB.

Currently, the MIB Authorization elicits the applicant's affirmative consent **to search** MIB while implied consent **to report** the applicant's personal information has been historically derived from the MIB Pre-Notice.^[1] MIB's General Rules currently specify that the Authorization should contain the following language or language substantially similar:

"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 health, to give to the XYZ Life Insurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original."

Effective January 1, 2013, MIB will require its members to supplement their authorizations with the following sentence in order to elicit an applicant's express written consent **to report** information to MIB:

"I authorize XYZ Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB." [Members may substitute substantially similar language, including "Protected Health Information."]

We have observed that many members already incorporate this type of language in their authorizations and will not need to make any change.

MIB has determined that this change is in the best interest of MIB's membership because it is consistent with state and federal laws addressing the privacy of individually identifiable health

^[1] The MIB Pre-Notice must say the following:

"Information regarding your insurability will be treated as confidential. XYZ Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. [formerly known as Medical Information Bureau], a not-for-profit membership organization of 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 in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the 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."

*The bracketed language is optional.



information (information that is associated with individuals) and the protection of consumers, including the Health Insurance Portability and Accountability Act (“HIPAA”), as amended by Health Information Technology for Economic and Clinical Health Act (“HITECH”). MIB has long been committed to making its strategies more proactive and adopting initiatives that further protect consumers and their personal information. Accordingly, MIB firmly believes that Members should elicit the express written authorization of every applicant to report codes to MIB in order to ensure that MIB can comply with developing trends in health information privacy regulation.

With respect to our members’ efforts to implement the new Authorization change, on January 13, 2012, the New York Department of Financial Services issued a Filing Guidance Note on its website in which it indicated that “any policy form revised solely to comply with the exact language” specified by MIB to its members does not have to be submitted to the Department for review and approval prior to use, provided the company provides appropriate notification to the Department in writing about the situation. In addition, the New Jersey Department of Banking and Insurance has confirmed that they will not require MIB’s member companies to re-file application forms that are being revised solely to incorporate the new MIB authorization language.

If you have any additional questions regarding MIB’s new Authorization requirements, do not hesitate to contact us:

Jonathan W. Sager
EVP & General Counsel
MIB Group, Inc.
(781) 751-6332
jsager@mib.com

Allyson L. Roklan
Associate General Counsel
MIB Group, Inc.
(781) 751-6321
aroklan@mib.com

Sue Corey
Director of Membership & Disclosure
MIB, Inc.
(781) 751-6500
scorey@mib.com