

**State:** Arkansas **Filing Company:** Federal Life Insurance Company (Mutual)  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Single Premium Whole Life Application  
**Project Name/Number:** SPWL App Update for MIB/FLIC165

## Filing at a Glance

Company: Federal Life Insurance Company (Mutual)  
Product Name: Single Premium Whole Life Application  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 09/04/2012  
SERFF Tr Num: FDLF-128666504  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: FLIC165AR  
  
Implementation: On Approval  
Date Requested:  
Author(s): Steve Mink, Matt Kindelin, PW Calfas  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 09/10/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Single Premium Whole Life Application  
**Project Name/Number:** SPWL App Update for MIB/FLIC165

**Filing Company:** Federal Life Insurance Company (Mutual)

## General Information

Project Name: SPWL App Update for MIB	Status of Filing in Domicile: Not Filed
Project Number: FLIC165	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Illinois is a Compacting State
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 09/10/2012
	State Status Changed: 09/10/2012
Deemer Date:	Created By: Matt Kindelin
Submitted By: Matt Kindelin	Corresponding Filing Tracking Number:

### Filing Description:

Filing is to Update Application form L-8081 with MIB Inc. required HIPAA language changes and updating of MIB Inc. notice and Fair Credit Reporting Act notice.

## Company and Contact

### Filing Contact Information

Matthew Kindelin, Actuarial Student	mkindelin@federallife.com
Federal Life Insurance Company (Mutual)	847-850-3263 [Phone]
3750 W. Deerfield Road	
Riverwoods, IL 60015	

### Filing Company Information

Federal Life Insurance Company (Mutual)	CoCode: 63223	State of Domicile: Illinois
3750 W. Deerfield Road	Group Code:	Company Type:
Riverwoods, IL 60015	Group Name:	State ID Number:
(847) 520-1900 ext. [Phone]	FEIN Number: 36-1063550	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50 per form
Per Company:	No

Company	Amount	Date Processed	Transaction #
Federal Life Insurance Company (Mutual)	\$50.00	09/04/2012	62230911

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/10/2012	09/10/2012

SERFF Tracking #:

FDLF-128666504

State Tracking #:

Company Tracking #:

FLIC165AR

State:

Arkansas

Filing Company:

Federal Life Insurance Company (Mutual)

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Single Premium Whole Life Application

Project Name/Number:

SPWL App Update for MIB/FLIC165

## Disposition

Disposition Date: 09/10/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Single Premium Whole Life Application (APP)		Yes

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## Form Schedule

### Lead Form Number: L-8081

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		L-8081	AEF	Single Premium Whole Life Application (APP)	Revised: Replaced Form #: L-8081 Previous Filing #: 50330	50.300	L-8081 Single Premium Whole Life Application 20120827.pdf

### Form Type Legend:

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



**PART I**

**Single Premium Whole Life Application (APP)**

**Proposed Insured**

Full Name (first, middle, last): \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 County: \_\_\_\_\_ Birthdate (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
 Is the Proposed Insured a US citizen or permanent resident of the United States?  Yes  No

**Owner (If other than Proposed Insured)**

Full Name (first, middle, last): \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 County: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Daytime Phone Number: \_\_\_\_\_

We invite you to provide us with the name and address of a second addressee in the space below. This is intended to provide additional assurance that you receive notice if your policy enters its grace period or lapses.

Second Addressee Name and Address:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Life Insurance Requested**

Plan \_\_\_\_\_ Face Amount \$ \_\_\_\_\_ Premium Amount \$ \_\_\_\_\_

**Beneficiary Information**

Primary	Contingent	Print Full Name	Allocation	Relationship	SSN
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	_____	_____

(Allocations in whole percentages only; Allocations to all Primary must equal 100%; Allocations to all Contingents must also equal 100%)

Signature of Spouse of Owner: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_  
spouse's signature required in the following states: (AZ, CA, ID, LA, NV, NM, TX, WA, WI)

**Replacement**

Do you have any existing life insurance in force or pending with this or any other company?  Yes  No  
 Will this policy, if issued, result in the replacement, termination or change in value of any existing life insurance in this or any other company?  Yes  No  
 If yes, please provide the information below and attach any required state replacement forms.  
 Insurance Company Name(s): \_\_\_\_\_  
 Contract Number(s): \_\_\_\_\_

**Purchase Payment**

Amount Paid with Application: \$ \_\_\_\_\_  
 Payment Submitted Via:  COD (Collect On Delivery)  Check  1035 Exchange

**Make check payable only to Federal Life Insurance Company (Mutual). Do not make check payable to the agent. Do not leave payee blank.**

If necessary, what is the best number and time for us to call you between the hours of 7:00am and 4:00pm Central Time?  
 \_\_\_\_\_

**PART II**

**Medical Questions**

**Yes No**

- 1. Within the past 24 months:
  - a. Has the Proposed Insured been declined, postponed, or offered a rated or modified life insurance policy, or been denied reinstatement? .....
  - If yes, explain: \_\_\_\_\_
  - b. Has the Proposed Insured used any form of tobacco or nicotine products? .....
- 2. a. Proposed Insured’s present height and weight \_\_\_\_ ft. \_\_\_\_ in. \_\_\_\_ lbs.
- b. Has the Proposed Insured lost more than 10 lbs. in the past 6 months? .....
- If Yes to 2b., please answer: Amount of weight loss \_\_\_\_ lbs. Reason for loss if known: \_\_\_\_\_

**IF ANY OF THE FOLLOWING QUESTIONS, 3 THROUGH 11, ARE ANSWERED ‘YES’, NO COVERAGE CAN BE ISSUED**

- 3. Does the Proposed Insured need ongoing personal assistance performing regular activities of daily living such as bathing, dressing, eating, taking medications, or moving around the house; or is the Proposed Insured currently receiving home nursing or hospice care; or using oxygen equipment to assist in breathing (excluding CPAP)? .....
- 4. Is the Proposed Insured now; or within the past 24 months has the Proposed Insured been, on two or more occasions, hospitalized, or confined to a hospice, assisted living, nursing, rehabilitative, or psychiatric facility? .....
- 5. Has the Proposed Insured had or been medically advised to have:
  - a. A diagnostic test or procedure which has not yet been completed, or for which results have not yet been received? .....
  - b. An organ transplant; or amputation caused by disease; or been diagnosed as having a terminal medical condition? .....
- 6. Has the Proposed Insured been medically treated or diagnosed, by a medical professional, as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), or any immune deficiency related disorder, or tested positive for the human immunodeficiency virus (HIV)? .....
- 7. Has the Proposed Insured ever been examined, evaluated, diagnosed or treated by a medical professional (including office or hospital visits or medication) for Congestive Heart Failure (CHF); cardiomyopathy; liver failure; cirrhosis; chronic or end stage kidney disease; dialysis; kidney failure; Alzheimer’s disease; dementia; or schizophrenia? .....
- 8. Is the Proposed Insured currently, or within the past 24 months has the Proposed Insured been examined, evaluated, diagnosed or treated by a medical professional (including office or hospital visits or medication) for:
  - a. Heart disease; heart attack; angina; heart valve disease; heart or vascular surgery (including coronary artery bypass; angioplasty; stent placement; pacemaker implant or replacement); or any procedure to improve circulation to the heart, brain or extremities; uncontrolled blood pressure; stroke; or transient ischemic attack (TIA)? .....
  - b. Chronic Obstructive Pulmonary Disease (COPD/COLD); emphysema; chronic bronchitis; respiratory failure; or any other chronic respiratory disease (excluding asthma under control with occasional inhaler use); or required oxygen equipment to assist with breathing (excluding CPAP)? .....
  - c. Liver disease including hepatitis B or C; pancreatitis; renal (kidney) insufficiency; Hodgkin’s disease; systemic lupus (SLE); Neuromuscular disease (including muscular dystrophy, multiple sclerosis, Parkinson’s disease); paralysis; epilepsy, seizures, Down’s syndrome; any mental or nervous disease; or brain tumor? .....
  - d. Complications of diabetes, diabetic coma, insulin shock or diabetes not under control with treatment or, was the Proposed Insured diagnosed with diabetes prior to age 20 or treated with insulin prior to age 50? .....
- 9. Within the past 24 months has the Proposed Insured been convicted of operating a motor vehicle while intoxicated, or impaired, or for reckless driving? .....
- 10. Is the Proposed Insured currently, or within the past 3 years, has the Proposed Insured been diagnosed with or treated, by a medical professional (including office or hospital visits, medication, chemotherapy, radiation or surgery) for: internal cancer; lymphoma; leukemia; melanoma; or other malignancy; or had, in their lifetime, more than one type of cancer; or recurrence of a cancer (other than basal or squamous cell skin cancer) ? .....
- 11. Within the past 5 years has the Proposed Insured been treated for, or been advised by a member of the medical profession to receive treatment or counseling for the use of alcohol, drugs, or medication abuse? .....

## Declaration and Authorization ("APP" means Application)

I declare that all answers written on Part I and II of this APP are full and correct, to the best of my knowledge and belief. Any statements made in this APP are representations and not warranties. The Company is not presumed to know any information not in this APP. I agree that:

The Company has the right to require a medical exam of any person proposed for insurance. I understand that the **USA PATRIOT Act** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and social security number allows us to verify your identity. I am not being paid cash and have not been promised services as an inducement to enter into this APP for life insurance. The purpose of this insurance APP is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company. **Prior to any Contract going into effect, insurance will be in effect only as provided in the Conditional Receipt issued in connection with this APP. If no such receipt is issued, no insurance will start by reason of this APP unless and until: a Contract is delivered; and the first payment for it is made while the person to be covered under it is alive and their health remains as described in this APP. In that case, the insurance under the Contract will begin on the date it provides that such coverage becomes effective.**

**Only an officer of the Company may change the APP or waive a right or requirement. No agent may do this.**

Dated at \_\_\_\_\_ On \_\_\_\_\_  
City State mm/dd/yyyy

X \_\_\_\_\_  
Proposed Insured

Is there existing life insurance and/or annuity contract(s) on the life of the proposed insured or proposed?  Yes  No

X \_\_\_\_\_  
Owner (if Company, Officer's signature and title)

Is replacement of life insurance or annuity contracts included in this transaction?  Yes  No

Agent's Number \_\_\_\_\_ Situation Code \_\_\_\_\_

If Yes, I presented and read the applicant any required notice regarding replacement.  Yes  No

Agent's Signature \_\_\_\_\_

Agent's Printed Name \_\_\_\_\_

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### Federal Life Insurance Company (Mutual) ("The Company")

#### Health Insurance Portability and Accountability Act (HIPAA) Authorization to obtain and disclose certain data

I hereby authorize the release of any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but should not be limited to, the following: treatment for alcohol or drug abuse, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKGs. This information will be used to determine my eligibility for insurance, underwrite my application for insurance, determine my eligibility for benefits under any temporary insurance, and if the contract is issued, determine my eligibility and contestability of the contract.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical, or medically related facility, the Veteran's Administration, insurance company, MIB, INC. ("MIB"), employer, consumer reporting agency or other organization, institution or person, that has any records or knowledge of me or my health to give to The Company or its reinsurers, any such information when this authorization or a copy of it is shown. I further authorize the sources listed above, except for MIB, Inc., to give such information to a consumer reporting agency acting on behalf of Federal Life Insurance Company (Mutual). Data about mental illness, alcoholism, and the use of drugs is to be included.

I authorize Federal Life Insurance Company (Mutual), or its reinsurers, to make a brief report of my personal health information to MIB, Inc. This authorization is good for 24 months after it is signed. **For AZ only 180 days in the case of HIV related information.** A copy of this authorization will be as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. The Company may obtain an investigative consumer report on me. I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows The Company to contest a claim under the contract or to contest the contract itself, by sending a written request to: Federal Life Insurance Company (Mutual) – 3750 W. Deerfield Rd. – Riverwoods, IL 60015. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance and the administration of any contract issued as a result of that application. I understand that the signing of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting information necessary to consider my application. I hereby acknowledge that The Company is subject to federal privacy regulations. I understand that information released to The Company will be used and disclosed as described in The Company's privacy policy, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

**I have read this authorization and read and received the MIB, Inc., notice and the FAIR CREDIT REPORTING ACT notice.**

\_\_\_\_\_  
Name of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured or their Personal Representative

\_\_\_\_\_  
Description of Authority of Personal Representative (if applicable)

**CONDITIONAL RECEIPT** (“APP” means Application)

Federal Life Insurance Company (Mutual) (“The Company”) has received from \_\_\_\_\_

a payment of \$ \_\_\_\_\_ for the insurance applied for with the APP.

This receipt is not valid unless it is signed by an agent of The Company. This receipt is not valid unless the amount paid with the APP if paid by check, is honored on first presentation for payment.

**IMPORTANT:** The payment of premiums is received subject to the following conditions:

- (A) 1. If the medical examinations required by The Company are completed; and
- 2. If The Company at its Home Office is satisfied that, at the time of completing Part I and Part II of the APP the person to be covered was insurable under The Company’s rules for insurance on the plan, in the amount and at the class of risk to be applied for in Part I of the APP;

Then, and only after these conditions are met, the insurance applied for shall be effective from the date of Part II, or the date requested in the APP, whichever is the latest, regardless of any change of insurability of the person to be covered occurring after completion of both parts of the APP.

The amount of insurance which may become effective under this conditional receipt shall not exceed the greater of \$50,000 or the amount of the single premium paid to The Company. Any insurance applied for as alternative or additional to the plan and amount of insurance applied for in the APP shall not become effective under this conditional receipt.

Except as provided in this conditional receipt, any Contract issued by The Company shall not take effect unless the full first premium is paid and such Contract is delivered to the Owner during the lifetime of each person to be covered by such Contract, and all the statements and answers given in the APP continue to be true and complete to the best of the Proposed Insured’s (Owner’s) knowledge and belief as of the date of delivery of such Contract.

Neither the agent nor the medical examiner is authorized to accept risks or pass upon insurability, to modify contracts, or to waive any of The Company’s rights or requirements.

**IMPORTANT:** The payment is received subject to the conditions of this receipt. This conditional receipt does not provide any insurance until after its conditions are met.

Agent Name \_\_\_\_\_ Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

If you do not hear from The Company regarding the proposed insurance within 30 days, notify The Company at its Home Office in Riverwoods, Illinois, giving the name of the agent, date and amount paid.

**Make check payable only to Federal Life Insurance Company (Mutual). Do not make check payable to the agent. Do not leave payee blank.**

----- DETACH HERE -----

**MIB, Inc.**

**Notice to Applicant:** Information regarding your insurability will be treated as confidential. Federal Life Insurance Company (Mutual) 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in the 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, MA 02184-8734.

Federal Life Insurance Company (Mutual) or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained at its website [www.mib.com](http://www.mib.com).

## Fraud Warnings

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

*Note: The following states require that alternate statements regarding insurance fraud be given. If you are a resident of any of the following states, please consider the following statements as replacement for the above statements.*

**Arkansas:** 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.

**District of Columbia:** Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.

----- DETACH HERE -----

## Fair Credit Reporting Act

**Notice to Applicant:** Federal law requires that notice of investigation be given to persons applying for insurance.

In making this application for insurance to Federal Life Insurance Company (Mutual) ("The Company"), it is understood that an investigative consumer report may be prepared by an outside insurance reporting organization whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, health and mode of living except as may be related directly or indirectly to your sexual orientation. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request to the Home Office of The Company within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. (See MIB, Inc. notice)

### Notice Of Information Practices – To our Contractholders, Applicants and Insureds:

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on the information provided by you. We may also seek information from others, such as medical professionals who have treated you or family members covered under such insurance, pharmacy benefit managers, the DMV, employers and other insurance companies.

A personal history interview may also be conducted by phone to assure that the application information is complete. When done, you will be contacted by either a member of our underwriting department or an outside insurance reporting organization. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, or as permitted or required by law.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of The Company's and its agents' information practices. If you would like to receive a more detailed explanation of those practices, please contact:

**Customer Service – Federal Life Insurance Company (Mutual)**  
3750 West Deerfield Road – Riverwoods, Illinois 60015

Agent's Report – To be completed by Field Underwriter (“APP” means Application)

1. How long have you known proposed insured? \_\_\_\_\_ How known? \_\_\_\_\_
2. Who first suggested the purchase of this insurance?  
 Agent     Proposed Insured     Owner     Other \_\_\_\_\_
3. Purpose of insurance (Insurable Interest): \_\_\_\_\_

Remarks: \_\_\_\_\_

Agent's Commission to be shared with: Name \_\_\_\_\_ % \_\_\_\_\_ No. \_\_\_\_\_ Situation Code \_\_\_\_\_

I certify that:

**Statements By Agent:**

- I asked and carefully explained each question to the Proposed Insured and owner/applicant personally and in my presence before recording each answer prior to the APP being signed by the Proposed Insured and owner;
- I have verified the personal information of the applicant by viewing either a state-issued driver's license, state-issued I.D. card, permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card.
- The answers in this APP and Agent's Report are complete and accurate to the best of my knowledge and belief;
- The Proposed Insured and agent know that any fraudulent statement of material misrepresentation in the application/enrollment form may result in loss of coverage under the contract;
- I have no personal knowledge of any other factors which may have an effect on the Proposed Insured's insurability;
- If I become aware of a change in the health or habits of the Proposed Insured occurring after the date of the application and before I deliver the contract, I will inform the Company of the change and agree to withhold delivery of the contract until instructed by the Company to do so;
- I have explained to the Proposed Insured that if money is submitted with this APP, conditions of the Conditional Receipt must be met;
- I have made no agreement whereby anyone has received or is to receive directly or indirectly, in settlement of the premium on the proposed insurance any concession or rebate from the full regular premium according to The Company's table of rates.
- The owner, Proposed Insured, or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement, or any other secondary market.

Agent's  
Signature \_\_\_\_\_

Agent's  
Printed Name \_\_\_\_\_

Date \_\_\_\_\_

SERFF Tracking #:

FDLF-128666504

State Tracking #:

Company Tracking #:

FLIC165AR

State:

Arkansas

Filing Company:

Federal Life Insurance Company (Mutual)

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Single Premium Whole Life Application

Project Name/Number:

SPWL App Update for MIB/FLIC165

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Revisions to application does not have any affect on Flesch scoring certified previously for this form.		