

State: Arkansas **Filing Company:** Provident American Life and Health Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Life Individual Combined
Project Name/Number: Life Individual Combined/A6121513NW

Filing at a Glance

Company: Provident American Life and Health Insurance Company
Product Name: Life Individual Combined
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 09/20/2012
SERFF Tr Num: GRAX-G128694514
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: A6121513NW

Implementation
Date Requested:
Author(s): SPI GreatAmericanFinancialRes
Reviewer(s): Linda Bird (primary)
Disposition Date: 09/25/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
Filing Company: Provident American Life and Health Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Life Individual Combined
Project Name/Number: Life Individual Combined/A6121513NW

General Information

Project Name: Life Individual Combined	Status of Filing in Domicile: Pending
Project Number: A6121513NW	Date Approved in Domicile:
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: 09/25/2012
	State Status Changed: 09/25/2012
Deemer Date:	Created By: SPI GreatAmericanFinancialRes
Submitted By: SPI GreatAmericanFinancialRes	Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval, please find the form referenced above. This form is a new form and does not replace any existing form, nor has it been previously submitted to your Department for preliminary review. This submission does not contain any provisions, conditions, or concepts that are uncommon, unusual or possibly controversial from the standpoint of normal company or industry standards.

Form A6121513NW will be used by policyholders to make changes such as reinstatement, increases in face amount, the addition of rider, etc to existing life insurance policies only.

At this time we are not currently selling "Life" policies in your state. If our position should change, this application may be used with life insurance policies approved by your Department in the future.

Please note form A612151NW is being filed for; Manhattan National Life Insurance Company, Great American Life Insurance Company, Continental General Insurance Company, United Teacher Associates Insurance Company, Central Reserve Life Insurance Company, and Loyal American Life Insurance Company, simultaneously under separate cover.

Company and Contact

Filing Contact Information

Brenda Little, Senior Compliance Filing Analyst	blittle@gafri.com
P. O. Box 5420	513-412-2725 [Phone] 12725 [Ext]
Cincinnati, OH 45201-5420	513-361-5967 [FAX]

Filing Company Information

Provident American Life and Health Insurance Company	CoCode: 67903	State of Domicile: Ohio
11200 Lakeline Blvd, Suite 100	Group Code: 84	Company Type:
Austin, TX 78717	Group Name: Great American Financial Resources, Inc.	State ID Number:
(512) 451-2224 ext. [Phone]	FEIN Number: 23-1335885	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00

State: Arkansas **Filing Company:** Provident American Life and Health Insurance Company

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

Product Name: Life Individual Combined

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Retaliatory? No

Fee Explanation:

Per Company: No

Company	Amount	Date Processed	Transaction #
Provident American Life and Health Insurance Company	\$50.00	09/20/2012	62883596

SERFF Tracking #:

GRAX-G128694514

State Tracking #:

Company Tracking #:

A6121513NW

State:

Arkansas

Filing Company:

Provident American Life and Health Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Life Individual Combined

Project Name/Number:

Life Individual Combined/A6121513NW

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/25/2012	09/25/2012

SERFF Tracking #:

GRAX-G128694514

State Tracking #:

Company Tracking #:

A6121513NW

State:

Arkansas

Filing Company:

Provident American Life and Health Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Life Individual Combined

Project Name/Number:

Life Individual Combined/A6121513NW

Disposition

Disposition Date: 09/25/2012

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
Supporting Document	Letter of Authorization		Yes
Supporting Document	Cover Letter		Yes
Form	Policy Change Request, Part II		Yes

SERFF Tracking #:

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State Tracking #:

Company Tracking #:

A6121513NW

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: Life Individual Combined
 Project Name/Number: Life Individual Combined/A6121513NW

Filing Company: Provident American Life and Health Insurance Company

Form Schedule

Lead Form Number: A6121513NW

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1		A6121513NW	AEF	Policy Change Request, Part II	Initial:	53.500	A6121513NW.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



Great American Financial Resources, Inc.:

- Continental General Insurance Company
- Great American Life Insurance Company®
- Manhattan National Life Insurance Company®
- United Teacher Associates Insurance Company

Administration for Life Insurance and Annuities:

- Central Reserve Life Insurance Company
- Loyal American Life Insurance Company®
- Provident American Life and Health Insurance Company

Life Products: P.O. Box 5416, Cincinnati, OH 45201-5416

POLICY CHANGE REQUEST, Part II

Name of Insured _____ **Policy Number** _____

Name of Owner _____ **Telephone No. of Owner** _____

Address of Owner _____ **City** _____ **State** _____ **Zip** _____

Reinstate Policy Face Amount Increase \$ _____ Child(ren) \$ _____

Add Riders: Children's Term Life Insurance Rider

(Please Print – Complete Form in Full)

Full Name of Insured:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Address: _____ City: _____ State: _____ Zip: _____

Driver's License No.: _____ State Issued: _____ Social Security No.: _____

Name of Employer: _____ Address of Employer: _____

Occupation: (Describe and give active duties)

Do you contemplate changing your occupation?

Please print full name of all persons proposed for coverage. Show spouse's maiden name in parentheses, if applicable.

Spouse/Other:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Address: _____ City: _____ State: _____ Zip: _____

Driver's License No.: _____ State Issued: _____ Social Security No.: _____

Name of Employer: _____ Address of Employer: _____

Occupation: (Describe and give active duties)

Do you contemplate changing your occupation?

Child 1:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.	
								\$

Child 2:								\$
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Does anyone proposed for coverage have any past, present or expected aviation activities or hazardous sports avocation or hobbies? Yes No (If yes, please explain.)

Has anyone proposed for coverage ever applied for insurance that was declined, postponed, rated, modified, or had any such insurance cancelled or had a renewal premium refused? Yes No

Does anyone proposed for coverage have other life insurance? Yes No If yes, please provide the following details.

Company	Plan	Amount	ADB	Year Issued

Will this policy replace or change any life insurance that is currently in force? Yes No

<p>SMOKING HABITS:</p> <p>Smoked cigarettes during the last 12 months? Smoked cigarettes during the last 36 months? Use other form of tobacco? (If "yes", describe.)</p>	<p>Proposed Insured</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Spouse/Additional Insured (Complete for Spouse/ Additional Insured Term Rider)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
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HAS ANYONE PROPOSED FOR COVERAGE:		Yes	No
1.	Been charged with but not acquitted of the violations of any criminal law?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Had in the past five years any motor vehicle violations, including driving while intoxicated, or had your license suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
3.	a. Ever filed for bankruptcy?	<input type="checkbox"/>	<input type="checkbox"/>
	b. If "yes," has it been discharged? Date of discharge: _____	<input type="checkbox"/>	<input type="checkbox"/>

NONMEDICAL DECLARATIONS – Complete All Questions

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:		Yes	No
1.	Has anyone proposed for coverage ever been treated for or had:		
a.	Impairment of the eyes or ears?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Dizziness, fainting, convulsions, headache, paralysis or stroke within the past ten years?	<input type="checkbox"/>	<input type="checkbox"/>
c.	Shortness of breath, blood spitting, bronchitis, asthma, emphysema, or chronic respiratory disorder, sleep apnea or other lung disorders within the past ten years?	<input type="checkbox"/>	<input type="checkbox"/>
d.	Chest pain, palpitation, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
e.	Jaundice, hepatitis, intestinal bleeding, ulcer, colitis, recurrent indigestion or any other disease of the stomach, intestines, liver, gallbladder or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>
f.	Sugar, protein, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
g.	Diabetes, thyroid, or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
h.	Disorder of the breasts, prostate, or pelvic organs?	<input type="checkbox"/>	<input type="checkbox"/>
i.	Neuritis, arthritis, or disorder of the muscles or bones, including the spine, back or joints?	<input type="checkbox"/>	<input type="checkbox"/>
j.	Disorder of skin, lymph glands, cyst, tumor or cancer?	<input type="checkbox"/>	<input type="checkbox"/>
k.	Anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
l.	Alcoholism, alcohol or drug abuse or addiction to use of habit-forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>
m.	Panic attacks, anxiety, depression, psychological or emotional or physical disorder not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has anyone proposed for coverage:	Yes	No
a.	Had a physical checkup, consultation, or surgery within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Been a patient in a hospital, clinic, or other medical facility within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
c.	Had an electrocardiogram, X-ray, or other diagnostic test within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
d.	Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>
e.	Been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is anyone proposed for coverage now pregnant? If yes, expected due date: _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is anyone proposed for coverage now under medical observation or treatment or currently taking any medication other than as stated above?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is anyone proposed for coverage currently taking medication? If "yes," list name, dosage, reason and date last taken. _____	<input type="checkbox"/>	<input type="checkbox"/>

Details of questions answered "Yes"

Name of Person and Question No.	Disease or Injury	No. of attacks, duration	Dates	Results	Name, Address of Physician

I/we have read the above questions and answers, and hereby declare that the answers and statements as written on this Request are complete and true to the best of my/our knowledge and may be relied on by the Company. I/we agree that this Policy Change Request may form a part of any policy issued. I/we further agree that no policy, addition, or change applied for shall in any event become effective unless and until this Policy Change Request is approved at the Administrative Office of the Company and the full premium due is paid during the lifetime of all proposed insureds, as stated in this Request.

Signed _____ Date _____ Signed _____ Date _____
Owner Spouse
Signed _____ Date _____ Signed _____ Date _____
Insured Additional Insured
(Parent or guardian if Insured is under 18)

Witness _____ Approved by _____ Date _____

AUTHORIZATION TO OBTAIN INFORMATION

I/we, the Proposed Insured(s), authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the MIB, Inc., consumer reporting agency, employer, or pharmacy benefit manager, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children, and any other nonmedical information of me or my minor children, to give to Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Central Reserve Life Insurance Company/Provident American Life and Health Insurance Company or its legal representative or its reinsurers any and all such information. I/we also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me or my minor children. The types of information may include my/our: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV); (10) drug and alcohol treatment; (11) other personal information; (12) Motor Vehicle record, and (13) pharmaceutical information. I/we also authorize Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Central Reserve Life Insurance Company/Provident American Life and Health Insurance Company or their reinsurers, to make a brief report of my protected health information to MIB, Inc.

I/we understand the information obtained by use of the Authorization will be used by Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Central Reserve Life Insurance Company/Provident American Life and Health Insurance Company and its reinsurers to determine eligibility or continued eligibility for insurance and eligibility for benefits under an existing policy or a policy applied for. The insurance agent, producer or broker may also use the information to help update my/our insurance program. Any information obtained will not be released by Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Central Reserve Life Insurance Company/Provident American Life and Health Insurance Company to any person or organization EXCEPT to reinsuring companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my/our application, claim, or as may be otherwise lawfully allowed or required or as I/we may further authorize.

I/we know I/we may request to receive a copy of this Authorization. I/we agree a photographic copy of this Authorization shall be as valid as the original. I/we agree this Authorization shall be valid for two and one-half years from the date shown below.

I ACKNOWLEDGE receipt of the Notice to Persons Applying for Insurance and Notice of Disclosure of Information/MIB, Inc. Disclosure and authorize preparation of an investigative consumer report.

NOTICES

[Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.]

[Alaska Residents: You have 20 days (30 for replacements) from the date you receive the policy to review it and cancel the policy, if you are not satisfied. Upon receipt of a written request, we will provide you with factual information regarding the benefits and provisions of this policy to aid you in your decision. We will respond to your request for additional information within ten (10) days of its receipt. If you cancel the policy, we will refund the premiums paid for it.]

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

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

[District of Columbia Residents: 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 a claim was provided by the applicant.]

Signature of Insured _____ Date _____
(Parent or guardian if Insured is under 18)

Signature of Spouse (If Applicable) _____ Date _____

Signature of Additional Insured (If Applicable) _____ Date _____

SERFF Tracking #:

GRAX-G128694514

State Tracking #:

Company Tracking #:

A6121513NW

State: Arkansas

Filing Company:

Provident American Life and Health Insurance Company

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

Product Name: Life Individual Combined

Project Name/Number: Life Individual Combined/A6121513NW

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
NW - Readability Certification.PDF			

		Item Status:	Status Date:
Satisfied - Item:	Letter of Authorization		
Comments:			
Attachment(s):			
provident authorization.PDF			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter		
Comments:			
Attachment(s):			
Cover Letter.PDF			



P.O. Box 5420, Cincinnati, Ohio 45201-5420

READABILITY CERTIFICATION

I, John P. Gruber, an officer of Great American Life Insurance Company, hereby certify that the following form(s) has (have) the following readability score(s) as calculated by the Flesch Reading Ease Test and that this (these) form(s) meet(s) the reading ease requirements of the laws and regulations of your state.

Form
A6121513NW

Readability Score
53.5

John P. Gruber, Esq.
Senior Vice President and
General Counsel

September 17, 2012

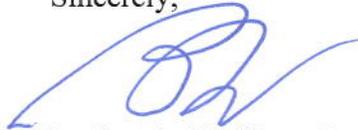
September 13, 2012

To Whom It May Concern,

Provident American Life & Health Insurance Company has engaged the services of Great American Life Insurance Company to act on our behalf with respect to filings related to policy forms, regulatory reporting, complaints, agent appointments, supplemental filings, assessments and advertising on annuities, life insurance and long term care products.

Feel free to contact me should you have any questions.

Sincerely,



Bradley A. Wolfram, President
Provident American Life & Health Insurance Company



Administrative Mailing Address: P.O. Box 5420, Cincinnati, Ohio 45201-5420

September 20, 2012

NAIC No. 0084-67903

FEIN No. 23-1335885

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Request For Approval - Provident American Life and Health Insurance Company
A6121513NW Policy Change Request, Part II

Dear Insurance Commissioner Bradford:

Enclosed for your review and approval, please find the form referenced above. This form is a new form and does not replace any existing form, nor has it been previously submitted to your Department for preliminary review. This submission does not contain any provisions, conditions, or concepts that are uncommon, unusual or possibly controversial from the standpoint of normal company or industry standards.

Form A6121513NW will be used by policyholders to make changes such as reinstatement, increases in face amount, the addition of rider, etc to existing life insurance policies only.

At this time we are not currently selling "Life" policies in your state. If our position should change, this application may be used with life insurance policies approved by your Department in the future.

Please note form A612151NW is being filed for; Manhattan National Life Insurance Company, Great American Life Insurance Company, Continental General Insurance Company, United Teacher Associates Insurance Company, Central Reserve Life Insurance Company, and Loyal American Life Insurance Company, simultaneously under separate cover.

With this information, I look forward to receiving a favorable response to this filing.

If you have any questions or require additional information regarding this submission, please feel free to contact me at either of the phone numbers indicated below or via e-mail at blittle@gafri.com.

Sincerely,

Brenda Little
Senior Compliance Filing Analyst

BRENDA LITTLE , SENIOR COMPLIANCE FILING ANALYST
(800) 854-3649 (TOLL FREE - EXT. 12725)
(513) 412-2725 (DIRECT DIAL) * (513) 361-5967 FAX