

State: Arkansas Filing Company: The Savings Bank Life Insurance Company of Massachusetts

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

Product Name: Reinstatement Application

Project Name/Number: /

Filing at a Glance

Company: The Savings Bank Life Insurance Company of Massachusetts

Product Name: Reinstatement Application

State: Arkansas

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

Date Submitted: 09/18/2012

SERFF Tr Num: SBMS-128689803

SERFF Status: Closed-Approved-Closed

State Tr Num:

State Status: Approved-Closed

Co Tr Num:

Implementation: On Approval

Date Requested:

Author(s): zSERFFStaff zIndustrySupportCM, Jim Coady, Cindy Milne, Grant Ward, Dan LeBlanc, Christopher Wilkie

Reviewer(s): Linda Bird (primary)

Disposition Date: 09/25/2012

Disposition Status: Approved-Closed

Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** The Savings Bank Life Insurance Company of Massachusetts
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Reinstatement Application
Project Name/Number: /

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Submitted simultaneously in all sates
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: Jim Coady
Submitted By: Jim Coady Corresponding Filing Tracking Number:

Filing Description:
K-11 APPLICATION FOR REINSTATEMENT OF LAPSED COVERAGE

We are filing the above referenced form for your approval.

This form is new and not intended to replace existing forms. It is laser printed, subject only to minor variations in color, fonts, duplexing and positioning. The forms will be effective on the date of approval.

No part of this filing contains any unusual or controversial items that deviate from normal Company or industry standards.

Text ordinarily bracketed appears in the specifications pages of the policy. See the attached Statement of Variability for a more complete description.

This form will be used in all licensed states for the purpose of applying for the reinstatement of lapsed life insurance policies issued by us, in accordance with the reinstatement provisions of such policies.

All requisite fees and filing documents are enclosed.

We appreciate receiving your approval of this new form at your earliest convenience. If you have any questions regarding this submission, please contact us.

Thank You.
SBLI of MA
NAIC# 70435

Company and Contact

Filing Contact Information

James Coady, Jcoady@SBLI.com
1 Linscott Road 781-994-5410 [Phone]
Woburn, MA 01801 781-994-4124 [FAX]

State: Arkansas **Filing Company:** The Savings Bank Life Insurance Company of Massachusetts
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Reinstatement Application
Project Name/Number: /

Filing Company Information

The Savings Bank Life Insurance Company of Massachusetts	CoCode: 70435	State of Domicile: Massachusetts
1 Linscott Road	Group Code: 4553	Company Type: Life
Woburn, MA 01801	Group Name:	State ID Number:
(781) 938-3500 ext. [Phone]	FEIN Number: 04-3117253	

Filing Fees

Fee Required? Yes
 Fee Amount: \$75.00
 Retaliatory? Yes
 Fee Explanation: Domicile state (MA) fee = \$75.00
 Per Company: No

Company	Amount	Date Processed	Transaction #
The Savings Bank Life Insurance Company of Massachusetts	\$75.00	09/18/2012	62802348

SERFF Tracking #:

SBMS-128689803

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

The Savings Bank Life Insurance Company of Massachusetts

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Reinstatement Application

Project Name/Number:

/

Correspondence Summary

Dispositions

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

SERFF Tracking #:

SBMS-128689803

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

The Savings Bank Life Insurance Company of Massachusetts

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Reinstatement Application

Project Name/Number:

/

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	Statement of Variability		Yes
Form	APPLICATION FOR REINSTATEMENT OF LAPSED COVERAGE		Yes

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: Reinstatement Application
 Project Name/Number: /

Filing Company: The Savings Bank Life Insurance Company of Massachusetts

Form Schedule

Lead Form Number: K-11(GEN)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		K-11(GEN)	OTH	APPLICATION FOR REINSTATEMENT OF LAPSED COVERAGE	Initial:	50.000	K-11(GEN) (9-13-12).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

I (WE) HEREBY APPLY for the reinstatement of the policy or policies listed below, including any eligible benefit riders attached thereto and in effect at the time of lapse.

A. INSURED (The person insured under the policy to be reinstated.)

Full Name (First, M. I., Last)		Date of Birth	Home Address (Number, Street, City, State, Zip Code)
Place of Birth	Social Security Number or TIN	Phone and E-mail (Check preferred method of contact): <input type="checkbox"/> Home #: <input type="checkbox"/> Cell#: <input type="checkbox"/> Work#: <input type="checkbox"/> E-mail:	
SBLI policy number(s) included under this Application for Reinstatement _____ _____			

B. OWNER – IF OTHER THAN THE INSURED

Full Name (First, M. I., Last)	Address (Number, Street, City, State, Zip Code)
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C. REQUIRED INFORMATION: The statements made below apply to the Insured named in section A above. For all "Yes" answers provide details in Section D.

1. (a) Current Height: _____ feet _____ inches (b) Current Weight: _____ pounds	2. Occupation (Include Duties): _____	
3. Name; address; and phone number of your primary care physician: _____ _____ - date last seen: _____ - reason for visit: _____ - outcome: _____		
4. Have you ever:		
a) Consulted with a health care provider regarding: symptoms; diagnosis; or treatment for any of the following conditions (Please check all that apply): <input type="checkbox"/> heart disease; <input type="checkbox"/> hypertension; <input type="checkbox"/> respiratory disease; <input type="checkbox"/> kidney disease; <input type="checkbox"/> diabetes; <input type="checkbox"/> cancer; <input type="checkbox"/> stroke (CVA or TIA); <input type="checkbox"/> depression; <input type="checkbox"/> anxiety; <input type="checkbox"/> mental disorder; <input type="checkbox"/> substance abuse; <input type="checkbox"/> liver disorder; <input type="checkbox"/> blood disorder; <input type="checkbox"/> tumor; <input type="checkbox"/> gastrointestinal disorder; <input type="checkbox"/> genito-urinary disorder; <input type="checkbox"/> neuromuscular; <input type="checkbox"/> seizure disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Been in a hospital or other health care facility for: observation; diagnoses; or surgical procedure?		<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Engaged in, or expect to engage in, hazardous (Please check all that apply): <input type="checkbox"/> sports; <input type="checkbox"/> avocations; <input type="checkbox"/> aviation activities; hobbies such as: <input type="checkbox"/> flying a plane; <input type="checkbox"/> scuba diving; <input type="checkbox"/> sky-diving; <input type="checkbox"/> hang-gliding; <input type="checkbox"/> racing boats; <input type="checkbox"/> racing motor vehicles, or engaging in <input type="checkbox"/> mountain, rock or ice climbing?		<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Received any type of treatment for (Please check all that apply): <input type="checkbox"/> alcohol; or drugs such as <input type="checkbox"/> cocaine; <input type="checkbox"/> marijuana; <input type="checkbox"/> heroin; <input type="checkbox"/> narcotics; <input type="checkbox"/> stimulants; <input type="checkbox"/> sedatives; <input type="checkbox"/> hallucinogens; <input type="checkbox"/> any other controlled substance?		<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Been convicted of a misdemeanor or felony?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you intend to reside or travel outside of the United States in the near future? If yes, please state for how long; and the name of city and country where you will be staying.		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been diagnosed with, or treated for Acquired Immune Deficiency Syndrome (AIDS); or have you ever tested positive for Human Immunodeficiency Virus (HIV)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has your driver's license been suspended or revoked; or have you received any motor vehicle moving violations within the last 10 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you used any form of tobacco, or nicotine by products such as nicotine gum within the last 10 years? If "yes", please provide: type _____; amount _____; frequency _____; date last used _____.		<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Please provide name, dosage and prescribing health care provider for any prescription medications that you are currently taking; or have taken in the last 10 years:		

D. DETAILS: Provide complete details in the space below for any "YES" answers to the questions in Section C. Identify question # and dates.

E. PREMIUMS

The Notice sent to you advising of the Lapse of your insurance stated the amount of overdue premium. If the Notice was dated over 30 days prior to your submission of this form, the amount due may be no longer be accurate. You may contact us (Tel: [(800) 694-7254, www.sbli.com]), for a current quote. If, upon review of this application, additional overdue premiums are required, we will advise of the additional amount due.

PLEASE MAKE YOUR CHECK PAYABLE TO "SBLI". ATTACH YOUR CHECK TO THIS APPLICATION

Amount of Payment: \$ _____

F. REPRESENTATIONS and SIGNATURES

I (we) represent that all statements and answers in this application are: full; complete; and true to the best of my (our) knowledge and belief. I (we) understand that said statements and answers are submitted as evidence of insurability of each person insured under the policy. I (we) further understand and agree that: (a) the Policy will not be reinstated; (b) no insurance coverage shall become effective; and (c) the company will have no liability, unless the following express conditions precedent are satisfied:

(1) Evidence of insurability acceptable to the company; (2) all money required for reinstatement of the lapsed coverage has been paid to SBLI; (3) this application has been approved by SBLI during the lifetime of all persons who would be insured under this Policy if reinstated; and (4) as of the time that conditions (1), (2) and (3) are met, all statements and answers in this application are full, complete and true. It is further agreed that with regard to the answers and statements provided in this Application for Reinstatement of Lapsed Coverage, that if the Policy is reinstated, then a new period of contestability shall begin from the effective date of such reinstatement.

_____ Date:

_____ Signature of Insured:

_____ Signature of Owner (if different):

COMPLETE, SIGN, COPY (FOR YOUR FILES), AND RETURN THE "AUTHORIZATION TO COLLECT AND DISCLOSE MEDICAL RECORDS"

Submit completed forms and all overdue premiums to:

[SBLI, P.O. Box 4046, Woburn, MA 01888]

APPLICATION FRAUD STATEMENTS

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or Producer 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: 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.

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

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

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

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

New Mexico: 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 civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer and/or insurance company, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance company containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer and/or insurance company, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

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

All other Jurisdictions not listed above: 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 maybe subject to fines and confinement in prison.]

AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

“Authorization” is defined as permission (in accordance with the provisions below) for the release of medical information.

Full Name of Insured (First, M. I., Last)	Date of Birth
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I hereby authorize all the entities listed below that have provided: payments; treatments; or services to me, or on my behalf, to disclose to SBLI (the “Company”) and its Producers, employees and representatives, including insurance support organizations, the following information: any and all information relating to: my health; my insurance policies; and claims, including, but not limited to: information relating to any medical consultations; treatments; surgeries; hospital confinements for physical and mental conditions; use of alcohol; drugs; and tobacco; drug prescriptions; and communicable diseases, including Human Immunodeficiency Virus (HIV) and AIDS [(except for HIV exposure or testing)].

I hereby authorize each of the following entities to provide the information outlined above:

- any physician; medical practitioner; or health care professional;
- any hospital; laboratory; pharmacy; pharmacy benefit manager; clinic; or other health care facility or provider;
- any insurance company; or reinsurance company;
- any consumer reporting agency; or insurance support organization;
- my employer; group policy holder; or benefit plan administrator; and
- MIB Inc.

This information may be disclosed pursuant to this authorization so that SBLI can use it to:

- determine my eligibility for insurance;
 - if a policy is reinstated, administer coverage; administer claims; and determine or fulfill responsibility for coverage and provision of benefits; and
 - Conduct other legally permissible activities that relate to any insurance coverage I have; or have applied for with SBLI.
- By my signature below, I acknowledge that any agreements I have made to restrict my information do not apply to this authorization. I instruct any: physician; medical practitioner; hospital; clinic; or other health care provider to release and disclose my entire medical record without restriction. I understand that my health care providers cannot refuse to provide treatment or payment for health care services if I refuse to sign this.
 - I further authorize SBLI to release any information obtained by this authorization to: MIB Inc.; other insurers in which I have policies (or to which I may apply; or to which a claim for benefits may be submitted); reinsurers; and other persons or organizations performing legal or business services in connection with my application or claim. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.
 - I authorize SBLI to release to me, or to my physician, results that I may request of any medical or laboratory tests taken in connection with this application. In connection with a claim for benefits, this authorization is valid no longer than the duration of the claim.
 - I also understand that failure to sign this authorization, or the subsequent revocation of this authorization by me, may impair the ability of SBLI to process my application or evaluate claims; and may be a basis for denying an application or claim for benefits.
 - By signing below, I: agree to the terms of this authorization; and acknowledge that I have read and understand it.

I may revoke this authorization in writing at any time; except to the extent that action has been taken in reliance of this authorization or to the extent SBLI has a legal right to contest a claim under an insurance policy or to contest the policy itself, by sending a written request to:, P.O. Box 4048, Woburn, MA 01888.

This authorization shall remain in force for 24 months following the date of my signature below or for the duration of any claim for benefits. A copy of this authorization is as valid as the original. I acknowledge that I have received a copy of this authorization.

Date: _____ **Signature of Insured*: X** _____

*If the insured is under the age of 18, signature of Parent Guardian Other: _____

SERFF Tracking #:

SBMS-128689803

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

The Savings Bank Life Insurance Company of Massachusetts

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Reinstatement Application

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Flesch Certification is attached.		
Attachment(s):			
K-11 Flesch Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:	Statement of Variability is attached.		
Attachment(s):			
K-11Statement Of Variability.pdf			

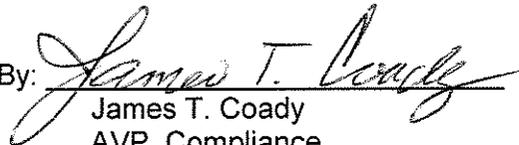
THE SAVINGS BANK LIFE INSURANCE
COMPANY OF MASSACHUSETTS

CERTIFICATION – FLESCH/READABILITY

Form Numbers	Form Name	FLESCH Score
K-11	Application for reinstatement of lapsed coverage	50.0

I hereby certify that in my judgment the above captioned form, submitted for approval under SERFF Filing #SBMS-128689803, meets the objective standards of readability/Flesch scores as required under IIPRC Standards.

Minimum Flesch score as stated above has been determined for the form.

By:  
James T. Coady
AVP, Compliance
SBLI of MA
Date

THE SAVINGS BANK LIFE INSURANCE
COMPANY OF MASSACHUSETTS

STATEMENT OF VARIABILITY

APPLICATION FOR REINSTATEMENT OF LAPSED COVERAGE
Form Series K-11

Bracketing will indicate the Company may concurrently make multiple versions of the same form number available using different values within the ranges provided. None of these items will be bracketed upon issuance of the contract to the owner. We hereby certify that any change will be done so in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

Other than John Doe information, only the items listed will be variable. We certify that the ranges for the bracketed items will be as follows:

Company Address (in 3 places)

This will allow for changes to the company's office location. Our current address at contract issue will appear.

Company Telephone Number and Internet address (in 3 places)

This will allow for changes to the company's telephone number and internet address. Our current telephone number and internet address at contract issue will appear.

Application Fraud Statements

Currently, the text displayed in the submitted form will be displayed. As individual states change existing fraud warnings, or add new fraud warning requirements, we wish to reserve the option of inserting the new or revised fraud warning without having to resubmit the form to all jurisdictions for approval.

Signature

9/17/2012

X James T. Coady, CLU

James T. Coady
AVP, Compliance
Signed by: James Coady