

State: Arkansas Filing Company: United Home Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 200-719
Project Name/Number: /

Filing at a Glance

Company: United Home Life Insurance Company
Product Name: 200-719
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 09/19/2012
SERFF Tr Num: UFFL-128692823
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 200-719

Implementation: 12/01/2012
Date Requested:
Author(s): Karen Hynes
Reviewer(s): Linda Bird (primary)
Disposition Date: 09/24/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 200-719
Project Name/Number: /

Filing Company: United Home Life Insurance Company

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Filed concurrently with Indiana, our state of domicile.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 09/24/2012
State Status Changed: 09/24/2012
Deemer Date: Created By: Karen Hynes
Submitted By: Karen Hynes Corresponding Filing Tracking Number:

Filing Description:

Attached please find the form referenced below for your review and approval. The requested implementation date of the form included in this submission is the later of your approval or December 1, 2012.

Form 200-719A 12-12 (AR) is an application for life insurance that will be used to apply for various products currently on file with your department and those that may be filed at a later date. The application is new and replaces form 200-679A 6-11 (AR) previously approved by your department August 9, 2011.

The main differences between the form enclosed and that previously approved are we: a) clarified employer information is only needed for proposed insureds under age 65; b) revised the statement regarding the accuracy of the tax identification number; c) revised the effective date wording in the Agreement/Acknowledgment, bank authorization, and receipt sections; d) as required by MIB, Inc., added language to the Authorization section to obtain consent to report personal health information to MIB and removed "or formerly known as Medical Information Bureau," from the second paragraph of the notice on page 6; and e) revised the bank authorization to allow for draft days on the Second, Third, or Fourth Wednesday of each month. Please note, the language regarding drafting on the Second, Third or Fourth Wednesday of each month has been added in brackets and will not appear on the printed applications until the programming for drafting on these specific Wednesday's is in place.

In addition to the above changes, we are also extending the use of our Terminal Illness Accelerated Benefit Rider to two of the plans shown in Section 4. As such, the terminal illness disclosure statement, an acknowledgement for receipt of the disclosure, and a statement for the agent to certify the disclosure has been provided have also been added to the application.

We reserve the right to make any typographical corrections or make minor revisions to the appearance of the form due to printing constraints.

If you have any questions or need any additional information, please feel free to contact me via SERFF, at 317-692-7465 or by email at Karen.Hynes@infarmbureau.com.

Company and Contact

Filing Contact Information

Karen Hynes, karen.hynes@infarmbureau.com
225 S East 317-692-7465 [Phone]
Indianapolis, IN 46202

State: Arkansas

Filing Company: United Home Life Insurance Company

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

Product Name: 200-719

Project Name/Number: /

Filing Company Information

United Home Life Insurance Company
 225 S. East St.
 Indianapolis, IN 46202
 (317) 692-7465 ext. [Phone]

CoCode: 69922
 Group Code: 542
 Group Name: Indiana Farm Bureau Group
 FEIN Number: 35-0841899

State of Domicile: Indiana
 Company Type: LAH
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: AR imposes a filing fee of \$50 per form.
 Per Company: No

Company	Amount	Date Processed	Transaction #
United Home Life Insurance Company	\$50.00	09/19/2012	62842993

State: Arkansas Filing Company: United Home Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 200-719
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/24/2012	09/24/2012

SERFF Tracking #:

UFFL-128692823

State Tracking #:

Company Tracking #:

200-719

State:

Arkansas

Filing Company:

United Home Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

200-719

Project Name/Number:

/

Disposition

Disposition Date: 09/24/2012

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	Application for Life Insurance		Yes

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
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Form Schedule

Lead Form Number: 200-719A 12-12 (AR)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		200-719A 12-12 (AR)	AEF	Application for Life Insurance	Initial:	50.400	200-719A - AR.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

Application for Life Insurance

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

SECTION 1 – Proposed Insured

Last Name		First Name		Middle Initial
Date of Birth (M-D-Y)	State of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status	Height	Weight		
Social Security Number	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, give immigration status/type of visa:</i>			
Street Address				
City		State	Zip Code	Phone Number ()
Employer/Occupation/Duties/How Long There (Required for Proposed Insureds under age 65)				
Billing Street Address		City	State	Zip Code
Secondary Addressee (For Past Due Notice)	Name	Street	City	State Zip Code

SECTION 2 – Ownership (Complete only if Owner is other than Proposed Insured)

Owner Name		Relationship	Social Security Number	
Owner Street Address		City	State	Zip Code
Contingent Owner Name		Relationship	Social Security Number	

SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name	Relationship	Age
Contingent Beneficiary Name	Relationship	Age

SECTION 4 – Plan of Insurance

Plan of Insurance <input type="checkbox"/> Modified Death Benefit Whole Life <input type="checkbox"/> Express Issue Deluxe <input type="checkbox"/> Express Issue Premier <input type="checkbox"/> Check here if you are willing to accept any product listed in this section for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit in the first 2 years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.	Face Amount: \$ _____
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If the Face Amount shown above is \$10,000 or greater and the product issued is the Modified Death Benefit Whole Life, the following riders will be attached to the policy: Identity Theft Waiver of Premium Rider, Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

Accidental Death Benefit Rider (not available with Modified Death Benefit WL) \$ _____

SECTION 5 – Payment Information

Modal Premium: Annual Semi-Annual Qtrly. PAC* Modal Premium Amount \$ _____
\$ _____ paid with application.

***If selected, bank information on Page 5 must be fully completed.**

SECTION 6 – Other Insurance

Do you have any existing life insurance policies or annuity contracts? Yes No
If "Yes," please complete any necessary replacement forms.

SECTION 7 – Nicotine Use

Has the Proposed Insured used nicotine in any form in the past 12 months? Yes No

SECTION 8 – Physician Information

Name and Address of Family Physician (Required)	Family Physician Telephone Number (Required) () -
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SECTION 9 – Medical Questions

PART A – MODIFIED DEATH BENEFIT WHOLE LIFE – COMPLETE PART A ONLY

If any question in Part A is answered “Yes”, you are not eligible for Modified Death Benefit Whole Life.

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been told that you need an organ transplant or have you been diagnosed as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Do you require assistance to feed, bathe, dress or take your own medication or are you currently confined to a hospital, nursing home, mental facility, hospice, or require home health nursing care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. In the past twelve (12) months:	
1. Other than for temporary or minor conditions, have you been hospitalized two or more times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Other than preventive, maintenance or risk lowering medications prescribed, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), heart attack, stroke, or had heart surgery (including angioplasty)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you used any illegal drugs, been treated for or advised to have treatment for drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART B - EXPRESS ISSUE DELUXE – COMPLETE PARTS A & B ONLY

If any question in Part B is answered “Yes”, you are not eligible for Express Issue Deluxe. Submit the case as Modified Death Benefit Whole Life.

A. In the past 2 years:	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer’s Disease or Dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Other than preventive, maintenance or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension) or Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Sickle Cell Anemia or Kidney Disease (including dialysis) or Liver Disease (including hepatitis B & C)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. ALS (Lou Gehrig’s Disease) or Neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been advised by a medical professional to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you excessively used, been treated for or been advised to have treatment for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. In the past 10 years have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART C - EXPRESS ISSUE PREMIER – COMPLETE PARTS A, B, & C

If any question in Part C is answered “Yes”, you are not eligible for Express Issue Premier. Submit the case as Express Issue Deluxe.

A. In the past 2 years:	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes requiring insulin treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. SLE (Systemic Lupus Erythematosus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver’s license suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been declined or postponed for Life Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. If under age 65, are you currently disabled, or been disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Do you now participate in, or do you have plans to participate in any hazardous sport or aviation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 10 – Agreement/Acknowledgment

I hereby apply for the insurance indicated above and I am submitting the first premium. I have read (or have had read to me) all statements and answers recorded on this application, and I certify that the answers are true and accurate whether written by my own hand or not. I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

*****WARNING*****

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.

I hereby certify under penalties of perjury, that the tax identification number provided is true, correct and complete.

SECTION 11 – Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc. ("MIB"), or other organization, institution, or person, that has any records or knowledge of me or my dependents, if they are to be insured, or our health, to give the United Home Life Insurance Company ("UHL") or its reinsurer(s) any such information. UHL may also disclose such information to reinsurers, MIB, persons or entities performing business, professional or insurance functions for UHL or as may otherwise be legally allowed. I further authorize UHL or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that UHL may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date of my signature below. I have a right to receive a copy of this authorization.

SECTION 12 – HIPAA Authorization

This authorization complies with the HIPAA Privacy Rule.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company and its agents, employees, and representatives. United Home Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Home Life Insurance Company or as may otherwise be legally allowed. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy, image, or facsimile of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I have a right to receive a copy of this authorization.

SECTION 13 – Disclosure Acknowledgement

I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount. (This benefit is not available with the Modified Death Benefit Whole Life plan.)

SECTION 14 – Signatures

Signature applies to Sections 1 through 13. Review before signing.

Dated at _____, this _____ day of _____, _____
City State Month Year

Signature of Proposed Insured or personal representative

Description of personal representative's authority to act

Signature of Owner (If other than Proposed Insured)

THE FOLLOWING SECTION MUST BE COMPLETED BY THE AGENT.

To the best of my knowledge and belief the applicant does does not have any existing life insurance policies or annuity contracts.

I certify that I have provided the Proposed Insured a copy of the Terminal Illness Accelerated Benefit Disclosure Statement and a numerical illustration.

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail _____

Agent: Phone # _____ Fax# _____ License Identification Number (_____)
State

AUTHORIZATION TO HONOR CHECKS
DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

The initial modal premium **must** be quoted in Section 5 of the application.
We do not accept debit or credit cards.

Please select ONLY one option. Include a copy of voided check for bank draft.

Draft my account for the first premium (initial premium may be drafted immediately upon submission of this application).
Please draft subsequent premiums on the _____ day of each month [or on the Second Wednesday Third Wednesday
 Fourth Wednesday of each month].

Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day
each month [or on the Second Wednesday Third Wednesday Fourth Wednesday of each month].

Do NOT draft my account for the first premium. The initial premium is attached, is being mailed, or will be collected on
delivery. **Please make check or money order payable to United Home Life Insurance Company. Do not leave Payee
blank or make it payable to the agent.** Please draft subsequent premiums on the _____ day of each month [or on the
 Second Wednesday Third Wednesday Fourth Wednesday of each month].

The policy may be placed on direct quarterly mode temporarily if we do not receive complete bank information or if there is a
difference in premium quoted.

**I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for
and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the
premium paid.**

Bank Name _____ Bank Address _____

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my
account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are
sufficient collected funds in said account to pay the same upon presentation. I understand that I am personally liable for
overdraft fees charged on said account if funds are not available at the designated date of withdrawal. I agree that your rights in
respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This
authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be
fully protected in honoring any such debit entry. I further agree that if any such debit entry be dishonored, whether with or without
cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in
the forfeiture of insurance.

Account Number: _____ Checking Savings Routing Number: _____

Premium Payor's Printed Name: _____ Relationship to Insured: _____

Signature of Premium Payor: _____ Date: _____

**In the event that a pre-printed void check or bank statement is not available, please complete the following information
for account verification:**

Financial Institution: _____ Phone Number: _____

Address: _____

I have personally verified that the above policy owner/payor has a current, active account.

Agent Name: _____ Agent #: _____

Agent Signature: _____ Date: _____

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application, please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank. I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

RECEIPT

Received from _____ The sum of \$ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance \$ _____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____, _____
Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., a non-profit membership organization of life 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 it may have in your file. If you question the accuracy of 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, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life 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 on its website at www.mib.com.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Terminal Illness Accelerated Benefit Disclosure Statement (This benefit is not available with the Modified Death Whole Life plan.)

Benefits paid under this benefit may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit.

Description of Benefits - This Benefit provides you with the right to access the Death Benefit (discounted at interest for one year)* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

Effect on the Policy - When the accelerated benefit is paid, the policy terminates.

Example - This example is for illustration only, uses a \$50,000 policy and an interest rate of 7%.* The amounts shown are not based on your specific policy.

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Table with 2 columns: Description, Amount. Rows: Death Benefit (\$50,000.00), Less 7% (3,271.03), Accelerated Benefit (\$ 46,728.97)

*The interest rate used to discount this benefit is defined in Section A of your Terminal Illness Accelerated Benefit Rider.

SERFF Tracking #:

UFFL-128692823

State Tracking #:

Company Tracking #:

200-719

State:

Arkansas

Filing Company:

United Home Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

200-719

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability - Signed.pdf			



CERTIFICATION

I hereby certify the following score(s) on the Flesch Reading Ease Test.

Form	Score
200-719A 12-12	50.4

Date: 9/19/2012



Joseph A. Martin
Chief Operating Officer
Senior Vice President, Life Operations
United Home Life Insurance Company