

State: Arkansas **Filing Company:** United Security Life and Health Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: EZ Whole Life Insurance
Project Name/Number: EZ Whole Life Insurance/EZWL-APP-12

Filing at a Glance

Company: United Security Life and Health Insurance Company
Product Name: EZ Whole Life Insurance
State: Arkansas
TOI: L071 Individual Life - Whole
Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Filing Type: Form
Date Submitted: 08/29/2012
SERFF Tr Num: USLH-128665285
SERFF Status: Closed-Accepted For Informational Purposes
State Tr Num:
State Status: Closed-Accepted for Informational Purposes
Co Tr Num: EZWL-APP-12

Implementation: On Approval
Date Requested:
Author(s): Jaime Gettemans, Peg Lundy
Reviewer(s): Linda Bird (primary)
Disposition Date: 09/07/2012
Disposition Status: Accepted For Informational Purposes
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** United Security Life and Health Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: EZ Whole Life Insurance
Project Name/Number: EZ Whole Life Insurance/EZWL-APP-12

General Information

Project Name: EZ Whole Life Insurance Status of Filing in Domicile: Pending
 Project Number: EZWL-APP-12 Date Approved in Domicile:
 Requested Filing Mode: Informational Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: Resubmission Previous Filing Number: EZL-07
 Individual Market Type: Overall Rate Impact:
 Filing Status Changed: 09/07/2012 Deemer Date:
 State Status Changed: 09/07/2012 Submitted By: Peg Lundy
 Created By: Peg Lundy
 Corresponding Filing Tracking Number:

Filing Description:

Please see the attached Cover Letter for details regarding this filing. Thank you very much!

EZ Whole Life Application with Attached Cash Receipt and Accelerated Death Benefit Rider Summary - Filing for Informational Purposes Only.

Company and Contact

Filing Contact Information

Peg Lundy, plundy@unitedsecuritylandh.com
 6640 S. Cicero Avenue 708-475-6025 [Phone]
 Bedford Park, IL 60638

Filing Company Information

United Security Life and Health Insurance Company CoCode: 81108 State of Domicile: Illinois
 6640 S. Cicero Group Code: Company Type:
 Bedford Park, IL 60638 Group Name: State ID Number:
 (708) 475-6000 ext. [Phone] FEIN Number: 36-3692140

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 for the Application and \$50.00 for the Cash Receipt. Thank you!
 Per Company: No

Company	Amount	Date Processed	Transaction #
United Security Life and Health Insurance Company	\$100.00	08/29/2012	62131766

SERFF Tracking #:

USLH-128665285

State Tracking #:

Company Tracking #:

EZWL-APP-12

State:

Arkansas

Filing Company:

United Security Life and Health Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

EZ Whole Life Insurance

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EZ Whole Life Insurance/EZWL-APP-12

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Linda Bird	09/07/2012	09/07/2012

SERFF Tracking #:

USLH-128665285

State Tracking #:

Company Tracking #:

EZWL-APP-12

State:

Arkansas

Filing Company:

United Security Life and Health Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

EZ Whole Life Insurance

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EZ Whole Life Insurance/EZWL-APP-12

Disposition

Disposition Date: 09/07/2012

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cash Receipt-Layout 1		Yes
Supporting Document	Cover Letter for EZ Whole Life Application		Yes

SERFF Tracking #:

USLH-128665285

State Tracking #:

Company Tracking #:

EZWL-APP-12

State:

Arkansas

Filing Company:

United Security Life and Health Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

EZ Whole Life Insurance

Project Name/Number:

EZ Whole Life Insurance/EZWL-APP-12

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Please see attached EZ Whole Life Insurance Application (EZWL-APP-12) being filed for Informational Purposes Only. The Accelerated Death Benefit Rider Summary (EZWL12-ADBR) is also attached to the Application as it has been in the past. Thank you very much!		
Attachment(s):			
EZ Whole Life Insurance Application - (EZWL-APP-12) - AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Cash Receipt-Layout 1		
Comments:	The Cash Receipt will be attached to the EZ Whole Life Application and it will be a perforated tear off section. Thank you very much!		
Attachment(s):			
Cash Receipt-Layout 1.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter for EZ Whole Life Application		
Comments:	Cover Letter for EZ Whole Life Application. Thank you very much!		
Attachment(s):			
8.30.12 - Cover Letter (EZ Whole Life Product) - AR.pdf			

INSURED'S STATEMENT AND HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby apply to United Security Life and Health Insurance Company ("USL&H") for insurance. I represent the statements I have made herein are complete and true. I understand the following: (a) if any material information on this application is incorrect, this coverage may be voided; and, (b) if this application is declined and a Policy is not issued, USL&H's only obligation will be to return any premium paid; and, (c) there is no insurance in force until a Policy indicating the effective date is received from USL&H and the initial premium, including the applicable fee, is paid in full. By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medical or medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of my health, to give USL&H, its reinsurers, affiliates, or business associates, any such information which shall include, but not be limited to, Alcohol or Drug abuse treatment, Mental Health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing. I understand the information obtained by use of this authorization will be used by USL&H to determine eligibility for insurance. Any information obtained will not be released by USL&H to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for two and one half years from the date shown below. (For residents of Arizona, this authorization is valid for 180 days for any HIV-related information.) I acknowledge receipt of the important notice regarding a consumer report and disclosure of information to the Medical Information Bureau. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to USL&H, 6640 S. Cicero Ave., Bedford Park, IL 60638. Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or the extent that USL&H has a legal right to contest a claim under an insurance policy or to contest the policy itself within the two year Contestable Period. A photographic copy of this authorization and acknowledgement shall be as valid as the original. Upon request I, or my authorized representative, is entitled to receive a copy of this authorization form. 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 may be guilty of a crime and may be subject to fines and confinement in prison.

I further authorize USL&H or its reinsurer(s) to make a brief report of my personal health information to MIB.

I have paid the sum of \$ _____ with this Application, dated at _____
 _____ City _____ State _____
 this _____ day of _____ 20____.
 _____ Day _____ Month

X _____ X _____
 Signature of Proposed Insured Signature of Applicant /Owner
 (if other than Proposed Insured)

AGENT'S STATEMENT: Is insurance being applied for intended to replace any insurance now in force?

If "YES", submit required Replacement Form. Yes No

I have truly and accurately recorded in this Application, the information supplied by applicant.

Print Agent Name _____ X _____ X _____
 _____ Licensed Agent Signature Agent No.



Application for EZ Whole Life Insurance

6640 S. Cicero Avenue
 Bedford Park, IL 60638
 708-475-6100 • www.uslandh.com

REQUESTED EFFECTIVE DATE
 _____ / _____ / _____
 MONTH DAY YEAR

*APL Yes No
 *Automatic Premium Loan Option

*ADB Yes No
 *Accelerated Death Benefit

If YES, sign Disclosure on reverse side

PLEASE TYPE OR PRINT

1. Name of Proposed Insured _____ Sex _____ Age _____

 (First, Middle Initial, Last Name)

Birth Date _____ / _____ / _____ State of Birth _____ Height _____ Weight _____

2. Residence of Proposed Insured

_____ Home Phone Number (_____) _____
 Street Number City State Zip Code

3. Occupation _____

4. Proposed Insured's Social Security Number _____ - _____ - _____

5. Face Amount (Choose from \$2,500 to \$25,000) \$ _____

6. Premium Payment Mode Annually Semi-Annually Quarterly PAC Monthly Direct Monthly
 Credit Card Monthly

Visa/MasterCard/Discover # _____ Expiration Date _____

7. Primary Beneficiary _____ Relationship _____

Contingent Beneficiary _____ Relationship _____

8. Applicant (Owner), if other than the Proposed Insured: (Complete below and sign Signature Block at bottom of Application)

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Social Security or Tax ID number of Applicant _____ - _____ - _____

9. Will the proposed insurance replace any existing Life Insurance policy or annuity? _____ Yes No

If yes, list company name, address and policy number: _____

10. Health questions (if the answer is "YES" to any question A- G, the Proposed Insured is not eligible for coverage).

A) Is the Proposed Insured currently bedridden, confined to a nursing facility or hospital, receiving Hospice or Home Health Care, requiring assistance with activities of daily living such as walking, eating, bathing, toileting or dressing, waiting for or had an organ transplant, been advised to use or using oxygen to assist in breathing, or paralyzed? _____ Yes No

B) Has the Proposed Insured ever:
 i) Had, been told they have, been treated for, or been prescribed medication for Alzheimer's disease, dementia, memory loss, sickle cell anemia, liver disease or cirrhosis, muscular dystrophy, Huntington's disease, ALS (Lou Gehrig's disease), congestive heart failure, or had a Pacemaker installed? _____ Yes No

ii) Had, been told they have, been treated for, or been prescribed medication for Chronic Obstructive Pulmonary Disease (COPD), Emphysema, chronic kidney disease, kidney failure (renal insufficiency including dialysis), Parkinson's Disease, Multiple Sclerosis, Cystic Fibrosis, Cerebral Palsey, or Down's Syndrome? _____ Yes No

iii) Been diagnosed as having, or been treated for, or tested positive by a physician or someone in the medical field for, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibiotics to Human T-Cell Lymphotropic Virus, Type III (HTLV-III) or HIV? _____ Yes No

C) In the past 10 years, has the Proposed Insured used illegal drugs of any kind or been convicted of a felony? _____ Yes No

Continued from page 1.

- D)** In the past 5 years, has the Proposed Insured been told they have or been treated by surgery, chemotherapy, radiation, or prescribed medication for internal cancer, leukemia, Hodgkin’s disease, or malignant melanoma or had more than one occurrence in their lifetime, other than Basal Cell Skin Cancer?..... Yes No
- E)** In the past two 2 years, has the Proposed Insured been hospitalized as an inpatient for Diabetes or complications of Diabetes, or was diagnosed with Diabetes before the age of 40 or had any amputation caused by disease? Yes No
- F)** In the past 2 years, has the Proposed Insured been told they have, been treated for, or taken medication or had surgery for:
- i) Heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), stroke, circulation or blood clot problems in the legs or to the heart or brain, or systemic lupus?..... Yes No
- ii) Drug or alcohol abuse/dependency or addiction?..... Yes No
- G)** In the past 6 months, has the Proposed Insured been advised to have testing, hospitalization, surgery, or treatment by a medical professional and not done so?..... Yes No

If all the above questions A-G are answered “NO” you may be eligible for a full face amount policy. You must meet the Height and Weight Requirements for the Plan. Your acceptance of a Life Insurance Policy is subject to approval by the Home Office of United Security Life and Health Insurance Company.

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED SECURITY LIFE & HEALTH INSURANCE COMPANY

Name of Bank: _____

Address of Bank: _____

As a convenience to me, I hereby request and authorize you to pay and charge my account (checks or electronic debits) drawn on my account by and payable to United Security Life & Health, provided there are sufficient funds in said account to pay the same on presentation. I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit 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. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

Printed Name of Depositor _____

Signature of Depositor _____

Date _____

If Bank Check Plan or Electronic Transfer **ATTACH VOIDED CHECK HERE** and Sign Authorization Above

Proposed Insured’s Telephone Number:

Home (____) _____

Available during day Yes No

Best time to contact: _____

Business: (____) _____

Available during day Yes No

Best time to contact: _____

ACCELERATED DEATH BENEFIT PAYMENT RIDER SUMMARY AND DISCLOSURE STATEMENT

THE EFFECT OF ACCELERATION OF A BENEFIT:

Any benefits paid under the Rider will reduce the Cash Value, Death Benefit, any Outstanding Policy Loan and Premiums of the Policy. The Death Benefit will be reduced by the amount of eligible proceeds You select when You exercise Your rights under the Rider. Any eligible proceeds requested under the Rider will be reduced by the amount required to repay a pro-rata portion of any outstanding loan, including any related accrued interest, and by the deduction of the processing charge. A Benefit Payment notice will be sent to You, the Owner, upon receipt by Us, United Security Life and Health Insurance Company of a request for Acceleration of Benefits. This notice will show the effect the Advance Payment will have on Policy benefits, and other Policy Values. When an Advance Payment is made under the Rider, a revised Schedule Page for the Policy will be furnished to You to show the revised Policy Values then in force..

TAX CONSEQUENCES:

The receipt of an Advance Payment may be considered a taxable event. The receipt of an Advance Payment may also affect the Insured’s eligibility to receive, or continue to receive, Medicaid benefits or other government benefits and entitlements. As with all legal matters, a personal tax and/or other legal advisor should be consulted to assess the impact of the receipt of an Advance Payment under the Rider.

THE BENEFIT:

Upon written request by You, We will make an Advance Payment, subject to the limitations and requirements outlined in the Rider. An Advance Payment will only be paid one time. This benefit can not be exercised if the Policy to which the Rider is attached has been assigned as collateral for a loan. If this Policy is in the Grace Period when an Advanced Payment is elected, the premium and fee due to pay this Policy current will be deducted from the Advanced Payment.

THE AMOUNT:

The amount of Eligible Proceeds is selected by You, subject to certain limitations. The minimum amount available for acceleration is \$1,250 of Eligible Proceeds. The maximum amount available for acceleration is 50% of the Eligible Proceeds, as defined in the Rider. After the Advance Payment is made to You, the amount of Eligible Proceeds remaining in force must be at least \$1,250.

SAMPLE ILLUSTRATION OF ACCELERATED BENEFIT PAYMENT

ASSUMPTIONS:

1. Eligible Proceeds	\$ 10,000.00
2. Premium	\$ 19.96 per month
3. Cash Value	\$ 1,725.00
4. Outstanding Policy Loan	\$ 600.00
5. Eligible Proceeds Selected	\$ 5,000.00
6. Processing Charge	\$ 100.00

ACKNOWLEDGEMENT

I (We), the undersigned, hereby acknowledge that I (we) have received the above Accelerated Death Benefit Payment Rider Summary and Disclosure Statement which was furnished to me (us) prior to the signing of the application for insurance.

Proposed Insured’s Signature _____

Date _____

Agent’s Signature _____

Date _____

EZWL12-ADBR

THE COST:

There is a \$1.00 per month charge for the Accelerated Death Benefit Payment Rider. A processing charge, not to exceed \$100, may be deducted from the Eligible Proceeds. The processing charge is directly associated with Our administrative costs related to the Advance Payment.

DIAGNOSIS:

A Terminal Illness or Injury must be diagnosed by a licensed practitioner, practicing within the scope of his or her license. Upon diagnosis of a life expectancy of 180 days or less, satisfactory evidence of such diagnosis may be required. Satisfactory evidence includes certification by a doctor of the Insured’s expected death within 180 days. We may require a second examination, at Our expense, by a doctor of Our choice, or any other evidence We deem necessary.

TERMINATION:

The Accelerated Death Benefit Payment Rider will terminate when: 1. An Advance Payment is made in accordance with the provisions of the Rider; 2. You make a written request to terminate the Rider and You return the Policy and Rider to Us; or 3. The Policy terminates.

DEFINITIONS:

Eligible Proceeds means the amount You requested in accordance with the limitations of the Rider. Prior to payment to You, this amount will be used to repay a pro-rata portion of any outstanding Policy Loan and will be further reduced by the deduction of the processing charge. Terminal Illness or Injury is defined as a condition with a life expectancy of 180 days or less, as diagnosed by a licensed practitioner. Practitioner or Doctor means a person who is duly qualified, legally licensed and practicing within the scope of the license who is:

1. a physician or surgeon practicing medicine and surgery; and authorized to and uses the designation M.D.; or
2. a physician of osteopathy who uses the designation D.O.. However, “Practitioner” or “Doctor” does not include the Owner, Insured, spouse, son or daughter, brother or sister, parent, grandchild, or grandparent of the Owner or the Insured.

POLICY STATUS BEFORE AND AFTER ELECTION:

<i>Before</i>	<i>After</i>
\$ 10,000.00	\$ 5,000.00
\$ 19.96 per month	\$ 11.23 per month
\$ 1,725.00	\$ 862.50
\$ 600.00	\$ 300.00
Advance Payment = Eligible Proceeds Selected less Loan Reduction Amount less	
Processing Charge	
Advance Payment = \$5,000.00 --- \$300.00 --- \$100.00	
Advance Payment = \$4,600.0	

Owner’s Signature _____

Date _____

CASH RECEIPT

Received of _____ this _____ day of _____,

the sum of \$ _____

being the payment of _____ month(s) premium.

The insurance applied for shall not take effect until the effective date of the policy, payment of the first premium and before any change in the applicant's insurability. In the event the application is declined, any payment made by the applicant will be returned.

Agent's Signature: _____

Make checks payable to United Security Life & Health. Do not make payable to agent or leave payee blank.



Underwritten by

UNITED SECURITY LIFE & HEALTH INSURANCE COMPANY

6640 S. Cicero Avenue • Bedford Park, IL 60638 • 708-475-6100

www.uslandh.com

August 30, 2012

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

RE: Company ID #205611
NAIC #81108 / FEIN # 36-3692140
EZWL-12-APP / Application for EZ Whole Life Insurance
Cash Receipt – Layout 1 / Cash Receipt for EZ Whole Life Application

To Whom It May Concern:

Please find the revised Application Form #EZWL-12-APP. The application replaces Application EZL-07. Application EZL-07 was filed and approved in your state on 02/07/2007. Please note that this revised application is making a change to the name of the product. Instead of EZ-Life, it will now be referred to as EZ Whole Life. The policy issued with this product will still be EZ-Life-07, which was filed with the original application as specified above. The Cash Receipt was originally on the back of the EZ Life Brochure. It will now be a perforated tear off section of the Application. The Brochure was also a part of the Application but it will now be a separate form. No other changes were made to the Brochure. The Accelerated Death Benefit Rider Summary is also attached to the Application, as it had in the past but has just been given a new form number. The Old Form Number for the Accelerated Death Benefit Rider Summary was EZ07-ADBR the New Form Number is EZWL12-ADBR.

If you should have any questions, feel free to contact me directly at (708) 552-2417 or via email at jaimegettemans@priscorp.net.

Sincerely,



Jaime Gettemans
Compliance Department

Quality Products from Caring Professionals