

**State:** Arkansas **Filing Company:** Standard Life and Accident Insurance Company  
**TOI/Sub-TOI:** L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life  
**Product Name:** SME 2013  
**Project Name/Number:** SME 2013/SME 2013

## Filing at a Glance

Company: Standard Life and Accident Insurance Company  
Product Name: SME 2013  
State: Arkansas  
TOI: L071 Individual Life - Whole  
Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Filing Type: Form  
Date Submitted: 01/09/2013  
SERFF Tr Num: AMNA-128841141  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: SME 2013

Implementation  
Date Requested:  
Author(s): Tyra Reed, Amber Adams, Tobie Brink  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/15/2013  
Disposition Status: Approved-Closed  
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: Standard Life and Accident Insurance Company  
TOI/Sub-TOI: L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life  
Product Name: SME 2013  
Project Name/Number: SME 2013/SME 2013

**General Information**

Project Name: SME 2013 Status of Filing in Domicile: Pending  
Project Number: SME 2013 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: 01/15/2013  
State Status Changed: 01/15/2013  
Deemer Date: Created By: Tobie Brink  
Submitted By: Tobie Brink Corresponding Filing Tracking Number:

Filing Description:  
January 9, 2013

Arkansas Insurance Department  
Compliance - Life and Health  
1200 West Third Street  
Little Rock AR 72201-1904

RE: Standard Life and Accident Insurance Company (NAIC: 86355 FEIN: 73-0994234)  
Form ST-10592 – Statements to Medical Examiner for Standard Life and Accident Insurance Company  
SERFF Tracking Number: AMNA-128841141  
Company Tracking Number: SME 2013 SLAICO

Dear Reviewer:

Please find attached the above referenced form for your department’s review and approval. This is a new form and will not replace any previously approved forms. This form will be used with currently approved and future-approved individual life insurance products.

The only change made to the forms is the addition of “high blood pressure” in Question 2a.

This form is the Statements to Medical Examiner form. During the underwriting process, additional information may be required. This form is completed by the proposed insured and the proposed insured’s physician and returned to the administrative office. A copy of the completed form will be attached to and made a part of the application/policy.

This questionnaire will be used with all current and future approved life insurance applications, insurability, and reinstatement applications.

Additional information/supporting documentation included in this submission is as follows:

- Statement of Variability
- Readability Certification
- As the above listed products are issued on a sex-distinct basis, we confirm that the policy will not be issued in any employer-employee plans that are subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964.

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- An insert page listing the compacting state's Department of Insurance information.
- Payment of the required filing fees have been submitted via EFT.
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Sincerely,

Tobie Brink  
 Life Policy Analyst III

## Company and Contact

### Filing Contact Information

Tobie Brink, Project Coordinator	Tobie.Brink@ANICO.com
One Moody Plaza	409-763-1112 [Phone] 4165 [Ext]
Actuarial Product Development	409-766-6933 [FAX]
14th Floor	
Galveston, TX 77550	

### Filing Company Information

Standard Life and Accident Insurance Company	CoCode: 86355	State of Domicile: Texas
Administrative Office:	Group Code: 408	Company Type: LifeHealth and Annuity
One Moody Plaza	Group Name:	State ID Number:
14th Floor	FEIN Number: 73-0994234	
Galveston, TX 77550		
(409) 763-4661 ext. 5222[Phone]		

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	\$50 for forms filed separate from policy; based on TX domicile fee.
Per Company:	No

Company	Amount	Date Processed	Transaction #
Standard Life and Accident Insurance Company	\$50.00	01/09/2013	66395300

SERFF Tracking #:

AMNA-128841141

State Tracking #:

Company Tracking #:

SME 2013

State:

Arkansas

Filing Company:

Standard Life and Accident Insurance Company

TOI/Sub-TOI:

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

Product Name:

SME 2013

Project Name/Number:

SME 2013/SME 2013

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/15/2013	01/15/2013

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## Disposition

Disposition Date: 01/15/2013

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	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Statement of Variability		Yes
Form	Statements to Medical Examiner		Yes

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## Form Schedule

Lead Form Number:								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Statements to Medical Examiner	Form ST-10582	OTH	Initial		50.700	Form ST-10592.pdf

### Form Type Legend:

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



1. Proposed Insured's Name: Last \_\_\_\_\_ Date of Birth (Mo-Day-Yr) \_\_\_\_\_ Sex: M  F   
 Name: First, M.I. \_\_\_\_\_

Name, address, and phone number of personal physician (If none, state "none")  
 Name of doctor: \_\_\_\_\_ Date last seen: \_\_\_\_\_  
 Address/Phone: \_\_\_\_\_ Reason for last visit: \_\_\_\_\_

2. <b>Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession ...</b>		YES	NO	Give full details below of all "Yes," answers to questions 2 through 11. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICATION ITEMS: Include diagnosis dates, duration and names and addresses of all attending physicians and medical facilities.)  Attach an additional sheet of paper, if necessary.
a) for a heart attack, high blood pressure, chest pain, angina, congestive heart failure, heart murmur, irregular heart beat, heart valve disease or any disease or disorder of the heart or arteries?	<input type="checkbox"/>	<input type="checkbox"/>		
b) for a stroke, cerebral vascular accident (CVA), Transient Ischemic Attack (TIA), aneurysm, or peripheral vascular disease (PVD)?	<input type="checkbox"/>	<input type="checkbox"/>		
c) for cancer, leukemia, lymphoma, malignant melanoma or any other malignancy?	<input type="checkbox"/>	<input type="checkbox"/>		
d) for diabetes, elevated blood sugar, impaired glucose intolerance or impaired fasting glucose?	<input type="checkbox"/>	<input type="checkbox"/>		
e) for human immunodeficiency virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>		
3. <b>Have you, in the last ten years, been diagnosed or treated by a member of the medical profession for ...</b>				
a) Seizures, epilepsy, or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>		
b) Multiple Sclerosis (MS), ALS (Lou Gerhig's disease), muscular dystrophy, or Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>		
c) Asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD), or any disease or abnormality of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>		
d) Cirrhosis, hepatitis, ulcerative colitis, Crohn's disease, disease of the pancreas, esophagus, ulcer or any other disease or disorder of the stomach or intestines?	<input type="checkbox"/>	<input type="checkbox"/>		
e) Anemia, blood disorder, clotting or bleeding disorder, or any lymph node disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
f) Arthritis, fibromyalgia, or any disease of the bones, muscles or joints?	<input type="checkbox"/>	<input type="checkbox"/>		
g) Lupus, rheumatoid arthritis, scleroderma, polymyositis, dermatomyositis or any connective tissue disease?	<input type="checkbox"/>	<input type="checkbox"/>		
h) Injuries associated with falls or imbalance?	<input type="checkbox"/>	<input type="checkbox"/>		
i) Disease of the prostate or genital system?	<input type="checkbox"/>	<input type="checkbox"/>		
j) Disease of the kidneys, bladder, urinary tract, protein or blood in the urine?	<input type="checkbox"/>	<input type="checkbox"/>		
k) Depression, anxiety, psychiatric treatment or counseling, or any disease or abnormality of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>		
4. <b>Within the past 10 years have you ...</b>				
a) Been advised by a member of the medical profession to reduce or discontinue use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>		
b) Received treatment or counseling by a member of the medical profession for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>		
5. <b>Within the past 5 years have you ...</b>				
a) had an operation or been hospitalized by a member of the medical profession for any illness, disease or accident?	<input type="checkbox"/>	<input type="checkbox"/>		
b) had any diagnostic testing by a member of the medical profession (EKG or other cardiovascular test, X-ray, blood, or other laboratory test)?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Are you currently being prescribed any medications or under any treatment by a member of the medical profession? (please list medications/treatment)	<input type="checkbox"/>	<input type="checkbox"/>		
7. Has your weight changed by more than 10 lbs in the past year? If yes, reason?	<input type="checkbox"/>	<input type="checkbox"/>		





19. URINALYSIS: (To be done in all cases.)  
Send specimen to laboratory in all cases. Specific Gravity: \_\_\_\_\_ Alb. \_\_\_\_\_ Sugar \_\_\_\_\_

**FRAUD WARNING:**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I certify that I examined \_\_\_\_\_ at \_\_\_\_\_ A.M./P.M. on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(Name of Applicant) Month Year

Examination made at my office \_\_\_\_\_, Individual's office \_\_\_\_\_, Individual's home \_\_\_\_\_, other \_\_\_\_\_

Examiner's Signature: \_\_\_\_\_, Examiner's Address: \_\_\_\_\_

SS#    or Tax I.D.#

**EXAMINER'S VOUCHER**

(Do not detach)

Medical Examiner \_\_\_\_\_

SS#    or Tax I.D.#

Fee \$ \_\_\_\_\_

Address of Examiner \_\_\_\_\_

Name of Person examined \_\_\_\_\_

Name of Agent/Insurance Producer \_\_\_\_\_ Agency \_\_\_\_\_

Date of Examination \_\_\_\_\_

SERFF Tracking #:

AMNA-128841141

State Tracking #:

Company Tracking #:

SME 2013

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## Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter		
Comments:			
Attachment(s):			
AR SLAICO.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
MVM - AR SLAICO.pdf			

READABILITY CERTIFICATION

We hereby certify that the following form(s), meet the requirements of the Readability Insurance Policies Act:

<u>Form</u>	<u>Form Name</u>	<u>Scoring(s)</u>
Form ST-10592	Statements to Medical Examiner	50.7



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Rex D. Hemme  
Senior Vice President & Actuary  
Standard Life and Accident Insurance Company  
1/9/2013

## STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

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Tobie Brink, Life Policy Analyst III  
Product Development – Actuarial  
Home Office : One Moody Plaza, 14<sup>th</sup> Floor  
Galveston, Texas 77550

e-mail: [tobie.brink@anico.com](mailto:tobie.brink@anico.com)  
Phone: (409) 763-4661 x 4265  
Fax: (409) 766-6522

January 9, 2013

Arkansas Insurance Department  
Compliance - Life and Health  
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Sincerely,

*Tobie Brink*

Tobie Brink  
Life Policy Analyst III

# STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

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January 9, 2013

## MEMORANDUM OF VARIABLE MATERIAL FOR: Form ST-10592

This memorandum was prepared for use with the form listed above by Standard Life and Accident Insurance Company.

Variable material contained within the form denoted by use of brackets.

### Variable Material

The form contains the following permissible variable material:

Home Office Address  
Mailing Office Address  
Business (telephone number)  
Business (fax number)

The above noted items, if changed, will be changed in accordance with department standards. It is understood that the items noted above may be changed without notice or prior approval.

We certify to the following:

- The final form issued to the consumer will not contain brackets denoting variable text;
- Any variable text included in this Statement of Variability will be effective only for future issues;
- The use of variable text will be administered in a uniform and non-discriminatory manner, and will not result in unfair discrimination;
- Only text included in this Statement will be allowed to be used on the referenced forms received by consumers; and
- Any changes to variable or permissible ranges of values will be submitted for approval prior to implementation as required.

Unless otherwise informed, we reserve the right to alter the layout of the enclosed form, including sequential ordering of the sections, color, and type font and size, and make any changes necessary to correct typographical errors or to comply with your state requirements, but we will only do so if such changes are within the allowable parameters or requirements set forth in your statutes.