

State: Arkansas **Filing Company:** Colorado Bankers Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: MIB Revision - PGP Application
Project Name/Number: /

Filing at a Glance

Company: Colorado Bankers Life Insurance Company
Product Name: MIB Revision - PGP Application
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 12/28/2012
SERFF Tr Num: FDLB-128829749
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: On Approval
Date Requested:
Author(s): Howard Moy
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/04/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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

Filing Company: Colorado Bankers Life Insurance Company

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: Filing not required in home state of Colorado

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/04/2013
State Status Changed: 01/04/2013

Deemer Date:
Submitted By: Howard Moy

Created By: Howard Moy
Corresponding Filing Tracking Number:

Filing Description:
TO BE FILED:
Form No.: A-FX-3 12-12
Description: Individual Life Insurance Application

REPLACES:
Form No.: A-FX-3 11-09
Date Previously Approved: 1/6/2010
File No.: FDLB-126408426

Dear Reviewer,

On behalf of our subsidiary, Colorado Bankers Life Insurance Company (CBL), we are submitting the above application listed under "TO BE FILED." This application replaces the application listed under "REPLACES."

The new form differs from its prior version by the insertion of verbiage requested by the Medical Information Bureau (MIB) in section 8G of the form. For ease of review, we have highlighted the revised wording (in green) in addition to providing copies of the form in its final format (without highlights).

The final form is subject only to changes in formatting (font style, margins, page numbers, ink and paper stock) and correcting typographical errors. Printing standards will not be lower than those required under the laws of your State.

In addition to the captioned form, we have included an authorization letter signed by an officer of CBL for this filing.

We hope that all is in order with this filing. If you have questions or comments regarding this matter, please do not hesitate to contact me.

Yours truly,
Howard Moy

Company and Contact

Filing Contact Information

Howard Moy,

howard_moy@dearbornnational.com

State: Arkansas

Filing Company: Colorado Bankers Life Insurance Company

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

Product Name: MIB Revision - PGP Application

Project Name/Number: /

1020 31st Street
Downers Grove, IL 60135

630-824-6702 [Phone]

Filing Company Information

Colorado Bankers Life Insurance Company
5990 Greenwood Plaza Blvd., #325
Greenwood Village, CO 80111
(303) 220-8500 ext. [Phone]

CoCode: 84786
Group Code: 917
Group Name:
FEIN Number: 84-0674027

State of Domicile: Colorado
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: 1 form @ \$50
Per Company: No

Company	Amount	Date Processed	Transaction #
Colorado Bankers Life Insurance Company	\$50.00	12/28/2012	66095464

SERFF Tracking #:

FDLB-128829749

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Colorado Bankers Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MIB Revision - PGP Application

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/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/04/2013	01/04/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Authorization letter	Howard Moy	12/31/2012	12/31/2012

SERFF Tracking #:

FDLB-128829749

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Colorado Bankers Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MIB Revision - PGP Application

Project Name/Number:

/

Disposition

Disposition Date: 01/04/2013

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	"Redline" version		Yes
Supporting Document	Authorization letter		Yes
Form	Individual application		Yes

SERFF Tracking #:

FDLB-128829749

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Colorado Bankers Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MIB Revision - PGP Application

Project Name/Number:

/

Amendment Letter

Submitted Date: 12/31/2012

Comments:

In our haste to get this filing out last week, we note that we neglected to include the authorization letter for the filing. Attached is the letter. We apologize for this oversight.

Thank you for your consideration of this filing.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes

Satisfied - Item:

Authorization letter

Comments:

Attachment(s):

Auth ltr-PGP.pdf

SERFF Tracking #:

FDLB-128829749

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Colorado Bankers Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

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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		Individual application	A-FX-3 12-12	AEF	Initial			A-FX-3 12-12 std final.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



1. PROPOSED INSURED AND BENEFICIARY INFORMATION

Form with fields for Last Name, First Name, MI, Social Security Number, Age, Sex, Date of Birth, State of Birth, Height, Weight, Primary Street Address, City, County, State, Zip Code, Email, Occupation, and Phone Number for Contact.

Secondary Addressee Option. Provide name and complete address. Under this option, we will send the Secondary Addressee a notice of the lapse of this insurance

PRIMARY BENEFICIARY - Name/Relationship and CONTINGENT BENEFICIARY - Name/Relationship

2. OWNER (If Other than Proposed Insured)

Form with fields for Last Name, First Name, MI, Tax ID# or Social Security #, Primary Street Address, City, County, State, Zip Code, Relationship to Proposed Insured, and Email.

3. INSURANCE APPLIED FOR

Plan: [] Plan I - Level Death Benefit [] Plan II - Graded Death Benefit Face Amount \$ _____

4. RIDERS (Not Available In All States)

[] Accidental Death Benefit [] Waiver of Premium for Hospital or Nursing Home Confinement (for Plan I only)

5. PREMIUM AND BILLING INFORMATION

A. Premium Information: 1. Premium \$ _____ 2. Premium Mode: [] Quarterly [] Semi-Annual [] Annual [] Other Billing - Must complete a separate payment authorization
B. Application\$ _____ Payment With
C. Premium Loan [] Yes [] No Automatic
By selecting this option a loan may be made against the cash value of the policy to pay premiums if the premium has not otherwise been paid.
[] Monthly EFT [] Payroll Deduction [] Weekly [] Bi-Weekly [] Semi-Monthly [] Monthly

6. HEALTH INFORMATION (Circle any condition which applies and for any "YES" answer give complete details in Section 6, Part IV)

Part I: If the Proposed Insured answers any question in this Part I: "YES", the Proposed Insured is not eligible for coverage.
1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving Hospice or Home Health care, waiting for organ transplant, or confined to a wheelchair? [] Yes [] No
2. Has the Proposed Insured ever had or ever been diagnosed or treated for Alzheimer's disease or dementia? [] Yes [] No
3. Has Proposed Insured ever tested positive for exposure to the HIV infection or ever been diagnosed as having ARC or AIDS caused by the HIV infection? [] Yes [] No
4. In the past 3 years, has the Proposed Insured had or been treated for: internal cancer, malignant melanoma or leukemia? [] Yes [] No
5. In the past 3 years, has the Proposed Insured had or been treated for:
a. Heart surgery, heart attack, stroke, aneurysm or angina (chest pain)? [] Yes [] No
b. A drug or alcohol dependency/habit, treatment for alcoholism or drug addiction, or used oxygen to assist in breathing? [] Yes [] No

Part II: If the Proposed Insured answers any question in this Part II: "YES", the Proposed Insured may be eligible for Plan II only.
6. In the past 3 years, has the Proposed Insured had or been treated for or taken medication for:
a. Emphysema, Pulmonary Fibrosis, Asthma, or any chronic lung disease (COPD), any other lung or respiratory disorder? [] Yes [] No
b. Kidney disease, kidney failure, kidney dialysis, cirrhosis or other liver disease? [] Yes [] No
c. Parkinson's Disease, Multiple Sclerosis (MS), Sarcoidosis, or Lupus? [] Yes [] No
d. Brain tumor, pacemaker, or congestive heart failure? [] Yes [] No
e. (1) insulin controlled diabetes or (2) both high blood pressure and orally controlled diabetes? [] Yes [] No
f. Cerebral Palsy, Down Syndrome, Mental Retardation, Muscular Dystrophy, Spina Bifida, or Sickle Cell Anemia? [] Yes [] No
g. Any heart or circulatory disorder not already disclosed in any of the answers given? [] Yes [] No
7. In the past 3 years, has the Proposed Insured taken medication for a heart attack or stroke that was not already disclosed in [] Yes [] No



any of the answers already given?

6. HEALTH INFORMATION (Circle any condition which applies and for any "YES" answer give complete details in Section 6, Part IV)

- Part III:**
8. Has the Proposed Insured used tobacco products in the past 12 months? Yes No
9. In the past 3 years, has the Proposed Insured been hospitalized, consulted a physician, or received treatment for an illness or injury, including a nervous or mental disorder, other than as indicated in the answers already given? Yes No
10. Within the last 90 days, has the Proposed Insured, if not retired, been unemployed or worked for wages or income less than 30 hours per week? Yes No
11. Are you currently taking or been advised to take prescription drugs, other than as indicated in the answers already given? If so, state the drug(s) and prescribing physician below. Yes No

Part IV:

Question #	Nature of Condition	Date and Duration	Medication	Name of Doctor, Hospital or Facility	Address and Telephone Number

7. REPLACEMENT INFORMATION

- A. Do you have any existing life insurance or annuity coverage? Yes No
- B. If yes, is this insurance intended to replace or change any of that existing life insurance or annuity coverage? Yes No

8. GENERAL INFORMATION

- (A) **I (we) state** that the information given in this application is true to the best of my (our) knowledge and belief. **I (we) agree** that this application will be the basis for and part of any insurance issued from it.
- (B) **I (we) understand** the insurance applied for will take effect on the application date; but, Colorado Bankers Life Insurance Company ("CBL") will have no liability under this application unless and until it is approved by **CBL** and the first premium is paid or an authorization for its payment has been signed by the applicant while the health and other conditions affecting the insurability of the Proposed Insured are as described in this application. No change in amount, classification, plan of insurance, age at issue, or benefits will be effective unless agreed to in writing by the Applicant.
- (C) **I (we) understand** that if **Plan II** is applied for: (a) the death benefit for a non-accidental death: (i) in the first policy year will be 30% of the full death benefit; and (ii) in the second policy year will be 70% of the full death benefit; (b) after the second year, the full death benefit is payable for any cause; and (c) there is no reduction in benefit for accidental deaths during the first two policy years.
- (D) **I (we) understand** that benefits may be denied during the first 2 years after the insurance applied for is issued if: (a) I (we) did not give true and complete answers in this application; or (b) the Proposed Insured's health, given in this application, changes before the first premium for the insurance applied for is paid or properly authorized.
- (E) **I (we) understand** that the agent is not authorized to: (a) accept risks or pass on a Proposed Insured's qualifications for insurance; b) make or change insurance contracts; or (c) waive any of **CBL's** rights or requirements, including the requirement that an adult Proposed Insured personally must sign the application in the agent's presence.
- (F) **I (we) acknowledge** receipt of the **Information Disclosure Notice** required by the Fair Credit Reporting Act.
- (G) **AUTHORIZATION TO RELEASE INFORMATION. I (the person to be insured) authorize** any physician, medical practitioner, pharmacists, pharmacy benefits managers, health care clearing houses, hospital, clinic, nurses, records custodians, health maintenance organization, including Mayo, Kaiser Foundation, Veterans Administration or other medical or medically related facility, insurance company, or EMSI, or MIB, Inc., or other organization, institute, or person that has any records or knowledge of me or my family, or our health, medical or pharmacy history or physical or mental condition, to give to **CBL**, its reinsurers, agents, contractors, employees, representatives, affiliates, assigns, and EMSI, as necessary any such information including alcohol abuse treatment, drug abuse treatment, psychiatric histories, pharmacy prescriptions, HIV (AIDS virus) testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's and to testify as to such information, for the purpose of evaluating my application for insurance or claim for benefits. I understand I may revoke this authorization at any time, by requesting such action of **CBL** and/or the other party to whom such revocation is to apply, in writing, unless action has already been taken in reliance upon this authorization, or during a contestability period under applicable law. I also authorize **CBL**, or its reinsurers, to make a brief report of my Protected Health Information available to MIB, Inc. A photostatic copy of this authorization will be as valid as the original, and I, or my representative, can obtain a copy on request. I also understand that when my medical records are disclosed pursuant to the authorization the information contained in those records may become subject to further disclosure by **CBL**. In such case, the information may no longer be protected by the rules governing this authorization. This authorization is valid for twenty-four (24) months after the date it was signed.

____ (Applicant's Initials) I (Applicant/Owner) authorize **CBL**, if I have given my email address in this application, to send all present and future notices regarding the insurance applied for, to me at that email address. I may revoke this authorization at any time by sending a written notice to **CBL** to do so.

DATED AT _____ THIS _____ DAY OF _____, 20____.

CITY STATE

Applicant/Owner's Signature Print Proposed Insured's Name Proposed Insured's Signature
(if different than Applicant)

SERFF Tracking #:

FDLB-128829749

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Colorado Bankers Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MIB Revision - PGP Application

Project Name/Number:

/

Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	"Redline" version		
Comments:			
Attachment(s):			
A-FX-3 12-12 std redline.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Authorization letter		
Comments:			
Attachment(s):			
Auth ltr-PGP.pdf			

COLORADO BANKERS LIFE INSURANCE COMPANY

CERTIFICATION OF COMPLIANCE

FORM(S): A-FX-3 12-12

I, Joseph D. Weiser, President of Colorado Bankers Life Insurance Company, hereby certify that, to the best of my knowledge, this submission meets the provisions of Rule & Regulation 19, Rule & Regulation 49, ACA 23-80-206 and ACA 23-79-138, as well as all applicable requirements of the Arkansas Department of Insurance.

By:

A handwritten signature in black ink, appearing to read "J.D. Weiser", written in a cursive style.

Joseph D. Weiser,
President,
Colorado Bankers Life Insurance Company

Date: December 28, 2012



1. PROPOSED INSURED AND BENEFICIARY INFORMATION

Form with fields for Last Name, First Name, MI, Social Security Number, Age, Sex, Date of Birth, State of Birth, Height, Weight, Primary Street Address, City, County, State, Zip Code, Email, Occupation.

Secondary Addressee Option. Provide name and complete address. Under this option, we will send the Secondary Addressee a notice of the lapse of this insurance

PRIMARY BENEFICIARY - Name/Relationship and CONTINGENT BENEFICIARY - Name/Relationship

2. OWNER (If Other than Proposed Insured)

Form with fields for Last Name, First Name, MI, Tax ID# or Social Security #, Primary Street Address, City, County, State, Zip Code, Relationship to Proposed Insured, Email.

3. INSURANCE APPLIED FOR

Plan: [] Plan I - Level Death Benefit [] Plan II - Graded Death Benefit Face Amount \$ _____

4. RIDERS (Not Available In All States)

[] Accidental Death Benefit [] Waiver of Premium for Hospital or Nursing Home Confinement (for Plan I only)

5. PREMIUM AND BILLING INFORMATION

A. Premium Information B. Payment With Application C. Premium Loan Automatic. Includes options for Direct Billing, Other Billing, and various payment methods like Monthly EFT, Payroll Deduction, etc.

6. HEALTH INFORMATION (Circle any condition which applies and for any "YES" answer give complete details in Section 6, Part IV)

Part I: If the Proposed Insured answers any question in this Part I: "YES", the Proposed Insured is not eligible for coverage. Part II: If the Proposed Insured answers any question in this Part II: "YES", the Proposed Insured may be eligible for Plan II only. Includes questions about hospitalization, chronic diseases, and medication.

any of the answers already given?

6. HEALTH INFORMATION (Circle any condition which applies and for any "YES" answer give complete details in Section 6, Part IV)

- Part III:**
8. Has the Proposed Insured used tobacco products in the past 12 months? Yes No
9. In the past 3 years, has the Proposed Insured been hospitalized, consulted a physician, or received treatment for an illness or injury, including a nervous or mental disorder, other than as indicated in the answers already given? Yes No
10. Within the last 90 days, has the Proposed Insured, if not retired, been unemployed or worked for wages or income less than 30 hours per week? Yes No
11. Are you currently taking or been advised to take prescription drugs, other than as indicated in the answers already given? If so, state the drug(s) and prescribing physician below. Yes No

Part IV:

Question #	Nature of Condition	Date and Duration	Medication	Name of Doctor, Hospital or Facility	Address and Telephone Number

7. REPLACEMENT INFORMATION

- A. Do you have any existing life insurance or annuity coverage? Yes No
- B. If yes, is this insurance intended to replace or change any of that existing life insurance or annuity coverage? Yes No

8. GENERAL INFORMATION

- (A) **I (we) state** that the information given in this application is true to the best of my (our) knowledge and belief. **I (we) agree** that this application will be the basis for and part of any insurance issued from it.
- (B) **I (we) understand** the insurance applied for will take effect on the application date; but, Colorado Bankers Life Insurance Company ("CBL") will have no liability under this application unless and until it is approved by **CBL** and the first premium is paid or an authorization for its payment has been signed by the applicant while the health and other conditions affecting the insurability of the Proposed Insured are as described in this application. No change in amount, classification, plan of insurance, age at issue, or benefits will be effective unless agreed to in writing by the Applicant.
- (C) **I (we) understand** that if **Plan II** is applied for: (a) the death benefit for a non-accidental death: (i) in the first policy year will be 30% of the full death benefit; and (ii) in the second policy year will be 70% of the full death benefit; (b) after the second year, the full death benefit is payable for any cause; and (c) there is no reduction in benefit for accidental deaths during the first two policy years.
- (D) **I (we) understand** that benefits may be denied during the first 2 years after the insurance applied for is issued if: (a) I (we) did not give true and complete answers in this application; or (b) the Proposed Insured's health, given in this application, changes before the first premium for the insurance applied for is paid or properly authorized.
- (E) **I (we) understand** that the agent is not authorized to: (a) accept risks or pass on a Proposed Insured's qualifications for insurance; b) make or change insurance contracts; or (c) waive any of **CBL's** rights or requirements, including the requirement that an adult Proposed Insured personally must sign the application in the agent's presence.
- (F) **I (we) acknowledge** receipt of the **Information Disclosure Notice** required by the Fair Credit Reporting Act.
- (G) **AUTHORIZATION TO RELEASE INFORMATION. I (the person to be insured) authorize** any physician, medical practitioner, pharmacists, pharmacy benefits managers, **health care clearing houses**, hospital, clinic, nurses, **records custodians**, health maintenance organization, including Mayo, Kaiser Foundation, Veterans Administration or other medical or medically related facility, insurance company, **or EMSI**, or **MIB, Inc.**, or other organization, institute, or person that has any records or knowledge of me or my family, or our health, medical **or pharmacy** history or physical **or mental** condition, to give to **CBL**, its reinsurers, agents, contractors, employees, representatives, affiliates, assigns, **and EMSI**, as necessary any such information including **alcohol abuse treatment, drug abuse treatment, psychiatric histories, pharmacy prescriptions, HIV (AIDS virus) testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's** and to testify as to such information, for the purpose of **evaluating my application for insurance or claim for benefits**. I understand I may revoke this authorization at any time, by requesting such action of **CBL** and/or the other party to whom such revocation is to apply, in writing, unless action has already been taken in reliance upon this authorization, or during a contestability period under applicable law. **I also authorize CBL, or its reinsurers, to make a brief report of my Protected Health Information available to MIB, Inc.** A photostatic copy of this authorization will be as valid as the original, and I, or my representative, can obtain a copy on request. I also understand that when my medical records are disclosed pursuant to the authorization the information contained in those records may become subject to further disclosure by **CBL**. In such case, the information may no longer be protected by the rules governing this authorization. This authorization is valid for twenty-four (24) months after the date it was signed.

____ (Applicant's Initials) **I (Applicant/Owner) authorize CBL, if I have given my email address in this application, to send all present and future notices regarding the insurance applied for, to me at that email address. I may revoke this authorization at any time by sending a written notice to CBL to do so.**

DATED AT _____ THIS _____ DAY OF _____, 20____.

CITY STATE

Applicant/Owner's Signature Print Proposed Insured's Name Proposed Insured's Signature
(if different than Applicant)



December 26, 2012

Re:
Colorado Bankers Life Insurance Company
NAIC #84786 - FEIN #84-0674027
MIB Revision for Individual Application A-FX-3 12-12

Dear Reviewer:

I authorize Dearborn National Life Insurance Company to file the captioned form(s) on behalf of Colorado Bankers Life Insurance Company.

Very truly yours,

A handwritten signature in black ink, appearing to read "J.D. Weiser".

Joseph D. Weiser
President,
Colorado Bankers Life Insurance Company

5990 Greenwood Plaza Boulevard, Greenwood Village, Colorado 80111
Toll Free: 800.367.7814 ▲ Fax: 303.220.8056 ▲ www.dearbornnational.com

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