

**State:** Arkansas **Filing Company:** Degree of Honor Protective Association  
**TOI/Sub-TOI:** L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life  
**Product Name:** DOH APP HLIFE-13  
**Project Name/Number:** DOH APP HLIFE-13/

## Filing at a Glance

Company: Degree of Honor Protective Association  
Product Name: DOH APP HLIFE-13  
State: Arkansas  
TOI: L071 Individual Life - Whole  
Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Filing Type: Form  
Date Submitted: 12/27/2012  
SERFF Tr Num: GBAC-128825344  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num:  
  
Implementation: 01/01/2013  
Date Requested:  
Author(s): Mary Gardner  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/04/2013  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

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## General Information

Project Name: DOH APP HLIFE-13 Status of Filing in Domicile: Pending  
 Project Number: 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: 01/04/2013  
 State Status Changed: 01/04/2013  
 Deemer Date: Created By: Mary Gardner  
 Submitted By: Mary Gardner Corresponding Filing Tracking Number:

### Filing Description:

RE: DEGREE OF HONOR PROTECTIVE ASSOCIATION - NAIC #57088  
 APP HLIFE-13(AR) -- Application for Membership and HonorLife Insurance

On behalf of Degree of Honor Protective Association, a fraternal benefit society incorporated under laws of the State of Minnesota, we are submitting the above-referenced individual life application.

APP HLIFE-13(AR) will replace application APP HLIFE-10(AR) approved 10/28/2010; SERFF #GBAC-126830730. The following are the basic changes made to the replaced application:

- Changes made to the Acknowledgement section, #1 for the MIB.
- Changed the Electronic Funds Transfer section to allow initial premium to be drawn direct from the bank account.
- Added NAIC compliant replacement regulation wording direct into the application.
- Changes to the medical questions and order.
- Cosmetic changes to the spacing.
- Added HIPAA authorization to the application.

APP HLIFE-13(AR) will be used with the following insurance forms:

GDBWLF-10(AR) - Whole Life Insurance – with Graded Death Benefit approved 10/28/2010; SERFF #GBAC-126830730  
 WL-05 - Whole Life Insurance approved 5/19/2005  
 SPWL-04 - Whole Life Insurance – single premium approved 1/21/2005

## Company and Contact

### Filing Contact Information

Mary Gardner, mgardner@lifebase.com  
 100 First Avenue N.E. 319-896-5970 [Phone]  
 Suite 117 319-896-5979 [FAX]  
 Cedar Rapids, IA 52401

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**Filing Company Information**

(This filing was made by a third party - griffithballardandco)

Degree of Honor Protective Association	CoCode: 57088	State of Domicile: Minnesota
287 W Lafayette Frontage Road	Group Code:	Company Type: Fraternal
Suite 200	Group Name:	State ID Number:
St. Paul, MN 55107-3464	FEIN Number: 41-0216310	
(800) 947-5812 ext. [Phone]		

**Filing Fees**

Fee Required?	Yes
Fee Amount:	\$125.00
Retaliatory?	Yes
Fee Explanation:	\$125.00 per form retaliatory fee (Minnesota state of domicile)
Per Company:	No

Company	Amount	Date Processed	Transaction #
Degree of Honor Protective Association	\$125.00	12/27/2012	66046575

SERFF Tracking #:

GBAC-128825344

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Degree of Honor Protective Association

TOI/Sub-TOI:

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

Product Name:

DOH APP HLIFE-13

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## Correspondence Summary

### Dispositions

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

SERFF Tracking #:

GBAC-128825344

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Degree of Honor Protective Association

TOI/Sub-TOI:

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Product Name:

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DOH APP HLIFE-13/

## 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	Life & Annuity - Acturial Memo		No
Supporting Document	Third Party Authorization Letter		Yes
Form	Application for Membership and HonorLife Insurance		Yes

SERFF Tracking #:

GBAC-128825344

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

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## Form Schedule

Lead Form Number: APP HLIFE-13

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Membership and HonorLife Insurance	APP HLIFE-13(AR)	AEF	Initial		40.600	AR John Doe.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



# Degree of Honor Protective Association

287 W. Lafayette Frontage Road, Suite 200, Saint Paul, Minnesota, 55107-3464  
1-800-947-5812 • (651)228-7600 • Fax: (651)224-7446  
www.degreeofhonor.org

## Application for Membership and HonorLife Insurance Final Expense Plan

PLEASE PRINT WITH BLACK INK, *medium point*  
*Please avoid using a highlighter*

**For Proposed Insured and Owner.** Identification Verification. The identification must be an unexpired government-issued identification card or document that includes a **photograph** and one or more of the following: driver's license number, taxpayer identification number, passport number and country of issuance, alien identification card number, or number and country of issuance of any other government-issued document evidencing nationality or residence.

Mail policy to:  Agent  Insured  Owner if other than Insured

### PROPOSED INSURED Please print.

Last Name Doe First Name John Middle Initial \_\_\_\_\_ Social Security # 123-45-6789  
 Mailing Address - RFD - Box Number 123 Main St City Anywhere State and Zip Code AR 00000  
 Home Phone Number (111) 111-1111 Work Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_  
 Date of Birth 1-1-59 Male/Female M Marital Status M Place of Birth AR U.S. Citizen Yes/No Yes  
 Type of ID(s) Driver's License ID#(s) 00000

### OWNER (if other than Insured)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Telephone H( ) \_\_\_\_\_  
 W( ) \_\_\_\_\_  
 Mailing Address - RFD - Box Number \_\_\_\_\_ City \_\_\_\_\_ State and Zip Code \_\_\_\_\_  
 Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Type of ID(s) \_\_\_\_\_ ID#(s) \_\_\_\_\_

### PAYOR (if other than Owner)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Telephone H( ) \_\_\_\_\_  
 W( ) \_\_\_\_\_  
 Mailing Address - RFD - Box Number \_\_\_\_\_ City \_\_\_\_\_ State and Zip Code \_\_\_\_\_  
 Relationship to insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_

### BENEFICIARY INFORMATION Must comply with Fraternal Code. Use a separate piece of paper for more space.

Primary Beneficiary % Relationship to Insured Home Telephone # Date of Birth SSN  
Jane Doe 100 Spouse 111-111-1111 1-1-59 012-34-5678

Contingent Beneficiary % Relationship to Insured Home Telephone # Date of Birth SSN

If there is no surviving Beneficiary as designated, the proceeds shall be paid to the Owner or the Owner's estate. Should the Owner or the Owner's estate fail to claim the funds within three years of the Insured's death, the funds shall be paid to the Degree of Honor Foundation.

**PLAN AND ANNUAL PREMIUM INFORMATION**

Plan of Insurance: Whole Life

Requested Face Amount \$ 5,000

Planned Annual Premium: \$ 174.30 Premium submitted with application: \$ 174.30

**Frequency of Premium Payment/Payment Method**

Single  Annual  Semi-annual  Quarterly  Monthly (by EFT only). Complete EFT section.

Automatic Premium Loan  Yes  No

Dividend Option  Paid in Cash  Paid-up Additions  Accumulate at Interest

**REPLACEMENT INFORMATION**

Does Proposed Insured have existing life insurance or annuities?  Yes  No

If "yes", complete section below, and include any required Replacement Forms with your application.

**Existing Insurance Company Information:**

Company Name: Policy or Contract # Address: Phone:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the policy applied for intended to replace, change or borrow on any existing life insurance or annuity in this or any other company?  Yes  No If "yes", complete and submit any required replacement forms.

Expected 1035 exchange: \$ \_\_\_\_\_

**BASIC INFORMATION**

Has the Proposed Insured smoked cigarettes in the last 12 months?  Yes  No

Proposed Insured's Height 6' 0" Weight 200

Please list all medications the proposed insured is taking (use an additional sheet of paper if needed):

Drug Name	Condition

**BASIC HEALTH QUESTIONS Declaration of Insurability**

**A. Please check "Yes" or "No" beside each question. If any answer to questions 1 through 3 is "Yes", a policy will not be issued.**

- 1. Are you currently waiting for a medical diagnosis or the results of medical tests which have not been received or been advised to have surgery requiring general anesthesia which has not been completed?  Yes  No
- 2. Are you currently hospitalized, confined to a nursing home, receiving hospice care, institutionalized, waiting for an organ transplant or, within the last twelve (12) months, received kidney dialysis?.....  Yes  No
- 3. Have you been diagnosed as having a terminal medical condition that is expected to result in death within the next twelve (12) months?.....  Yes  No

**B. Please check "Yes" or "No" beside each question. If any answer to questions 4 through 10 is "Yes", apply for Graded Death Benefit Plan. A "Yes" answer will make applicant ineligible for the Single Premium Plan.**

- 4. Have you ever been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you tested positive for Human Immunodeficiency Virus (HIV)?.....  Yes  No
- 5. Have you ever had an organ transplant or been told you will need a transplant (other than kidney?).....  Yes  No
- 6. Are you receiving or been advised to receive personal assistance with activities of daily living such as bathing, dressing, eating, taking medications, toileting, moving about or are you confined to a wheelchair?.....  Yes  No
- 7. Have you had, been diagnosed with, treated for or prescribed medication for:
  - a. More than one stroke or TIA, or more than one heart attack with the most recent occurrence in the last two years?.....  Yes  No
  - b. More than one heart surgery, including angioplasty with the most recent occurrence in the last two years?.....  Yes  No
  - c. Cardiomyopathy, congestive heart failure or heart valve disease?.....  Yes  No
- 8. In the past two years have you smoked cigarettes and have you had, been diagnosed with, treated for or prescribed medication for; chronic obstructive pulmonary disease, chronic bronchitis, asthma, emphysema or any other respiratory disease?.....  Yes  No
- 9. Have you ever been diagnosed with diabetes and within the past two years had a stroke or TIA, heart or heart valve surgery, carotid artery disease or any procedure to improve circulation (including angioplasty or stent in any part of the body)?.....  Yes  No
- 10. In the past two years have you had, been diagnosed with, treated for or prescribed medication for:
  - a. Complications of diabetes (such as eye or kidney disorder, neuropathy or coma) or were you diagnosed with diabetes prior to age 20?.....  Yes  No
  - b. Alzheimer's Disease, dementia, Amyotrophic Lateral Sclerosis (ALS) or Huntington's Disease?.....  Yes  No
  - c. Amputation due to disease, kidney failure, kidney dialysis, liver failure, cirrhosis or kidney disease?...  Yes  No
  - d. A combination of a pacemaker or defibrillator and; coronary artery disease (CAD), or heart valve disease?.....  Yes  No
  - e. Hepatitis C, chronic hepatitis (including chronic hepatitis B) or pancreatitis?.....  Yes  No
  - f. Sarcoidosis requiring treatment or systemic lupus?.....  Yes  No
  - g. Any psychiatric illness requiring hospitalization?.....  Yes  No
  - h. Any internal cancer (other than thyroid or testicular), melanoma or leukemia?.....  Yes  No
  - i. Treatment or been advised to have treatment for alcohol or drug abuse?.....  Yes  No
  - j. Used oxygen equipment to assist in breathing (except when hospitalized)?.....  Yes  No

**C. Please check "Yes" or "No" beside each question. If any answer to questions 11 through 12 is "Yes", apply for Table 8 Whole Life Plan. If all answers to questions 1 through 9 are "No", apply for Table 4 Whole Life Plan.**

- 11. In the past two years have you had, been diagnosed with, treated for or prescribed medication for:
  - a. Kidney transplant?.....  Yes  No
  - b. Multiple Sclerosis or Parkinson's disease?.....  Yes  No
  - c. Stroke, TIA, aneurysm, heart attack, peripheral vascular disease, carotid artery disease, coronary artery disease, heart disease, irregular heart rhythm, pacemaker, chest pain due to angina, or any treatments to improve circulation to any part of the body?.....  Yes  No
- 12. In the past 12 months have you had or taken medication for thyroid cancer or testicular cancer?.....  Yes  No

**ACKNOWLEDGEMENT**

**I understand and agree that:**

1. I have read and received the MIB, Inc. Pre-Notice and I hereby authorize Degree of Honor or its reinsurer to make a brief report of my personal health information to MIB, Inc.
2. I have read the previous statements and answers and to the best of my knowledge they are true and complete.
3. This application shall become part of the insurance contract together with our Articles of Incorporation and Bylaws, as amended from time to time.
4. No change in this application shall be made without my written consent.
5. No agent of Degree of Honor Protective Association is authorized to make or alter any contract or waive any Degree Honor Protective Association rights or requirements.
6. No insurance shall take effect (unless otherwise provided in a completed Conditional Receipt) until:
  - a) the Policy is delivered and you accept it;
  - b) the first full premium is paid by check, money order or cashiers check made payable only to Degree of Honor Protective Association during the lifetime of the Proposed Insured; and
  - c) the insurability of the Proposed Insured remains as described in this application and all representations are true and correct.

Signed at Anywhere AR Date: 1-1-2013  
City, State

John Doe  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Owner if different than Proposed Insured

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
E-Mail Address

Fraud 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.

**HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, or society, the Medical Information Bureau, or other organization, institution, or person that has any records or knowledge of me or my health to give Degree of Honor Protective Association, its National Medical Examiner, its Reinsurers or Assigns any such information, including but not limited to that which involves treatment for alcohol or drug abuse, sickle cell anemia, or mental problems.

I understand that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation and may be redisclosed, although it will continue to be subject to state privacy laws.

I am not required to sign this Authorization, but if I refuse, my eligibility for life insurance may be affected.

I understand that I may revoke this Authorization at any time in writing, delivered to Degree of Honor Protective Association at its registered address, but that the revocation shall not affect any actions the Association took before receiving the revocation.

I understand that I may have a copy of the completed Authorization form.

I understand that I have the right to inspect and copy records to be disclosed.

This authorization will expire on 1-1-2015.  
If I fail to specify an expiration date this authorization will expire two years from the date of signing.

Date 1-1-2013

Signature of Proposed Insured John Doe

Print Name of Proposed Insured John Doe

Date of Birth: 1-1-59

**LODGE/SERVICE CLUB MEMBERSHIP INFORMATION**

Is the Proposed Insured now a member of the Association?  Yes  No. If "no", complete Membership Application:

I hereby apply for membership in the Association and its local Lodge/Service Club # 530 in the State of AR

I understand that unless I select a specific Lodge/Service Club, the Association shall select the Lodge/Service Club to which I will be assigned membership.

I agree, if accepted, to abide by the Articles of Incorporation and Bylaws of the Association and Bylaws of said Lodge/Service Club, all as the same now exist or are hereafter amended.

I hereby affirm my belief in:

- Christian beliefs and values and demonstration of high moral character.
- The support and protection of family members and their dependents through fraternal insurance products.
- Promotion of the family unit and the seeking of ways to strengthen it.
- Assistance to members, their dependents, and others in times of adversity.
- The desire to help others in need through community service and the principle of volunteerism.
- Maintenance of a representative form of government by providing members with the opportunity to become involved in structured events, club meetings, and programs.
- Respect for and allegiance to the United States of America and its flag by promoting patriotism.
- Adherence to the Golden Rule: "Do unto others as you would have them do unto you. "

Signature of Proposed Member \_\_\_\_\_ Date \_\_\_\_\_

**ELECTRONIC FUNDS TRANSFER** I hereby authorize Degree of Honor Protective Association to initiate automatic premium payments to be charged to my account shown below and the Financial Institution named below to charge these premiums to such account. **Name of Financial Institution** \_\_\_\_\_

**Routing #** \_\_\_\_\_ **Account #** \_\_\_\_\_

**EFT WITHDRAWAL ACCOUNT**  Checking Account\*  Savings Account\*\*

\* If choosing EFT from **Checking Account**, attach a voided check for account and transit numbers.

\*\* If choosing EFT from **Savings Account**, attach a voided withdrawal slip with the preprinted account and transit numbers.

Draft my account for the first premium **ONLY** (initial premium may be drafted upon receipt of this application).

Draft my account for ongoing monthly premium payments **ONLY**.

Draft my account for **BOTH** first premium and ongoing monthly premium payments.

**COMPLETE FOR ONGOING PREMIUM PAYMENTS:**

**EFT WITHDRAWAL DATE BUSINESS DAY OF THE MONTH**  1st Day  8th Day  10th Day  23rd Day

**NOTICE TO POLICYHOLDERS:** This authority is to remain in full force and effect until the Financial Institution has received written notification from you of its termination in such time and in such manner as to afford the Financial Institution a reasonable opportunity to act on it. The Policyholder has the right to stop payment of a premium by notification to the Financial Institution prior to charging the account. After the account has been charged, a customer has the right to have the amount of an erroneous payment immediately credited to his(her) account by the Financial Institution up to 15 days following notification.

No premium payment shall be deemed to have been paid until Degree of Honor receives actual payment in its office, and the account, check or draft has been honored. Degree of Honor shall incur no liability as a result of the dishonor of any account debit, check or draft made under this authorization.

Name(s) (Please print) \_\_\_\_\_

Signature \_\_\_\_\_ 2nd Signature if Joint Account \_\_\_\_\_

**SALES VERIFICATION**

This must be completed if applicant answered yes to any question listed on page 2 under the Replacement Information section.

I hereby verify the following in connection with this application for life insurance applied for that only the following Degree of Honor Protective Association approved preprinted sales materials were used:

- 1. NA
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

and that copies of all individualized sales materials including but not limited to, sales illustrations and financial needs analyses related to the specific policy or contract purchased are herewith enclosed with this application.

Agent Signature: Agent Date 1-1-2013

**CONFIDENTIAL AGENT REPORT**

Did you personally see the Proposed Insured and ask each question?  Yes  No

The Personal Health Interview was completed.  Yes  No

**To the best of my knowledge and belief:**

- I have asked all questions and recorded all answers as they were given to me by the Proposed Insured or parent or guardian.
- I know nothing about the Proposed Insured's health, habits, avocations, or lifestyle affecting insurability which has not been stated in this application.
- The insurance applied for on this application  is  is not intended to replace or change any life insurance or annuity with this or any other organization except as indicated. Replacement Information section must be completed.
- MIB, Inc. Pre-Notice and disclosure or outline(s) of coverage, if required, were left with the Proposed Insured.
- I have explained the anti-money laundering/terrorist financing information collecting requirements to the Owner and Proposed Insured.
- I have  seen  not seen the Owner's photo ID and verified such identity.
- I have  seen  not seen the Proposed Insured's photo ID and verified such identity.

Name of Agent (Please Print) Agent

Signature of Agent Agent Date 1-1-2013

Agent # 00000 % 100

Agent telephone \_\_\_\_\_ Agent E-mail Address \_\_\_\_\_

Name of Agent (Please Print) \_\_\_\_\_

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_

Agent # \_\_\_\_\_ % \_\_\_\_\_

Agent telephone \_\_\_\_\_ Agent E-mail Address \_\_\_\_\_

**CONDITIONAL RECEIPT To remain with Owner only if first premium is received**

- A. WHEN INSURANCE IS EFFECTIVE. It is mutually agreed that the insurance applied for will take effect prior to delivery of a policy as of the latest of the date hereof or the date of any required medical examination only if: (1) the application is fully and truthfully completed; (2) all medical tests or examinations required by our published underwriting rules have been completed; (3) the Proposed Insured(s) is(are) eligible as of the Policy Date for the plan and amount of insurance applied for; (4) the Proposed Insured(s) is(are) approved as an insurable risk at standard rates under Association rules after receipt of required information; and (5) the required first full premium is paid by check, money order, cashiers check or order for payment that is honored and collectible. All payments shall be made payable to Degree of Honor Protective Association. Do not pay in cash. Do not make payable to the agent, agency or leave the payee blank.
- B. WHEN RECEIPT IS VOID. This receipt shall be void and no insurance shall be in force hereunder if: (1) any of the required conditions in A above are not fulfilled; or (2) if any plan or amount applied for is declined or is not approved for issuance within 60 days of the date of the application; or (3) if a check in payment of premium is not honored on first presentation or the amount payable is not otherwise good and collectable; or (4) if death occurs as a result of suicide or attempted suicide.

**NO AGENT OR REPRESENTATIVE OF THE ASSOCIATION IS AUTHORIZED TO WAIVE ANY OF THE FOREGOING CONDITIONS  
THIS RECEIPT DOES NOT PROVIDE INSURANCE UNTIL ITS CONDITIONS ARE MET**

Received from John Doe the sum of \$ 174.30 dated 1-1-2013  
as first premium for application relating to John Doe  
subject to the foregoing terms and conditions. Proposed Insured

Degree of Honor Protective Association  
287 W. Lafayette Frontage Road, Suite 200  
Saint Paul, Minnesota 55107-3464  
Telephone: 651.228.7600, 800.947.5812  
degreeofhonor.org

Agent  
Authorized Agent

-----<-----<-----<-----<-----

**DETACH AND LEAVE WITH APPLICANT**

**MIB, Inc. PRE-NOTICE**

Information regarding your insurability will be treated as confidential. Degree of Honor and its reinsurers may make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 in your file. If you question the accuracy of the 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 the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734; telephone number 866-692-6901 (TTY 866-346-3642). Degree of Honor, or its reinsurers, may also release information from its file to other insurance companies to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

## Application for Membership and HonorLife Insurance Final Expense Plan

### NOT JUST AN ORDINARY INSURANCE COMPANY...

**S**ince 1886, Degree of Honor Protective Association has helped families with their financial protection needs through its life insurance and annuity products.

Degree of Honor Protective Association offers over a century of experience and customer service with a strong financial position. Our investment portfolio is conservatively managed with an emphasis on investments in bonds.

As an insured member of our fraternal benefit society, you immediately become eligible for non-contractual fraternal benefits. These benefits help you and your family in meeting your financial needs.

As a fraternal insurance society, Degree of Honor Protective Association upholds standards that strengthen families and communities. We offer organized support that makes it easy for families to experience the benefits of helping others. Call it fraternalism, outreach, volunteering, or simply lending a hand; when we join hands to help others we all benefit. We offer a variety of ways for you to give back to your community.



### Degree of Honor Protective Association

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

Product Name:

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## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Flesch Certification.pdf			
AR Cert of Compl Reg 19.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Third Party Authorization Letter		
Comments:			
Attachment(s):			
AR Auth Generic Foundation.pdf			

STATE OF ARKANSAS

DEPARTMENT OF INSURANCE

1200 West Third Street  
Little Rock, AR 72201

CERTIFICATION

Readability Requirement

DEGREE OF HONOR PROTECTIVE ASSOCIATION hereby certifies that this filing complies with Ark. Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and achieves a Flesch reading ease test score as follows:

<u>Form #</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables/ Characters</u>	<u>Flesch Score</u>
APP HLIFE-13(AR)	110	3,088	19,182	40.6

  
\_\_\_\_\_  
Signature

Karen Patwell  
Name (Signed by Officer of Company)

Controller/Secretary  
Title

**STATE OF ARKANSAS**

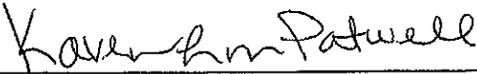
1200 West Third Street  
Little Rock, AR 72201

**Certification of Compliance  
Rule and Regulation 19**

Carrier: **Degree of Honor Protective Association**

Form Number and Title: APP HLIFE-13(AR) Application for Membership and HonorLife Insurance

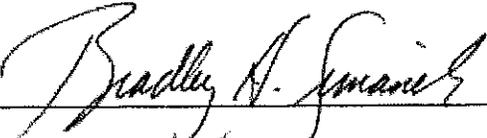
We hereby certify that to the best of our knowledge and belief the above submission complies with the Arkansas Rule and Regulation 19 as well as all applicable requirements of this department.

Signature of Officer: 

Name (typed or printed): Karen Patwell

Title or business affiliation: Controller/Secretary

Date: December 17, 2012

Signature of Actuary : 

Name (typed or printed): Bradley H. Simanek

Title or business affiliation: Consulting Actuary, Griffith, Ballard and Company

Date: December 17, 2012



# Degree of Honor

Protective Association

Insurance with a heart

December 17, 2012

Re: DEGREE OF HONOR PROTECTIVE ASSOCIATION – NAIC #57088  
APP HLIFEF-13(AR) Application for Membership and HonorLife Insurance

To Whom it May Concern:

I HEREBY CERTIFY that Griffith, Ballard and Company has supervised the development of the form included in this submission, and that they are authorized to submit this form on behalf of DEGREE OF HONOR PROTECTIVE ASSOCIATION.

Any questions regarding this submission should be directed to Bradley H. Simanek of Griffith, Ballard and Company, Consulting Actuaries, as the individual responsible for this filing.

A handwritten signature in cursive script that reads "Karen Patwell".

Karen Patwell, Controller/Secretary