

State: Arkansas **Filing Company:** New York Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: GPA-DI-EZ-3
Project Name/Number: GPA-DI-EZ3/GPA-DI-EZ3

Filing at a Glance

Company: New York Life Insurance Company
Product Name: GPA-DI-EZ-3
State: Arkansas
TOI: H11G Group Health - Disability Income
Sub-TOI: H11G.004 Other
Filing Type: Form
Date Submitted: 01/28/2013
SERFF Tr Num: NYLM-128864623
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num: GPA-DI-EZ-3

Implementation: On Approval
Date Requested:
Author(s): Kristy Ferrante
Reviewer(s): Donna Lambert (primary)
Disposition Date: 01/28/2013
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** New York Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: GPA-DI-EZ-3
Project Name/Number: GPA-DI-EZ3/GPA-DI-EZ3

General Information

Project Name: GPA-DI-EZ3 Status of Filing in Domicile:
Project Number: GPA-DI-EZ3 Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Employer, Association, Discretionary, Overall Rate Impact:
Trust
Filing Status Changed: 01/28/2013
State Status Changed: 01/28/2013 Deemer Date:
Created By: Kristy Ferrante Submitted By: Kristy Ferrante
Corresponding Filing Tracking Number:

Filing Description:
Re: Informational Filing OF Application Form: GPA-DI-EZ-3

FEIN No. 13-5582869
NAIC No. 66915

Enclosed for filing on a general basis is the above referenced application. We respectfully request approval of these forms for delivery both in and out of Arkansas.

This application is new and does not replace any previously approved form. The purpose of this form is to enroll eligible persons and their eligible spouses in a group Disability Insurance plan. The application may be used to offer Disability coverage alone or in conjunction with Professional Overhead Expense coverage, depending on specific plan design.

This is a new form and does not replace any form previously approved by the Department. It does not contain any provision or clause currently disapproved by the Department.

This application is generally used for lower amounts of insurance or shorter benefit periods where the rating on the group assumes simplified underwriting.

We have also enclosed an Explanation Of Variable, which summarizes the intended use of the forms and provides an explanation of the illustrative and variable language. This language appears in the shaded areas of the forms.

We would appreciate your filing and approval of this form at your earliest convenience. Should you have any questions, please feel free to contact us.

Sincerely,

State: Arkansas **Filing Company:** New York Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: GPA-DI-EZ-3
Project Name/Number: GPA-DI-EZ3/GPA-DI-EZ3

Bruce E. Dreizen
 Corporate Vice President
 Bruce_E_Dreizen@newyorklife.com

Company and Contact

Filing Contact Information

Kristy Ferrante, kristy_ferrante@newyorklife.com
 One Rockwood Road 914-846-5566 [Phone]
 Sleepy Hollow, NY 10591 914-846-4568 [FAX]

Filing Company Information

New York Life Insurance Company	CoCode: 66915	State of Domicile: New York
51 Madison Avenue	Group Code: 826	Company Type:
New York, NY 10010	Group Name:	State ID Number:
(212) 576-5814 ext. [Phone]	FEIN Number: 13-5582869	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

Company	Amount	Date Processed	Transaction #
New York Life Insurance Company	\$50.00	01/28/2013	66928683

SERFF Tracking #:

NYLM-128864623

State Tracking #:

Company Tracking #:

GPA-DI-EZ-3

State:

Arkansas

Filing Company:

New York Life Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.004 Other

Product Name:

GPA-DI-EZ-3

Project Name/Number:

GPA-DI-EZ3/GPA-DI-EZ3

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/28/2013	01/28/2013

SERFF Tracking #:

NYLM-128864623

State Tracking #:

Company Tracking #:

GPA-DI-EZ-3

State:

Arkansas

Filing Company:

New York Life Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.004 Other

Product Name:

GPA-DI-EZ-3

Project Name/Number:

GPA-DI-EZ3/GPA-DI-EZ3

Disposition

Disposition Date: 01/28/2013

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Explanation of Variable	Approved	Yes
Form	Group Disability insurance Application	Approved	Yes

SERFF Tracking #:

NYLM-128864623

State Tracking #:

Company Tracking #:

GPA-DI-EZ-3

State:

Arkansas

Filing Company:

New York Life Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.004 Other

Product Name:

GPA-DI-EZ-3

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GPA-DI-EZ3/GPA-DI-EZ3

Form Schedule

Lead Form Number: GPA-DI-EZ-3

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 01/28/2013	Group Disability insurance Application	GPA-DI-EZ-3	AEF	Initial			GPA-DI-EZ-3_6.12.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

**GROUP DISABILITY INCOME / GROUP PROFESSIONAL OVERHEAD EXPENSE
ENROLLMENT FORM**

ABC Logo
Phone Number

Complete this form and return to:

**XYZ Administrators, Inc.
Any Street
Any Where, US 00000**

Request for Group Insurance from:

**New York Life Insurance Company
51 Madison Avenue
New York, New York 10010**

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

I. MEMBER INFORMATION

Last Name _____ First _____ Initial _____ ABC ID Number _____

Billing Address Street _____ City _____ State/Province _____ Zip Code _____

Home Address Street _____ City _____ State/Province _____ Zip Code _____

Social Security No. _____ Home Phone Number _____ Office Phone Number _____ Fax Number _____

Date of Birth _____ Height _____ Weight _____ Sex _____
___/___/___ ___ft. ___in. ___lbs. M F

Marital Status: Married Single Civil Union*
 Domestic Partner* *(Submit a completed Declaration of Domestic Partnership form - not applicable in OR)*

* Eligibility of Domestic Partnership / Civil Union is determined by State Law.

Maiden Name _____ I am a: Member of _____

Employee of _____ Date you Became a Member or Date of Employment: ___/___/___

Home E-mail Address _____ Work E-mail Address _____

Are you presently insured by any ABC plan? Yes No

If yes, provide details. _____

SPOUSE INFORMATION: If spouse coverage is requested, list lawful spouse.

Last Name _____ First _____ Initial _____

Date of Birth _____ Height _____ Weight _____ Sex _____ Social Security No. _____
___/___/___ ___ft. ___in. ___lbs. M F

Do you intend to reside outside the U.S. or Canada in the next 12 months?
Member: Yes Country _____ No **Spouse:** Yes Country _____ No
If yes, for how long? _____

SEND CORRESPONDENCE TO: Home Billing Address

G-xxxxxx

2. PAYMENT OPTION SELECTED: (Choose only one)

OPTION 1: AUTOMATIC PAYMENT

I request and authorize ABC Insurance Program, Inc. to make Quarterly Semi-Annual Annual withdrawals against the account specified on the attached voided check statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED / WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

OPTION 2: CREDIT CARD PAYMENT

I request and authorize ABC Insurance Program, Inc. to make Quarterly Semi-Annual Annual charges against the credit card specified below, or any credit card subsequently named by me, for the purpose of collecting premium contributions due under this plan.

VISA MasterCard Account Number _____ Exp. Date _____

X

CARDHOLDERS NAME AS IT APPEARS ON CARD CARDHOLDER SIGNATURE DATE

OPTION 3: PERIODIC BILLING

OPTION 4: PAYROLL ALLOTMENT

Quarterly Semi-Annual Annual

3. OCCUPATIONAL STATUS:

- a) What is your occupation? _____ Main Duties _____
- b) FULL-TIME WORK means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours each week at the place such duties are normally performed. Are you now at FULL-TIME WORK? Yes No
- c) Gross Annual Income from: Salary \$ _____ Self Employment \$ _____
Bonus \$ _____ Commissions \$ _____ Total \$ _____
- d) ANNUAL NET EARNED INCOME \$ _____

Is ANNUAL NET EARNED INCOME more than 25% above or below your previous year? Yes No

If "Yes," what was your ANNUAL NET EARNED INCOME last year? \$ _____

If "Yes," what do you anticipate your ANNUAL NET EARNED INCOME will be for next year? \$ _____

"ANNUAL NET EARNED INCOME" means your wages, salaries, commissions, fees and other amounts received for personal services – before deduction of income or social insurance taxes and after deduction of the normal business expense which is deductible for income tax purposes – for any twelve month period.

Your gross ANNUAL NET EARNED INCOME must be at least \$20,000 for you to be eligible for this coverage.

4. DISABILITY INCOME INSURANCE REQUESTED: (Refer to the brochure for eligibility, options and coverage description.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): New Additional

NOTE: If you are increasing or altering present coverage in any way, do not indicate on line (b) below just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

Group Disability Income:

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you may have does not exceed 60% of your AVERAGE MONTHLY INCOME as defined in the brochure.

I hereby apply for the coverage indicated below, based upon all my statements made in this Request Form:

G-xxxxxx

Member _____

- a) **Benefit Period:** Five-Year Plan Two-Year Plan
- b) **Monthly Benefit Option:** \$ _____ **Waiting Period:** 30-day 90-day 180-day 365-day
- c) Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability? Yes No
- If "Yes," please list:

Company	Plan	Monthly Benefit	Benefit Period

- d) **Future Purchase Option** (\$500 to \$2,000 in \$100 Units) \$ _____
- e) **Cost of Living Adjustment (COLA) Option** _____
- f) **"Own Occupation Plus" Definition Option** _____

Spouse _____

- a) **Benefit Period:** Five-Year Plan Two-Year Plan
- b) **Monthly Benefit Option:** \$ _____ **Waiting Period:** 30-day 90-day 180-day 365-day
- c) Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability? Yes No

If "Yes," please list:

Company	Plan	Monthly Benefit	Benefit Period

5. PROFESSIONAL OVERHEAD EXPENSE INSURANCE:

- POE Plan Maximum Benefit Period** (Plan 1 – 15-day/12-month, Plan 2 – 30-day/24-month) Plan _____
- POE monthly benefit amount** (\$300 to \$20,000 in \$100 units) \$ _____

1. What was your average monthly amount of eligible overhead expenses in past 6 months? \$ _____
2. If practicing as partnership or corporation, for what percentage of these were you responsible? _____ %
3. What was your average number of employees in past 6 months? _____

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated [above, below, on the reverse of this page, on the attached, enclosed], including how [my/our] information is exchanged with MIB, and that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.

FRAUD NOTICE – For Residents of all states except those listed below: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO**, the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

RESIDENTS OF AR/LA/RI: 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.

FOR RESIDENTS OF D.C., WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

RESIDENTS OF FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

RESIDENTS OF KS: 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 insurance fraud as determined by a court of law.

RESIDENTS OF ME: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

RESIDENTS OF MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

RESIDENTS OF NY: For accident and health insurance only, any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

RESIDENTS OF OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF TN/WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

Member's Signature X _____ Date _____

(Please sign and date in ink)

Spouse's Signature X _____ Date _____

(Necessary only if spouse coverage is requested)

G-XXXXXX

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For XYZ Insurance

Information regarding insurability will be treated as confidential. In considering your request for insurance, we will rely on the medical information you provide, and on the information you authorize us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance. Other insurance companies may also furnish New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

New York Life may release this information to the plan administrator, other insurance companies to whom you may apply for insurance, or to whom a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided, you may contact New York Life and seek a correction.

For NM Residents: PROTECTED PERSONS¹ have a right of access to certain **CONFIDENTIAL ABUSE INFORMATION**² we maintain in our files and they may choose to receive such information directly. You have the right to register as a **PROTECTED PERSON** by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.

¹ **PROTECTED PERSON** means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.

² **CONFIDENTIAL ABUSE INFORMATION** means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company

4.11 ed

G-xxxxxx

SERFF Tracking #:

NYLM-128864623

State Tracking #:**Company Tracking #:**

GPA-DI-EZ-3

State:

Arkansas

Filing Company:

New York Life Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.004 Other

Product Name:

GPA-DI-EZ-3

Project Name/Number:

GPA-DI-EZ3/GPA-DI-EZ3

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/28/2013
Comments:			
Attachment(s):			
Flesch Reading Ease Score.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	01/28/2013
Bypass Reason:	This filing is for an Application.		

		Item Status:	Status Date:
Satisfied - Item:	Explanation of Variable	Approved	01/28/2013
Comments:			
Attachment(s):			
APP ExplanationofVariable.pdf			



New York Life Insurance Company
– A Mutual Company Founded in 1845 –
51 Madison Avenue, New York, NY 10010

Flesch Reading Ease Score

The Application is written to be used in conjunction with our generally filed GMR-ER-FACE, et al. forms which have an aggregate Flesch Test score of +63.42.

Date: January 28, 2013

New York Life Insurance Company

Name of Company

A handwritten signature in cursive script that reads "Bruce E. Dreizen".

by: _____

Signature

Bruce E. Dreizen
Corporate Vice President

Name and Title of Person

EXPLANATION OF VARIABLE

GPA-DI EZ-3

GENERAL

1. References to “Member” will appear as illustrated, “Employee” may replace or be added to Member or a generic term such as “Applicant” may be substituted. References to “membership” will appear as illustrated or “employment” will replace or be added to such references.
2. References to “ABC” and “XYZ” are illustrative and will be replaced by the Policyholder and plan Administrator.
3. In the bottom left code, the reference to “G-xxxxxx” will be replaced by the applicable Policy number. The bottom right will be replaced by the applicable edition date of the initial application and may be changed to a different edition date if the application is subsequently revised, e.g. the addition of a Professional Overhead Expense Plan.
4. References to “below”, “above” and/or “on the reverse side” will appear as illustrated or modified to reflect the finalized format of the form.

HEADING

1. The form heading will appear as illustrated or include either Disability Income only or Professional Overhead Expense only as applicable. The reference to “Group” may be replaced by Franchise Insurance **(except in VA and WA)**. “Enrollment Form” will appear as illustrated or synonymous terms such as “Application” or “Request Form” may be substituted.
2. The Administrator’s name, logo and address may be changed as required.

MEMBER INFORMATION

1. The ID number may be deleted or replaced by another form of identification for the applicant.
2. The billing address will appear as shown or deleted if this is not within the scope of a particular Policyholder/Administrator’s computer system capabilities or if the coverage is non-contributory.
3. The Social Security Number will appear as illustrated or deleted, dependent upon the “privacy requirements” of a particular State.
4. Home or office phone number may be replaced by day, night or work phone number.
5. “Marital Status” will appear as illustrated or may be deleted.
6. “Maiden Name” and “Date of Employment or Membership” will appear as shown, be modified or deleted, dependent on whether the applicant’s eligibility is based on membership or employment.
7. “Traveling and residing outside of U.S. or Canada question” will appear as illustrated, or may be modified or deleted for state compliance or if the group is employer based.
8. “Home and Work Email address” and “Send correspondence to” will appear as shown or deleted if this is not within the scope of a particular Policyholder/Administrator’s computer system capabilities.
9. The question concerning other insurance sponsored by the Policyholder will appear as illustrated for consideration as it applies to "overinsurance" standards or deleted if not applicable.
10. Spouse Information will only appear if coverage is also available to spouses of eligible members/employees.

EXPLANATION OF VARIABLE

GPA-DI EZ-3 (Continued)

PAYMENT OPTION SELECTED

Will appear as illustrated or be modified to accommodate a particular Policyholder/Administrator's billing method and/or computer system capabilities or may be deleted if the coverage is non-contributory.

OCCUPATIONAL STATUS

Questions similar to those shown will appear in order to gather information on occupation, full-time work status, salary, annual net earned income, and net worth, as applicable to the coverage being offered.

INSURANCE REQUESTED

1. The Disability Income section will be deleted if the application is used only for Professional Overhead Expense Insurance. The Professional Overhead Expense Insurance section will be deleted if the application is used only for Disability Income Insurance.
2. "Spouse" references will be deleted if Spouse Insurance is not available for a particular Policyholder or Plan.
3. The election of benefit options and amounts will vary based on plan design by a particular Policyholder.

STATEMENT OF HEALTH

1. References to "any other person to be insured" will appear as illustrated throughout or may be deleted throughout if Dependent Insurance is not available.
2. Items b. and c.: The "five years" timeframe may be modified to provide for a period of less than five years but in no event more than five years.
3. Item f.: This question will only appear if smoking status results in a premium differential for a particular Policyholder's plan.
4. Item g.: This question will appear as illustrated or may be modified to provide for a lesser time period or deleted dependent on product design.

AUTHORIZATION/ SIGNATURE BLOCK

The AUTHORIZATION will appear as illustrated or may be deleted if the AUTHORIZATION is not a part of the Enrollment form or may be modified to revise the AIDS reference and/or other references in the AUTHORIZATION to comply with State mandates.

The signature block will appear as illustrated or may be modified if Dependent Insurance is not available and/or to provide Owner data in the event the Owner is someone other than the applicant.

FRAUD NOTICE

The Fraud Notice will appear as illustrated or may be modified to provide for other State variations in addition to those shown.

IMPORTANT NOTICE

A version of the IMPORTANT NOTICE will appear as illustrated, or may be modified to revise the AIDS reference and/or other references to the AUTHORIZATION to comply with State mandates.