

State: Arkansas **Filing Company:** Oxford Life Insurance Company
TOI/Sub-TOI: L071 Individual Life - Whole/L071.311 Current Assumption - Single Premium - Single Life
Product Name: REINAPP2012AR
Project Name/Number: REINAPP2012AR/

Filing at a Glance

Company: Oxford Life Insurance Company
Product Name: REINAPP2012AR
State: Arkansas
TOI: L071 Individual Life - Whole
Sub-TOI: L071.311 Current Assumption - Single Premium - Single Life
Filing Type: Form
Date Submitted: 12/18/2012
SERFF Tr Num: OXFR-128817271
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: REINAPP2012AR

Implementation: On Approval
Date Requested:
Author(s): Pat O'Hara
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/02/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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General Information

Project Name: REINAPP2012AR	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: 01/02/2013
	State Status Changed: 01/02/2013
Deemer Date:	Created By: Pat O'Hara
Submitted By: Pat O'Hara	Corresponding Filing Tracking Number:

Filing Description:
December 18, 2012

Arkansas Department of Insurance

We are filing this Reinstatement Application for use with our whole life insurance products.

I have attached the HIPAA Notification and General Notice form that will be used with this Reinstatement Application to the Supporting Documents tab.

Please advise if you have any questions.

Patrick O'Hara
602-263-6666 ext 679130

Company and Contact

Filing Contact Information

Pat O'Hara, Regulatory Compliance Analyst PatO'Hara@Oxfordlife.com
 2721 N. Central Ave. 602-263-6666 [Phone] 670130 [Ext]
 Phoenix, AZ 85004

Filing Company Information

Oxford Life Insurance Company	CoCode: 76112	State of Domicile: Arizona
2721 N. Central Avenue	Group Code: 574	Company Type:
Phoenix, AZ 85004-1172	Group Name:	State ID Number:
(888) 757-3732 ext. [Phone]	FEIN Number: 86-0216483	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	Filing or review of life and health policy/contracts, endorsements, certificate, riders, applications or annuity forms, per form...\$50.00

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Per Company: No

Company	Amount	Date Processed	Transaction #
Oxford Life Insurance Company	\$50.00	12/18/2012	65859895

SERFF Tracking #:

OXFR-128817271

State Tracking #:

Company Tracking #:

REINAPP2012AR

State:

Arkansas

Filing Company:

Oxford Life Insurance Company

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/02/2013	01/02/2013

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Disposition

Disposition Date: 01/02/2013

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		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	HIPAA Notice		Yes
Supporting Document	General Notices		Yes
Form	Reinstatement App.		Yes

State: Arkansas

Filing Company:

Oxford Life Insurance Company

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Form Schedule

Lead Form Number: AR-REINSTATE-OLIC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Reinstatement App.	AR-REINSTATE-OLIC	AEF	Initial		50.000	GEN-REINSTATE-OLIC-2012.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

INDIVIDUAL WHOLE LIFE INSURANCE - REINSTATEMENT

Return completed form with the signatures of both the Owner(s) and the Insured to the address above.

OWNER (S) NAME	OWNER SOCIAL SECURITY NUMBER (S)	POLICY/CONTRACT NUMBER
OWNER ADDRESS, CITY, STATE, ZIP CODE		
OWNER PHONE NUMBER	RELATIONSHIP TO PROPOSED INSURED	
PROPOSED INSURED NAME	PROPOSED INSURED SOCIAL SECURITY NUMBER	PROPOSED INSURED DATE OF BIRTH
PROPOSED INSURED ADDRESS, CITY, STATE, ZIP CODE		
PROPOSED INSURED PHONE NUMBER	GENDER OF PROPOSED INSURED	PROPOSED INSURED STATE OF BIRTH

HEALTH QUESTIONS RELATED TO PROPOSED INSURED

1.	What is your height and weight?	Height _____ Weight _____
2.	Have you had, or been medically advised to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or have you been diagnosed, treated (including dialysis) or taken medication for chronic kidney disease or kidney (renal) insufficiency or kidney or liver failure or do you have paralysis of two or more extremities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Are you currently: hospitalized, confined to a bed or nursing facility, or using oxygen equipment to assist in breathing, or receiving Hospice Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you been treated for insulin shock, diabetic coma, or ever taken insulin shots prior to the age of 50 or were you diagnosed with Diabetes prior to age 30?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever been medically diagnosed, treated, or taken medication for: congestive heart failure (CHF), cardiomyopathy, Alzheimer's, dementia, organic brain syndrome, schizophrenia, bipolar disorder, mental incapacity, Lou Gehrig's disease (ALS), or Huntington's disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Within the past 24 months have you been diagnosed with internal cancer or melanoma, leukemia, lymphoma, stroke, transient ischemic attack (TIA) or have you had an amputation caused by any disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you had more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Within the past 24 months have you: (a) been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure or required oxygen equipment to assist in breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No

	(b) been diagnosed as having, been treated for or hospitalized for: heart attack, heart disease, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty or stent implant), uncontrolled high blood pressure or any procedure to improve circulation to the heart or brain? (c) had Hodgkin's Disease, cirrhosis, liver disease, or systemic lupus (SLE)? (d) had any neuromuscular disease (including cerebral palsy, multiple sclerosis, grand mal seizures, or Parkinson's disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Within the past 10 years, have you been convicted of a felony or are you currently on parole or on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Within the last 5 years have you been treated for, been advised to have treatment for, or excessively used, alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while impaired or under the influence of alcohol or any drugs, or had your driver's license suspended or revoked, or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Have you been declined or postponed for life or health insurance in the past two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as dressing, eating, bathing, incontinence, toileting, taking medications, or moving without any type of physical assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Are you taking medication for any impairment listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Have you used any nicotine based products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Have you applied for life insurance with any other insurance companies in the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No

STATEMENTS AND AUTHORIZATIONS

PROPOSED INSURED'S STATEMENT (or Owner if legal representative)

I have read and understood this Application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. The representations in Sections A, B, C, D and E are true. I agree the policy shall not be in effect until it has been issued by Oxford Life Insurance Company ("the Company") and the premium is paid during my lifetime. I understand that the Producer has no authority to approve this Application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date signed in the policy and all eligibility requirements are met. The purpose of this Application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company.

Initials of Proposed Insured

MEDICAL AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, the Medical Information Bureau ("MIB"), pharmacy, pharmacy benefit manager, insurance laboratories, my employer or consumer reporting agency, to give Oxford Life Insurance Company or its reinsurers any information they have about my health, including confidential HIV-related information. I expressly authorize Oxford Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB. I acknowledge receipt of the MIB Pre-Notice. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for use in underwriting risk selection purposes only and is valid for 36 months (24 months for North Dakota residents), except for HIV-related information, which is only valid for 180 days from the date below.

Initials of Proposed Insured

WARNING

FRAUD NOTICE

FOR YOUR PROTECTION – THE LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly 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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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.

All Other States: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I have read, understand, and acknowledge the applicable Fraud Notice.

Initials of Proposed Insured

Initials of Owner

MISREPRESENTATION NOTICE

If your answers to the questions in the application are incorrect or untrue, Oxford Life Insurance Company may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary (ies). I have read, understand, and acknowledge the Misrepresentation Notice. I agree that the information on this application will be relied on to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy.

Initials of Proposed Insured

Initials of Owner

Dated this _____ day of _____, 20 _____

At (City) _____ (State) _____

Signature – Owner

Signature – Joint Owner (*if any*)

Signature – Insured

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Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Attached to Form Schedule tab		

		Item Status:	Status Date:
Satisfied - Item:	HIPAA Notice		
Comments:			
Attachment(s):			
GEN-HIPAA-OLIC 2.pdf			

		Item Status:	Status Date:
Satisfied - Item:	General Notices		
Comments:			
Attachment(s):			
Notices.pdf			

READABILITY CERTIFICATION

This is to certify that the attached form, GEN-REINSTATE-OLIC, achieved a minimum Flesch Reading Ease Score of 50 and is in compliance with the applicable laws and regulations of the State.

Oxford Life Insurance Company



Anthony Meier

Secretary

Title

December 18, 2012

Date

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION

This authorization complies with the HIPAA Privacy Rule.

Name(s) of Primary Proposed Insured/Patient

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB Group, Inc. ("MIB") or any of its members or affiliates), or other health care provider that has provided payment, treatment or services to me or on my behalf (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their Producers, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I further expressly authorize Oxford Life Insurance Company, or its reinsurers, to make a brief report of my personal and/or protected health information to MIB.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization shall remain in force for 36 months (24 months for North Dakota residents) following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company addressed, **Attention: Policyholder Service Department, 2721 North Central Avenue, Phoenix, AZ 85004**. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record the Company may not be able to process my Application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Insured

Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

Power of Attorney (Please attach) Other (please describe): _____

Proposed Insured Policy or contract number (If known): _____

PRIVACY NOTICE

Your privacy is protected. Oxford Life Insurance Company (We, Us, Our), like other insurance companies, sometimes evaluates the medical history and other personal information about Applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and career.) We also use this information to administer Your insurance coverage after it is in force.

We rely heavily on information provided by You. We may also supplement this information from other sources, such as medical professionals or institutions that have treated You or family members covered under Your policy; insurance support organizations; other insurance companies to which You have applied; and employers.

Any information You give Us regarding Your insurability and any information received from other sources will be treated as strictly confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless You request otherwise, Your name, address, date of birth and phone number may be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

You have the right to be told about and to copy, if you wish, items of personal information that appear in Our files. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO OUR PRIVACY OFFICER AT OXFORD LIFE INSURANCE COMPANY, 2721 NORTH CENTRAL AVENUE, PHOENIX, AZ 85004-1172, OR VISIT WWW.OXFORDLIFE.COM.

FAIR CREDIT REPORTING ACT NOTICE

With regard to Your Application, We may have requested an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health except as may be related directly or indirectly to Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, We will give You the name and address of the consumer reporting firm so that You may request a copy of the report.

MIB PRE-NOTICE – Proposed Insured

Information regarding Your insurability will be treated as confidential. Oxford Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, that 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, the MIB, upon request, will supply Oxford Life Insurance Company with the information in its file.

Upon receipt of a request from You, the MIB will arrange disclosure of any information it may have in Your file. Please contact MIB at 866-692-6901 (TTY: 866-346-3642). If You question the accuracy of information in the MIB's file, you may contact the 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, Suite 400, Braintree, Massachusetts 02184-8734.

Oxford Life Insurance Company, or its reinsurers, may also release information in its file to MIB and to other life or health insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.