

**State:** Arkansas **Filing Company:** Assurity Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Misc 2012 Grp Life  
**Project Name/Number:** Misc 2012 Grp Life/Misc 2012 Grp Life

## Filing at a Glance

Company: Assurity Life Insurance Company  
Product Name: Misc 2012 Grp Life  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 01/18/2013  
SERFF Tr Num: SEFL-128856351  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: MISC 2012 GRP LIFE  
  
Implementation: On Approval  
Date Requested:  
Author(s): Kristi Hendrickson  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/23/2013  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

State: Arkansas  
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
 Product Name: Misc 2012 Grp Life  
 Project Name/Number: Misc 2012 Grp Life/Misc 2012 Grp Life

Filing Company: Assurity Life Insurance Company

## General Information

Project Name: Misc 2012 Grp Life  
 Project Number: Misc 2012 Grp Life  
 Requested Filing Mode: Review & Approval  
 Explanation for Combination/Other:  
 Submission Type: New Submission  
 Group Market Type: Employer  
 Filing Status Changed: 01/23/2013  
 State Status Changed: 01/23/2013  
 Created By: Kristi Hendrickson  
 Corresponding Filing Tracking Number: SEFL-128853240

Status of Filing in Domicile: Authorized  
 Date Approved in Domicile: 12/11/2012  
 Domicile Status Comments: Approved  
 Market Type: Group  
 Group Market Size: Small and Large  
 Overall Rate Impact:  
 Deemer Date:  
 Submitted By: Kristi Hendrickson

### Filing Description:

Form Number Form Title  
 75-863-01114 Group Life Statement of Health  
 75-883-05055 Application for Conversion

The above forms are submitted for review and approval.

When approved, the above forms will replace the forms indicated on the form schedule.

Form 75-863-01114, Group Life Statement of Health: This form is utilized at the time of application or when an increase in coverage is requested. It is used with group life products G040, G050, G060 all approved 01/12/2001.

Form 75-883-05055, Application for Conversion: This form is utilized to convert individual and group term life insurance to one of our permanent life insurance plans.

Please note that filing SEFL-128853240 contains one of the same forms. Therefore, we ask that they be reviewed simultaneously. Thank you!

## Company and Contact

### Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist policyfiling@assurity.com  
 P.O. Box 82533 402-437-3452 [Phone]  
 Lincoln, NE 68501-2533 402-437-3802 [FAX]

### Filing Company Information

Assurity Life Insurance Company	CoCode: 71439	State of Domicile: Nebraska
P.O. Box 82533	Group Code:	Company Type: Life/Health
Lincoln, NE 68501-2533	Group Name:	State ID Number:
(800) 276-7619 ext. [Phone]	FEIN Number: 38-1843471	

## Filing Fees

**State:** Arkansas **Filing Company:** Assurity Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Misc 2012 Grp Life  
**Project Name/Number:** Misc 2012 Grp Life/Misc 2012 Grp Life

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? No  
Fee Explanation: \$50 per form  
Per Company: No

Company	Amount	Date Processed	Transaction #
Assurity Life Insurance Company	\$100.00	01/18/2013	66675065

SERFF Tracking #:

SEFL-128856351

State Tracking #:

Company Tracking #:

MISC 2012 GRP LIFE

State:

Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Misc 2012 Grp Life

Project Name/Number:

Misc 2012 Grp Life/Misc 2012 Grp Life

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/23/2013	01/23/2013

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Group Life Statement of Health	Kristi Hendrickson	01/22/2013	01/22/2013

SERFF Tracking #:

SEFL-128856351

State Tracking #:

Company Tracking #:

MISC 2012 GRP LIFE

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Misc 2012 Grp Life  
**Project Name/Number:** Misc 2012 Grp Life/Misc 2012 Grp Life

**Filing Company:** Assurity Life Insurance Company

## Disposition

Disposition Date: 01/23/2013

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
Form (revised)	Group Life Statement of Health		Yes
Form	Group Life Statement of Health		Yes
Form	Application for Conversion		Yes

State: Arkansas  
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
 Product Name: Misc 2012 Grp Life  
 Project Name/Number: Misc 2012 Grp Life/Misc 2012 Grp Life

Filing Company: Assurity Life Insurance Company

## Amendment Letter

Submitted Date: 01/22/2013

Comments:

The statement of Health contains the AR required Fruad statement.

Changed Items:

### Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Group Life Statement of Health	47-863-01114 (R12-12)	OTH	Other	Other Explanation : Will replace the G030 approved 1/12/2001	55.200	47-863-01114.pdf	Date Submitted: 01/22/2013 By:
<i>Previous Version</i>								
1	Group Life Statement of Health	75-863-01114 (R12-12)	OTH	Other	Other Explanation : Will replace the G030 approved 1/12/2001	55.200	75-863-01114.pdf	Date Submitted: 01/18/2013 By: Kristi Hendrickson

No Rate Schedule Items Changed.

No Supporting Documents Changed.

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Misc 2012 Grp Life  
**Project Name/Number:** Misc 2012 Grp Life/Misc 2012 Grp Life

**Filing Company:** Assurity Life Insurance Company

## Form Schedule

### Lead Form Number: 75-863-01114 (R12-12)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Group Life Statement of Health	47-863-01114 (R12-12)	OTH	Other	Will replace the G030 approved 1/12/2001	55.200	47-863-01114.pdf
2		Application for Conversion	75-883-05055	AEF	Other	replaces LC02 approved 9/13/2002	54.300	75-883-05055.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



**PLEASE PRINT WITH BLACK INK**

**1. PROPOSED INSURED**

Employee's <i>First, Middle, Last</i> Legal Name		Other Proposed <i>First, Middle, Last</i> Insured's Name			
Relationship to Employee		<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security No.	
Residing with employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		Birth State/ Country		Date of Birth <i>(MM/DD/YYYY)</i>	
Home Address <i>Street Address</i>		<i>City</i>		<i>State</i> <i>ZIP+4</i>	
				Phone No. ( )	
Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident ( <i>green card</i> ) status? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No					

**2. HEALTH SECTION**

1. During the past **2 years**, has the Proposed Insured been convicted of three or more moving traffic violations? .....  Yes  No

2. During the past **5 years**, has the Proposed Insured had a driver's license revoked or suspended; been convicted of driving while under the influence of alcohol or drugs; or been involved as a driver in two or more accidents? .....  Yes  No  
 Driver's license no./State \_\_\_\_\_ Details and dates \_\_\_\_\_

3. During the past **5 years**, has the Proposed Insured had any illness, surgery or injury requiring treatment by a licensed medical professional, hospital or other medical facility? .....  Yes  No

4. During the past **12 months**, has the Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum? .....  Yes  No  
 Employee .....  Yes  No  
 Spouse .....  Yes  No

5. During the past **5 years**, has the Proposed Insured been medically diagnosed or treated by a medical professional for a neurological or psychiatric disorder, alcohol abuse or illegal drug abuse? .....  Yes  No

6. During the past **5 years**, has the Proposed Insured been medically diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or had a positive test for human immunodeficiency virus (*HIV*) antibodies? .....  Yes  No

7. During the past **7 years**, has the Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for cancer, diabetes, stroke, heart or blood disorder, kidney or liver disorder, or a lung or breathing disorder? .....  Yes  No

**Please complete for any YES answer in questions 1-7 above. If additional space is needed, attach a separate sheet of paper.**

Question No.	Onset Date <i>(MM/DD/YYYY)</i>	Duration <i>(Days, Mos, Yrs)</i>	Health Condition and Details	Remaining Effects	Medical Care Provider's Name/Address/Phone
	/ /				
	/ /				

8. Family History: Have any of your immediate family members (*father, mother, siblings*) had heart disease, stroke, cancer (*specific type*), diabetes, kidney disease, mental illness, alcoholism, Huntington's chorea, amyotrophic lateral sclerosis (*ALS or Lou Gehrig's disease*), motor disease, multiple sclerosis, Alzheimer's disease or any other hereditary disease? .....  Yes  No  
 If YES, please provide the information below. If additional space is needed, attach a separate sheet of paper.

Name of Family Member	Relationship	Health Condition	Age at Onset	Age at Death <i>(if applicable)</i>

**AUTHORIZATION AND ACKNOWLEDGEMENT**

**I, the Proposed Insured, agree that all answers and statements in this Application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability.**

**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.**

Signed at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*City State Date (MM/DD/YYYY)*

\_\_\_\_\_  
*Signature of Proposed Insured Employee (or Owner for juveniles)*

\_\_\_\_\_  
*Signature of Spouse (if Proposed Insured)*





**PLEASE PRINT WITH BLACK INK**

**1. INSURED**

Legal Name <i>First Middle Last</i>	Existing Policy/ Certificate No.		
Other Names <i>(i.e., maiden name, nickname, derivative form of first and/or middle name or an alias)</i>	Date of Birth <i>(MM/DD/YYYY)</i> / /		
Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Email	
<i>Street Address</i>		<i>City</i>	<i>State ZIP+4</i>
Home Address			
Personal Phone No. ( )	Birth State/Country	Height ft. in.	Weight lbs.
Has the Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, please list type: _____ amount per day		last date of use <i>(MM/DD/YYYY)</i> / /	

**2. POLICYOWNER (Complete if Owner is NOT the Insured)**

Legal Name <i>First Middle Last</i>	Date of Birth <i>(MM/DD/YYYY)</i> / /		
Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Email	
<i>Street Address</i>		<i>City</i>	<i>State ZIP+4</i>
Home Address			
Personal Phone No. ( )	Birth State/Country	Relationship to Insured	
Contingent Owner's Name <i>First Middle Last</i>	Contingent Owner's Relationship to Insured		

**3. BENEFICIARIES (If more space is needed, please attach additional sheets)**

Primary Beneficiary Name <i>(First, Middle, Last)</i>	Relationship to Insured	Social Security No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name <i>(First, Middle, Last)</i>	Relationship to Insured	Social Security No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

Trust:  Living Trust *(Please complete section below.)*  Testamentary Trust *(Will)*

Name of Living Trust \_\_\_\_\_

Date of Trust *(MM/DD/YYYY)* / / Tax ID No. of Trust \_\_\_\_\_

Name of Trustee \_\_\_\_\_

Address of Trustee \_\_\_\_\_

**4. POLICY DESCRIPTION**

**Evidence of Insurability** – Complete the Evidence of Insurability form if: 1) the face amount of the new policy exceeds the amount convertible, 2) the new policy is to include any additional riders that are not on the current policy, 3) any rider on the current policy is not available on a conversion basis without evidence of insurability, or 4) requesting a change to the underwriting class or rate reconsideration.

Plan:  Whole Life Face Amount \$ \_\_\_\_\_

Riders:  Disability Waiver of Premium  Other \_\_\_\_\_

If cash value is available, should the Automatic Premium Loan (APL) provision be made effective?  Yes  No (If no option is selected, APL will apply.)

Non-Forfeiture Option:  Extended Term Insurance (ETI)  Reduced Paid-up Insurance (RPU) (If no option is selected, ETI will apply.)

Dividend Option:  Paid in Cash  Paid-up Additions (PUA)  Accumulate at Interest  Reduce Premium/Cash\*  
 Reduce Premium/PUA\*  Reduce Premium/Accumulate at Interest\* (If no option is selected, Paid-up Additions (PUA) will apply.)

\*Reduce Premium/Cash, Reduce Premium/PUA and Reduce Premium/Accumulate at Interest are **not** available on monthly mode.

Special Instructions or Comments \_\_\_\_\_

Plan:  Universal Life Face Amount \$ \_\_\_\_\_

Death benefit is face amount unless shown differently here:  Face Amount + Accumulated Value

Riders:  Disability Waiver of Premium  Other \_\_\_\_\_

Special Instructions or Comments \_\_\_\_\_

**5. PREMIUM PAYMENT MODE**

Payor Name	First	Middle	Last	Relationship to Insured
Billing Address	Street Address		City	State ZIP+4

Please indicate preference for payment type and billing frequency below:

Type:  Direct billing  
 New automatic bank withdrawal — submit signed bank authorization form and, to ensure accuracy, a voided check.  
 New automatic credit card withdrawal — submit signed credit card authorization form.  
 Add to existing bank [or credit card] withdrawal Policy No. \_\_\_\_\_  
 Add to existing list bill no. \_\_\_\_\_ and/or name of company \_\_\_\_\_

Frequency:  Annual  Semi-Annual  Quarterly  Monthly (not available with Direct Billing)

If Universal Life, indicate planned premium amount \$ \_\_\_\_\_

**6. EXISTING POLICY/RIDER HANDLING**

Policy — terminate in its entirety  Term Rider — terminate in its entirety  
 Policy — reduce to \$ \_\_\_\_\_  Term Rider — reduce to \$ \_\_\_\_\_

Signed at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
City State Date (MM/DD/YYYY)

\_\_\_\_\_  
Signature of Insured Signature of Owner(s) of Term Policy/Rider being Converted

\_\_\_\_\_  
Signature of Parent/Guardian of Minor Child Signature of Owner(s) of New Policy (If other than Insured)

\_\_\_\_\_  
Signature of Licensed Agent Print Agent Name and Agent No.



SERFF Tracking #:

SEFL-128856351

State Tracking #:

Company Tracking #:

MISC 2012 GRP LIFE

State:

Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Misc 2012 Grp Life

Project Name/Number:

Misc 2012 Grp Life/Misc 2012 Grp Life

## Supporting Document Schedules

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

## READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word XP program and achieved the following test results:

**Company Name:** Assurity Life Insurance Company

**Form Number(s):** Life Application Forms 2012

**Type of Form:** Supplements to Applications

<b>Form No.</b>	<b>Description</b>	<b>Flesch Score</b>
75-863-01114 (R12-12)	Group Life Statement of Health	55.2
75-883-05055	Application for Conversion	54.3



Signature

January 18, 2013

Date

Carol S. Watson  
Vice President, General Counsel & Secretary

**SERFF Tracking #:**

SEFL-128856351

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

MISC 2012 GRP LIFE

**State:**

Arkansas

**Filing Company:**

Assurity Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

Misc 2012 Grp Life

**Project Name/Number:**

Misc 2012 Grp Life/Misc 2012 Grp Life

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/18/2013		Form	Group Life Statement of Health	01/22/2013	75-863-01114.pdf (Superseded)



**PLEASE PRINT WITH BLACK INK**

**1. PROPOSED INSURED**

Employee's <i>First, Middle, Last</i> Legal Name		Other Proposed <i>First, Middle, Last</i> Insured's Name			
Relationship to Employee		<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security No.	
Residing with employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		Birth State/ Country		Date of Birth <i>(MM/DD/YYYY)</i>	
Home Address <i>Street Address City State ZIP+4</i>		Height ft. in.		Weight lbs.	
Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident ( <i>green card</i> ) status? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No					

**2. HEALTH SECTION**

1. During the past **2 years**, has the Proposed Insured been convicted of three or more moving traffic violations? .....  Yes  No

2. During the past **5 years**, has the Proposed Insured had a driver's license revoked or suspended; been convicted of driving while under the influence of alcohol or drugs; or been involved as a driver in two or more accidents? .....  Yes  No  
 Driver's license no./State \_\_\_\_\_ Details and dates \_\_\_\_\_

3. During the past **5 years**, has the Proposed Insured had any illness, surgery or injury requiring treatment by a licensed medical professional, hospital or other medical facility? .....  Yes  No

4. During the past **12 months**, has the Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum? .....  Yes  No  
 Employee .....  Yes  No  
 Spouse .....  Yes  No

5. During the past **5 years**, has the Proposed Insured been medically diagnosed or treated by a medical professional for a neurological or psychiatric disorder, alcohol abuse or illegal drug abuse? .....  Yes  No

6. During the past **5 years**, has the Proposed Insured been medically diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or had a positive test for human immunodeficiency virus (*HIV*) antibodies? .....  Yes  No

7. During the past **7 years**, has the Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for cancer, diabetes, stroke, heart or blood disorder, kidney or liver disorder, or a lung or breathing disorder? .....  Yes  No

**Please complete for any YES answer in questions 1-7 above. If additional space is needed, attach a separate sheet of paper.**

Question No.	Onset Date <i>(MM/DD/YYYY)</i>	Duration <i>(Days, Mos, Yrs)</i>	Health Condition and Details	Remaining Effects	Medical Care Provider's Name/Address/Phone
	/ /				
	/ /				

8. Family History: Have any of your immediate family members (*father, mother, siblings*) had heart disease, stroke, cancer (*specific type*), diabetes, kidney disease, mental illness, alcoholism, Huntington's chorea, amyotrophic lateral sclerosis (*ALS or Lou Gehrig's disease*), motor neuron disease, multiple sclerosis, Alzheimer's disease or any other hereditary disease? .....  Yes  No  
 If YES, please provide the information below. If additional space is needed, attach a separate sheet of paper.

Name of Family Member	Relationship	Health Condition	Age at Onset	Age at Death <i>(if applicable)</i>

**AUTHORIZATION AND ACKNOWLEDGEMENT**

**I, the Proposed Insured, agree that all answers and statements in this Application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability.**

**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 is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.**

Signed at \_\_\_\_\_ on \_\_\_\_\_ / / \_\_\_\_\_  
*City State Date (MM/DD/YYYY)*

\_\_\_\_\_  
*Signature of Proposed Insured Employee (or Owner for juveniles)*

\_\_\_\_\_  
*Signature of Spouse (if Proposed Insured)*

