

State: Arkansas **Filing Company:** VantisLife Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Vantis Life Term Application
Project Name/Number: /VLT1A

Filing at a Glance

Company: VantisLife Insurance Company
 Product Name: Vantis Life Term Application
 State: Arkansas
 TOI: L08 Life - Other
 Sub-TOI: L08.000 Life - Other
 Filing Type: Form
 Date Submitted: 12/24/2012
 SERFF Tr Num: VLIC-128824908
 SERFF Status: Closed-Approved-Closed
 State Tr Num:
 State Status: Approved-Closed
 Co Tr Num:

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

 State Filing Description:

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Vantis Life Term Application
Project Name/Number: /VLT1A

Filing Company: VantisLife Insurance Company

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: VLT1A 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: Margaret Mancarella
Submitted By: Margaret Mancarella Corresponding Filing Tracking Number: VLT1A

Filing Description:

Application forms VL-VLT1A-AR and VL-VLT1C-AR are individual term life applications used to apply for the Company's Term Life Insurance Policy, form CMP 0501 AR, approved by your Department on 05/18/2006 and will be used form CMP EX-10-1 approved under filing VLIC-126356470 on 10/29/2009.

The applications will be used by the Company either through paper or electronic format depending upon the sales channel being utilized by the customer.

These applications are identical in content to Forms VL-EZT1A-AR and VL-EZT1C-AR which were approved under FRCS-128649362 on 08/27/2012, the only exception being the Plan of Insurance Section which provides coverage selections specific to form CMP 0501 AR.

VL-VLT1A-AR is used in situations where there consumer completes the application with agent involvement and VL-VLT1C-AR is used in situations here the consumer applies for coverage electronically. Please see the enclosed Consumer E-Application Process document for more information regarding the Company's electronic procedures.

The questions answered by the applicant will be the same regardless of whether the application is completed in paper or electronic format.

When all questions are answered, the final application will be populated. This application will look exactly like the VL-VLT1C-AR form filed for approval and will be available for the consumer to review, print and save.

This form does not contain any unusual or innovative features.

To the best of my knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call 1-860-298-5448.

Thank you for your assistance.

Sincerely,
Margaret Mancarella

Company and Contact

State: Arkansas **Filing Company:** Vantislife Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Vantis Life Term Application
Project Name/Number: /VLT1A

Filing Contact Information

Margaret Mancarella, mmancarella@vantislife.com
 200 Day Hill Road 860-298-5488 [Phone]
 Windsor, CT 06095

Filing Company Information

Vantislife Insurance Company CoCode: 68632 State of Domicile: Connecticut
 200 Day Hill Road Group Code: Company Type:
 Windsor, CT 06095 Group Name: State ID Number:
 (860) 298-6008 ext. [Phone] FEIN Number: 06-0523876

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50 per form x 2 forms = \$100
 Per Company: No

Company	Amount	Date Processed	Transaction #
Vantislife Insurance Company	\$100.00	12/24/2012	66001797

SERFF Tracking #:

VLIC-128824908

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

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/VLT1A

Correspondence Summary

Dispositions

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

SERFF Tracking #:

VLIC-128824908

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

Arkansas

Filing Company:

Vantislife Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

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Vantis Life Term Application

Project Name/Number:

/VLT1A

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	CONSUMER APPLICATION PROCESS		Yes
Form	INDIVIDUAL TERM LIFE APPLICATION-AGENT		Yes
Form	INDIVIDUAL TERM LIFE APPLICATION-CONSUMER		Yes

SERFF Tracking #:

VLIC-128824908

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

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Form Schedule

Lead Form Number: VL-VLT1A-AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		INDIVIDUAL TERM LIFE APPLICATION-AGENT	VL-VLT1A-AR	AEF	Initial		50.100	VL-VLT1A-AR VLTerm Application 11-12.pdf
2		INDIVIDUAL TERM LIFE APPLICATION-CONSUMER	VL-VLT1C-AR	AEF	Initial		50.400	VL-VLT1C-AR VLTerm Application 11-12.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

VANTIS LIFE INSURANCE COMPANY

200 DAY HILL RD, WINDSOR, CT 06095
1-866-826-8471 WWW.VANTISLIFE.COM

PART 1A:

Application for Individual Life Insurance

For Agency Use Only

Agency:		Producer #:	
Date Prem Rec'd		Branch #	Rec'd By

For Home Office Use Only

Pol. No.		Issue Date	Ins. Amount
<input type="checkbox"/> APP <input type="checkbox"/> DEC <input type="checkbox"/> W/D <input type="checkbox"/> PP	UND. _____ Date __/__/__	Age (ANB)	Amt. Of Premium

◆ PLAN OF INSURANCE

Plan of Insurance: _____

Type of Coverage and Amount Requested:

- 10 Year Level \$25,000-[\$1,000,000] \$ _____
- 15 Year Level \$25,000-[\$1,000,000] \$ _____
- 20 Year Level \$25,000-[\$1,000,000] \$ _____
- 25 Year Level \$25,000-[\$1,000,000] \$ _____
- 30 Year Level \$25,000-[\$1,000,000] \$ _____

Select Optional Riders:

- Disability Waiver of Premium* (Available on issue ages 15 through 55.)
- Return of Premium* (Available on 20-Yr, 25-Yr and 30-Yr Level Term only.)

*additional costs apply

◆ Premium Payment Schedule

- Annually Semi-Annually Quarterly
 Monthly (*electronic payment method only*)
- Check here if you wish to pay electronically via Electronic Fund Transfer or Credit Card. Please submit Premium Payment Charge Authorization Form.
- Premium Paid \$ _____
(Payment with Application)

◆ PROPOSED INSURED INFORMATION

First Name:	Middle Initial:	Last Name:	Gender:
			<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)	Place of Birth (State/Country):	Social Security #:	Drivers License # & State:
Proposed Insured is: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> U.S. Permanent Resident	Do you hold a Green Card? <input type="checkbox"/> Yes, please provide photocopy <input type="checkbox"/> No		
Occupation:	Employer's Name:		
Home Address (Number, Street, and Apt.#) (<i>No P.O. Box please</i>)	Phone (HOME/CELL):	(WORK):	
City	State	Zip	Email Address:
Mailing Address if different than home (Number, Street)	City	State	Zip

◆ OWNER INFORMATION: (If other than Proposed Insured)

◆ Billing Address

Owner's First Name:	Middle Initial:	Last Name:	Payor's Name, if other than Owner :
Owner's Relationship to proposed Insured:	Owner's Social Security #:		
Owner's Address (Number, Street, and Apt.#):	Address (Number, Street, and Apt.#):		
City:	State:	Zip:	
Phone (HOME):	(WORK):	City:	
Email:	State:		Zip:

◆ INSURANCE REPLACEMENT QUESTIONS

- Are there existing life insurance or annuity contracts in force on the Proposed Insured? Yes No
- Do you intend to replace, discontinue or change any existing life insurance or annuity contracts with the applied for policy? Yes No
If yes, complete state required forms and Company Name(s) _____

◆ **BENEFICIARY INFORMATION (ATTACH SEPARATE SHEET IF MORE SPACE NEEDED)**

<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent	Name: _____	Date of Birth: _____	Social Security _____	Relationship to Insured: _____	Split%* _____
Address (Number, Street) _____		City _____	State _____ Zip _____	Phone Number _____	
<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent	Name: _____	Date of Birth: _____	Social Security _____	Relationship to Insured: _____	Split%* _____
Address (Number, Street) _____		City _____	State _____ Zip _____	Phone Number _____	
<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent	Name: _____	Date of Birth: _____	Social Security _____	Relationship to Insured: _____	Split%* _____
Address (Number, Street) _____		City _____	State _____ Zip _____	Phone Number _____	
<i>* Split percentages within designated beneficiary classification must equal 100%. If none specified, benefit will be split equally by class.</i>					

PART 1B - INSURANCE INFORMATION ON THE PROPOSED INSURED

1. In the last 5 years, to the best of your knowledge and belief have you been diagnosed or been treated by a physician or other licensed practitioner, or been hospitalized for any of the following: Heart disease, heart attack, chest pains, stroke, (CVA), Transient Ischemic Attack (TIA), heart arrhythmia, seizure, kidney disorder, liver, blood, pulmonary, nervous, mental disorder, depression, anxiety, diabetes, cancer of any type, disease or enlargement of the lymph nodes, drug or alcohol abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? (If Yes, provide details in 9 and physician's information in the space provided.) Yes No
2. Within the last three years, have you engaged in or in the next two years do you contemplate engaging in: skin-diving or scuba diving, mountain climbing, motorcycle or auto racing, hang gliding, sky diving or aviation other than commercial aviation? (If yes, please complete avocation questionnaire)..... Yes No
3. a) Have you used tobacco products or products containing nicotine in any form (to include cigarettes, snuff/chew/dip, cigars, pipes, nicotine patch and nicotine gum) in the past **12 months** Yes No
 b) in the past **24 months**? Yes No
 c) in the past **36 months**? Yes No
 d) in the past **60 months**? Yes No
4. Have you had life insurance declined, rated, cancelled or been refused issue, renewal or reinstatement? Yes No
5. In the last five years, have you been convicted of a felony; been charge or convicted with assault; been charge with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; currently have a revoked or suspended license, or currently on parole or incarcerated in a correctional institution? Yes No
6. Other than the above, are you under observation or taking treatment? Yes No
7. Current Height: _____ Ft. _____ Ins. Weight: _____ Lbs.
8. Please note any recent weight change in the past year; number of pounds gained _____ or lost _____
9. Give details as required to "Yes" responses. (Attach separate sheet, signed and dated, if more space is required.)

- 10a. Full Name of Physician: (If none, state "none" here. Required if question 1 is answered "Yes") _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
- 10b. Date Last Consulted? _____ Reason Consulted? _____
- 10c. Was any treatment given or medication prescribed? (If Yes, give details.) Yes No _____

VANTIS LIFE INSURANCE COMPANY

200 DAY HILL RD, WINDSOR, CT 06095
1-866-826-8471 WWW.VANTISLIFE.COM

For Home Office Use Only

PART 1A: Application for Individual Life Insurance

Pol. No.	Issue Date	Ins. Amount
<input type="checkbox"/> APP <input type="checkbox"/> DEC <input type="checkbox"/> W/D <input type="checkbox"/> PP	UND. _____ Date __/__/__	Age (ANB)
		Amt. Of Premium

◆ PLAN OF INSURANCE

Plan of Insurance: _____	Select Optional Riders:
Type of Coverage and Amount Requested:	<input type="checkbox"/> Disability Waiver of Premium* (Available on issue ages 15 through 55.)
<input type="checkbox"/> 10 Year Level \$25,000-[\$1,000,000] \$ _____	<input type="checkbox"/> Return of Premium* (Available on 20-Yr, 25-Yr and 30-Yr Level Term only.)
<input type="checkbox"/> 15 Year Level \$25,000-[\$1,000,000] \$ _____	
<input type="checkbox"/> 20 Year Level \$25,000-[\$1,000,000] \$ _____	
<input type="checkbox"/> 25 Year Level \$25,000-[\$1,000,000] \$ _____	
<input type="checkbox"/> 30 Year Level \$25,000-[\$1,000,000] \$ _____	
	*additional costs apply

◆ Premium Payment Schedule

<input type="checkbox"/> Annually	<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Monthly (<i>electronic payment method only</i>)		
<input type="checkbox"/> Check here if you wish to pay electronically via Electronic Fund Transfer or Credit Card. Please submit Premium Payment Charge Authorization Form.		
Premium Paid	\$ _____	(Payment with Application)

◆ PROPOSED INSURED INFORMATION

First Name:	Middle Initial:	Last Name:	Gender:
			<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)	Place of Birth (State/Country):	Social Security #:	Drivers License # & State:
Proposed Insured is: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> U.S. Permanent Resident	Do you hold a Green Card? <input type="checkbox"/> Yes, please provide photocopy <input type="checkbox"/> No		
Occupation:	Employer's Name:		
Home Address (Number, Street, and Apt.#) (<i>No P.O. Box please</i>)	Phone (HOME/CELL):	(WORK):	
City	State	Zip	Email Address:
Mailing Address if different than home (Number, Street)	City	State	Zip

◆ OWNER INFORMATION: (If other than Proposed Insured)

◆ Billing Address

Owner's First Name:	Middle Initial:	Last Name:	Payor's Name, if other than Owner :
Owner's Relationship to proposed Insured:	Owner's Social Security #:		
Owner's Address (Number, Street, and Apt.#):	Address (Number, Street, and Apt.#):		
City:	State:	Zip:	
Phone (HOME):	(WORK):	City:	
Email:	State:		Zip:

◆ INSURANCE REPLACEMENT QUESTIONS

1. Are there existing life insurance or annuity contracts in force on the Proposed Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you intend to replace, discontinue or change any existing life insurance or annuity contracts with the applied for policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, complete state required forms and Company Name(s) _____	

◆ **BENEFICIARY INFORMATION (ATTACH SEPARATE SHEET IF MORE SPACE NEEDED)**

<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent	Name: _____	Date of Birth: _____	Social Security _____	Relationship to Insured: _____	Split%* _____
Address (Number, Street) _____		City _____	State _____	Zip _____	Phone Number _____
<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent	Name: _____	Date of Birth: _____	Social Security _____	Relationship to Insured: _____	Split%* _____
Address (Number, Street) _____		City _____	State _____	Zip _____	Phone Number _____
<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent	Name: _____	Date of Birth: _____	Social Security _____	Relationship to Insured: _____	Split%* _____
Address (Number, Street) _____		City _____	State _____	Zip _____	Phone Number _____
<i>* Split percentages within designated beneficiary classification must equal 100%. If none specified, benefit will be split equally by class.</i>					

PART 1B - INSURANCE INFORMATION ON THE PROPOSED INSURED

1. In the last 5 years, to the best of your knowledge and belief have you been diagnosed or been treated by a physician or other licensed practitioner, or been hospitalized for any of the following: Heart disease, heart attack, chest pains, stroke, (CVA), Transient Ischemic Attack (TIA), heart arrhythmia, seizure, kidney disorder, liver, blood, pulmonary, nervous, mental disorder, depression, anxiety, diabetes, cancer of any type, disease or enlargement of the lymph nodes, drug or alcohol abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? (If Yes, provide details in 9 and physician's information in the space provided.) Yes No
2. Within the last three years, have you engaged in or in the next two years do you contemplate engaging in: skin-diving or scuba diving, mountain climbing, motorcycle or auto racing, hang gliding, sky diving or aviation other than commercial aviation? (If yes, please complete avocation questionnaire)..... Yes No
3. a) Have you used tobacco products or products containing nicotine in any form (to include cigarettes, snuff/chew/dip, cigars, pipes, nicotine patch and nicotine gum) in the past **12 months** Yes No
 b) in the past **24 months**? Yes No
 c) in the past **36 months**? Yes No
 d) in the past **60 months**? Yes No
4. Have you had life insurance declined, rated, cancelled or been refused issue, renewal or reinstatement? Yes No
5. In the last five years, have you been convicted of a felony; been charge or convicted with assault; been charge with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; currently have a revoked or suspended license, or currently on parole or incarcerated in a correctional institution? Yes No
6. Other than the above, are you under observation or taking treatment? Yes No
7. Current Height: _____ Ft. _____ Ins. Weight: _____ Lbs.
8. Please note any recent weight change in the past year; number of pounds gained _____ or lost _____
9. Give details as required to "Yes" responses. (Attach separate sheet, signed and dated, if more space is required.)

- 10a. Full Name of Physician: (If none, state "none" here. Required if question 1 is answered "Yes") _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
- 10b. Date Last Consulted? _____ Reason Consulted? _____
- 10c. Was any treatment given or medication prescribed? (If Yes, give details.) Yes No _____

SERFF Tracking #:

VLIC-128824908

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Vantislife Insurance Company

TOI/Sub-TOI:

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Product Name:

Vantis Life Term Application

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/VLT1A

Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	CONSUMER APPLICATION PROCESS		
Comments:			
Attachment(s):			
Consumer E.pdf			

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: Vantis Life Insurance Company

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
VL-VLT1A-AR	50.1
VL-VLT1C-AR	50.4



Margaret Mancarella
Compliance Manager

December 24, 2012

Date

Vantis Life Consumer E-app Process

The Consumer e-app process has been designed to work for consumers to apply for insurance on-line without the assistance of an Agent. This system is internet based and allows applicants to quote, answer questions and electronically fill out a PDF application for submission to Vantis Life Insurance Company.

The client either clicks on our website or is directed to our website from a referral website (such as one of our business partners...a bank, a credit union etc.). From that point the client is asked some preliminary data for purposes of Vantis Life being able to quote insurance for them. If they want to proceed with an application, they would authenticate through a software system that creates an ID and password and proceed to a questionnaire which guides them through the application.

The end result is a completed application that can be electronically signed by the applicant, payment can also be received through an on line credit card process, and submitted electronically to the Vantis Life new business system.

As part of this Consumer E-app process the following components are included:

Electronic Signature Vantis Life will gather electronic signatures from the applicant as part of this process. This will include the applicant agreeing to required disclosures needed for E-sig processing. We will gather one E-sig for all signing's required for the application. As the E-sig is the last component to the Consumer E-app process, the applicant will have the ability to review all data in completed PDF format before E-signing and submitting their application.

XML mapping of information All information to questions asked as part of the application questionnaire are specifically mapped to an appropriate area on the application (PDF). This ensure complete and accurate mapping of all information.

Data Security This application conforms to all standards of the Vantis Life Data Security Program and includes maintaining customer data privacy. All information entered by the user is protected by Verisign 128 bit SSL encryption. Any transfer of personal information done is either through SSL or secure VPN connection and is never shared with outside parties.

Personal Identity Vantis Life ensures the identity of the applicant due to the nature of the questions asked as part of this Consumer E-app process, specifically questions that the user answers that only the applicant knows as well as additional steps taken by the company to maintain insurable interest .