

REGULATORY UPDATE

TO: ALL AGENTS
ALL BRANCH SALES MANAGERS
ALL ADMINISTRATORS
- STATE OF PENNSYLVANIA -

CC: M. KELLOUGH, DVP # 1060
R. BRADY, VP Agency
G. MONROY, V.P. Field Support
S. PERRY, SVP Sales

FROM: G. Gresik, Manager
Agency Relations/Field Procedures

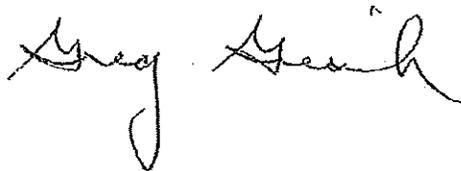
DATE: June 30, 2003

SUBJECT: SURRENDER COMPARISON INDEX DISCLOSURE FORM L-4383

The Surrender Comparison Index Disclosure Form, L-4383-PA(9/01), is generated at time of issue for applicable policies. It is important to note that a completed copy of this form is required to be left with the policyholder and a **copy is to be returned to the Home Office** as set forth in Pennsylvania Regulation Title 31. A reading of the regulation is mandatory and a copy is attached.

This is also a reminder to return all required, post-issue documents to the Home Office especially the Delivery Receipt Form #16088. The Policy Delivery Receipt is designed to benefit the policyholder, the agent and the Company and must be fully completed, **including the agent's signature.**

Please add pages VI-35 through VI-41 to your
STATE OF PENNSYLVANIA
SPECIAL RULES AND REGULATIONS




BANKERS
LIFE AND CASUALTY COMPANY

We specialize in seniors

January 19, 2004

Honorable Diane Koken
Insurance Commissioner
Commonwealth of Pennsylvania
Bureau of Rates & Policies
1311 Strawberry Square
Room 1787-41921
Harrisburg, PENNSYLVANIA 17120

NAIC #: 233- BLC: 61263

RE: LIFE APPLICATIONS
LIFE APPLICATION FORM L-2260B (04) PA
LIFE APPLICATION FORM L-11602B-PA
LIFE APPLICATION FORM L-12570B-PA
INCOME REPLACEMENT APPLICATION 12046B-PA

Dear Commissioner:

We are submitting for your review and approval the above referenced forms. Your favorable consideration would be greatly appreciated. This filing contains no unusual or controversial items from normal Company or industry standards. These forms are not required to be filed in our home state of Illinois.

We are formally filing these forms for approval as a result of a recent market conduct exam conducted by your department. The only revision from the previously approved forms made to these applications is that a fraud warning has been added.

Form L-12260B (04) PA replaces form L-2260A (86) PA which was approved September 4, 1987. Form L-11602B-PA replaces form L-11602A-PA which was approved December 13, 1994. Form L-12570B-PA replaces form L-12570-PA which was approved June 21, 1996. Form 12046B-PA replaces form 12046A-PA which was approved October 4, 1994.

Your consideration and approval of the above form would be appreciated.

Very truly yours,



Dan Murphy
Compliance Administrator
Product Approval and Compliance

CC Kerren Leonard

DJM/
Encls

Transmittal Header
Transmittal Header

SERT-5VCRL2835/00-00/00-00/00
 Created by Dan Murphy on 01/19/2004
 Assigned To: Paul Makurath, Diane Matrese,
 [Receiver]
 Company List: Bankers Life and Casualty
 Comp
 publicAccess
 No value

Sent: 01/19/2004 02:49:12 PM
 Other Authors: None
 TOI: Life
 SubTOI: Individual Whole Life

Filing Information:

Filing Action:	Initial	Filing Date:	01/19/2004
State:	Pennsylvania	State Instance	None
State Domain:	stateserff	Identifier:	
Type of Insurance:	Life	Filing Type:	Form
Product Name:	L-2260B (04) PA	Sub TOI:	Individual Whole Life
Implementation	None	Effective Date	None
Date Requested:		Requested:	
Project Name:	Revised Life Applications	Project #:	L-2260B (04) PA
Fee Required:	No	Fee Amount:	
Reference	No	Reference Org:	None
Filing:		Advisory Org	None
Reference #:	None	Circular #:	

Components sent originally with filing:

SERT-5VCRL2835/00-01/00-00/00
 SBRT-5VCRL2835/00-02/00-00/00
 SERT-5VCRL2835/00-03/00-00/00
 SBRT-5VCRL2835/00-04/00-00/00
 SERT-5VCRL2835/00-05/00-00/00
 SBRT-5VCRL2835/00-06/00-00/00
 SERT-5VCRL2835/00-07/00-00/00
 SBRT-5VCRL2835/00-08/00-00/00
 SBRT-5VCRL2835/00-09/00-00/00

Company Contact:

Lead Company: Bankers Life and Casualty Company

Filing Company Info	Contact Info
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Submission Requirements:

Status	Requirement
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Tracking Information:

Company Tracking #:	None	State Tracking #:	None
Company Status:	None	State Status:	Received
Date Company Status Changed:	None	Date State Status Changed:	None
SERFF Tracking #:	SERT-5VCRL2835/00	Delivery Date:	01/19/2004 03:07:44 PM

Transmittal Header

SERFF Status:	Closed - Approved	Disposition Date:	02/03/2004
Date SERFF	02/03/2004	Implementation Date:	02/03/2004
Status Changed:			
Deemer Date:	None	Effective Date:	None
Reviewers:	Paul Makurath, Diane Matrese, [Receiver]		

Additional State Tracking Numbers

State--Specific Fields:

Filing Fee	100.00	Filing Fee Check	2527647
Amount:		Number:	
Date Filing Fee	01/19/2004		
Mailed:			

Re--Opened Filing History 01/30/2004 08:46:35 AM An additional CH was created by Dan Murphy 01/19/2004 02:49:12 PM An additional CH was created by Dan Murphy

Filing
Description:

File None
Attachments:

Disposition Report

Report Type: Disposition Report

Created by Diane Matrese on 02/03/2004

Filing Originally Sent: 01/19/2004 02:49:12
PM

Sent: 02/03/2004 07:57:37 AM

State: Pennsylvania
SERFF Tracking No.: SERT-5VCRL2835/00-00/00-04/00

Response To: TransmittalHeader
Response To No.: SERT-5VCRL2835/00-00/00-00/00
SERFF Tracking No.:

Lead Company: Bankers Life and Casualty
Company

Company: Bankers Life and Casualty
Company

Product Name: L-2260B (04) PA
Filing Date: 01/19/2004 02:49:12 PM

Project Name: Revised Life Applications
Project No.: L-2260B (04) PA

State Tracking No.: None

Company Tracking No.: None

TOI: Life
Disposition: Approved
Reviewer Phone No.: 717-783-4400

Sub TOI: Individual Whole Life
SERFF Status: None

No disposition descriptions.

Disposition: Approved
Disposition Date: 02/03/2004
Effective Date: None
Type:
Effective Date: None
Implementation Date: 02/03/2004
Decemer Date: None
Comments:

Applies to Components

CH 01/00 — Transmittal Letter
CH 02/00 — Policy Forms
CH 03/00 — Actuarial Illustration Certifi
CH 04/00 — Variability Explanation
CH 05/00 — Change of Nonforfeiture Intere
CH 06/00 — Authorization to File
CH 07/00 — Insert Page Explanation
CH 08/00 — Rider Explanation
CH 09/00 — Filing Fee
CH 11/00 — Response to 1/23 Disposition R
CH 12/00 — Response to 1/30 Disposition R

File Attachments: None

Transmittal Header SERT-5VEREV509/00-00/00-00/00

Transmittal Header

SERT-5VEREV509/00-00/00-00/00
 Created by Dan Murphy on 01/21/2004
 Assigned To: Yen Lucas, Jeff Russell,
 [Receiver]
 Company List: Bankers Life and Casualty
 Comp
 publicAccess
 No value

Sent: 01/22/2004 04:14:35 PM
 Other Authors: None
 TOI: Accident and Health

SubTOI: Individual Long or Short Term
 Disability

Filing Information:

Filing Action:	Initial	Filing Date:	01/22/2004
State:	Pennsylvania	State Instance	None
State Domain:	stateserff	Identifier:	
Type of	Accident and Health	Filing Type:	Form
Insurance:		Sub TOI:	Individual Long or Short Term Disability
Product Name:	12046B-PA	Effective Date	None
Implementation	None	Requested:	
Date Requested:		Project #:	12046B-PA
Project Name:	12046B-PA	Fee Amount:	
Fee Required:	No	Reference Org:	None
Reference	No	Advisory Org	None
Filing:		Circular #:	
Reference #:	None		

Components sent originally with filing:

SERT-5VEREV509/00-01/00-00/00
 SERT-5VEREV509/00-02/00-00/00
 SERT-5VEREV509/00-03/00-00/00
 SERT-5VEREV509/00-04/00-00/00
 SERT-5VEREV509/00-05/00-00/00
 SERT-5VEREV509/00-06/00-00/00
 SERT-5VEREV509/00-07/00-00/00
 SERT-5VEREV509/00-08/00-00/00
 SERT-5VEREV509/00-09/00-00/00
 SERT-5VEREV509/00-10/00-00/00
 SERT-5VEREV509/00-11/00-00/00

Company Contact:

Lead Company: Bankers Life and Casualty Company

Filing Company Info	Contact Info
Bankers Life and Casualty Company 222 Merchandise Mart Plaza, Chicago, IL 60654-9988 USA Phone: 1-800-621-3724 FAX: 312-396-5907 CoCode: 61263 Group Code: 233 FEIN: 36-0770740 State of Domicile: Illinois State ID Number: None.	Dan Murphy Compliance Administrator Bankers Life and Casualty Company 222 Merchandise Mart Plaza, Chicago, IL 60654-9988 USA Phone: 312-396-6134 or 1-800-621-3724 Ext. 6134 FAX: 312-396-5907 Email: d.murphy@banklife.com

Submission Requirements:

Status Requirement

Transmittal Header SERT-5VEREV509/00-00/00-00/00

Satisfied	Transmittal Letter
Bypassed	Authorization to File
Bypassed	Listing of Forms
Satisfied	Policy Forms
Bypassed	Replacement Form with Highlighted Change
Bypassed	Variability Explanation
Bypassed	Rider Explanation
Bypassed	Requirements for App, Replacement Covera
Bypassed	Outline of Coverage
Bypassed	Actuarial Memorandum and Explanatory Inf
Satisfied	Filing Fee

Tracking Information:

Company Tracking #:	None	State Tracking #:	None
Company Status:	None	State Status:	None
Date Company Status Changed:	None	Date State Status Changed:	None
SERFF Tracking #:	SERT-5VEREV509/00	Delivery Date:	01/22/2004 04:29:30 PM
SERFF Status:	Closed -- Approved	Disposition Date:	02/24/2004
Date SERFF Status Changed:	02/24/2004	Implementation Date:	02/24/2004
Decemr Date:	None	Effective Date:	None
Reviewers:	Yen Lucas, Jeff Russell, [Receiver]		

Additional State Tracking Numbers

Bankers Life and Casualty
Company

State-Specific Fields:

Filing Fee Amount:	25.00	Filing Fee Check Number:	00008603
Date Filing Fee Mailed:	01/22/04		

Filing Description: None

File Attachments: None

Disposition Report SERT-5VEREV509/00-00/00-01/00

Disposition Report

Report Type: Disposition Report

Filing Originally Sent: 01/22/2004 04:14:35 PM

Created by Jeff Russell on 02/24/2004

Sent: 02/24/2004 12:30:45 PM

State: Pennsylvania
SERFF Tracking No.: SERT-5VBREV509/00-00/00-01/00

Response To: TransmittalHeader
Response To: SERT-5VBREV509/00-00/00-00/00
SERFF Tracking No.:

Lead Company: Bankers Life and Casualty Company

Company: Bankers Life and Casualty Company

Product Name: 12046B-PA
Filing Date: 01/22/2004 04:14:35 PM

Project Name: 12046B-PA
Project No.: 12046B-PA

State Tracking No.: None

Company Tracking No.: None

TOI: Accident and Health

Sub TOI: Individual Long or Short Term Disability

Disposition: Approved
Reviewer Phone No.: 717-783-2852

SERFF Status: None

No disposition descriptions.

Disposition: Approved
Disposition Date: 02/24/2004
Effective Date: None
Type:
Effective Date: None
Implementation Date: 02/24/2004
Deemer Date: None
Comments: None

Applies to Components

- CH 01/00 — Transmittal Letter
- CH 02/00 — Authorization to File
- CH 03/00 — Listing of Forms
- CH 04/00 — Policy Forms
- CH 05/00 — Replacement Form with Highligh
- CH 06/00 — Variability Explanation
- CH 07/00 — Rider Explanation
- CH 08/00 — Requirements for App, Replacem
- CH 09/00 — Outline of Coverage
- CH 10/00 — Actuarial Memorandum and Expla
- CH 11/00 — Filing Fee

File Attachments: None

APPLICATION FOR LIFE INSURANCE TO

BANKERS LIFE AND CASUALTY COMPANY
222 Merchandise Mart Plaza . Chicago, IL 60654-2001

1. Print Applicant's Full Name (Last, First & Middle Initial) _____

I hereby apply for a Juvenile Estate Builder Life Insurance Policy for _____ Units (each Unit provides \$1,000 of Initial Death Benefit) to be issued on the basis of my answers to the following questions and my answers to the Medical Examiner on Part II hereof, if any.

2. Name of Proposed Risk _____

3. Address _____ Post Office Box No. _____
City _____ State _____ Zip Code _____ County _____

4. Sex Male Female Height ft. _____ in. _____ Weight pounds _____ Date of Birth (Mo) _____ (Day) _____ (Year) _____ Age years _____

5. Place of Birth _____ State or Country _____ Name of Beneficiary _____ Related to Proposed Risk as _____

6. What is the total amount of other Life insurance in force or applied for on the life of the Proposed Risk? (If none, so state) \$ _____ 7. Policy numbers of Bankers' policies: _____

8. Has the Proposed Risk to the best of your knowledge and belief: (Circle the appropriate condition)
- | | |
|--|---|
| <p>(a) Ever been declined, restricted, rated-up, or postponed upon application for issue or renewal of any kind of personal insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) Ever had mental retardation or illness, epilepsy, paralysis or rheumatic fever? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) Ever had chronic cough, asthma, lung disease, goitre, or jaundice? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(d) Ever had heart disease or heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e) Ever had any disease of the liver, sugar or blood in urine, diabetes, or kidney disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>(f) Ever had meningitis, leukemia, eye or ear disease, or any disease of the internal or external genital organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(g) Ever had any intestinal diseases, tumor, cyst, cancer or neoplasm in any part of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(h) Ever had an immune deficiency disorder, AIDS, AIDS Related Complex (ARC), or test results indicating exposure to AIDS. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

9. List full details of any sickness above, also give full details of any other sickness, disability, medical, mental or surgical treatments or check-ups in the past five (5) years. If None, check here .

Conditions and Complications	Date of			Days in Hosp.	Names and Addresses of Physicians/Doctors
	Onset Mo. Yr.	Operation Mo. Yr.	Recovery Mo. Yr.		

10. Is the Proposed Risk to the best of your knowledge and belief, in good health and free from mental or physical deformity or defect except as noted above? If "No" give details in question 9. Yes No

11. Will any existing Life, Health, Accident & Sickness, Disability Income or Annuity contract(s) be replaced or changed if this proposed policy is issued? Yes No

12. I have paid \$ _____ as premium on this policy until the policy anniversary nearest the Proposed Risk's 23rd birthday. Yes No

I have witnessed the signature of the Applicant. I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the proposed policy, is or is likely, is not or is not likely, to replace or change any existing policy(ies) or contract(s).

Signature of licensed resident agent _____ No. _____

Signature of licensed resident agent _____ No. _____

I represent that the statements contained in this application are, to the best of my knowledge and belief, complete, true and correct. I understand that: (1) the proposed policy will not take effect until the first premium is paid and the policy is delivered during the Proposed Insure's lifetime while in the condition of health set forth in this application and (2) No agent or other person has the right to pass on insurability or waive any of the Company's rights or requirements.

Dated at _____ this _____ day of _____ 20____

Signature of the Applicant

Social Security Number

Related to the Proposed Risk As

MAKE ALL CHECKS PAYABLE ONLY TO BANKERS LIFE AND CASUALTY COMPANY

NOTICE: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICATION FOR LIFE INSURANCE TO
BANKERS LIFE AND CASUALTY COMPANY
 222 Merchandise Mart Plaza, Chicago, IL 60654-2001

1 Print Applicant's Full Name (Last, First, & Middle Initial) _____

2 First Name & Initial of Applicant and Each Person to be Insured (and Last if not same as Applicant)	A. (Applicant)	B.	C.	D.	E.	F.
Sex						
Married (M): Single (S)						
Relationship to Applicant						
Date of Birth (Mo/Day/Yr)/Age	/ /	/ /	/ /	/ /	/ /	/ /
State or Country of Birth						
U.S. Citizen	Yes <input type="checkbox"/> No <input type="checkbox"/>					
Height/Weight	/	/	/	/	/	/

3 LIFE PLAN NAME _____ FORM NO. _____

IF UNIVERSAL LIFE is applied for, complete the following:
 Death Benefit Option A B
 Planned Premium \$ _____ Payable _____
 Lump Sum Premium \$ _____

Benefit Amount	\$ _____	\$ _____
Term Period		

3a. APPLICATION OF EXCESS INTEREST (If Applicable) Paid-Up Additions Reduce Premium One Year Term

3b. ADDITIONAL BENEFITS APPLIED FOR

Waiver of Prem. Accidental Death (Units) _____ Spouse Insurance (Units) _____ Other _____
 Waiver of Cost Ins. Waiver of Planned Periodic Payment _____ Children Insurance (Units) _____ _____ Term Rider for _____ yrs.

3c. ACCELERATED DEATH BENEFIT (If Applicable) Yes No (If YES, complete required form.)

4 HOME ADDRESS (List previous address in Section 16, if residing here less than 2 years)

Street or P.O. Box _____
 City/Town _____ State _____
 Zip Code _____ Phone No. () _____

5 BILLING ADDRESS (If different than Home Address)

Name _____
 Street or P.O. Box _____
 City/Town _____ State _____ Zip Code _____

6 Requested Issue Date _____

7a. Premium To Be Paid Annually (12) Quarterly (03) PRD (01)
 Semi-Annually (06) A/O (0)

7 Amt. Pre-Paid \$ _____ or COD P.P.S.P. (01) Government Allotment (01) Draft Date _____

8 Beneficiary (Primary) _____ Relationship/Age _____
 (Contingent) _____ Relationship _____
 (Show additional beneficiaries, if any in Section 16)

9 Will any existing Life, Health, Accident & Sickness, Disability Income or Annuity Contract(s) be replaced or changed if the proposed insurance is issued? If yes, attach required replacement forms. Yes No

10 EMPLOYMENT/FINANCIAL INFORMATION (On Insured) (On Payor If Payor Benefits Are Requested or Joint Insured)

a. Name of Employer/Length of Employment _____
 Business Address _____
 Annual Income-This Occupation \$ _____
 Describe duties _____

b. Annual Income other than above. Earned \$ _____ Unearned \$ _____ Earned \$ _____ Unearned \$ _____

11 (questions 11 thru 15 refer to proposed insured(s) and the applicant if payor benefits requested.)

Has any person to be insured:	Yes	No	Details of Yes answers, and person(s) involved
a. Ever been declined, postponed, rated or charged extra premium for Life or Health insurance or offered a policy different from that applied for, or been refused reinstatement or renewal of Life or Health insurance?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Applied for any other Life or Health insurance now pending or contemplated?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Plans to make, or in the past 12 months made any flight as a pilot, student pilot, or member of the crew of any aircraft? (If Yes, complete aviation questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	

11	Has any person to be insured: (Continued)	Yes	No	Details of Yes answers, and person(s) involved
d.	Plans to engage in, or in the past 12 months engaged in, parachuting, hang gliding, vehicle racing, skin or scuba diving, or mountain climbing? (If Yes, complete appropriate questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
e.	Any intention of traveling, working or living outside the U.S.A. in the next 2 years or lived or traveled outside the U.S.A. within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
f.	Used tobacco in the past year? If Yes, type.	<input type="checkbox"/>	<input type="checkbox"/>	
g.	Had their drivers license suspended, or revoked or received two (2) or more moving violations in the past 3 years? Been convicted for driving under the influence of alcohol or drugs within the past 5 years? If Yes, list license number.	<input type="checkbox"/>	<input type="checkbox"/>	
h.	Been convicted of a felony within the past 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	

12	MEDICAL DATA Has any person to be insured:	Yes	No	Details of Yes answers, and person(s) involved
a.	Been under observation or taking treatment or been medically advised to have any diagnostic test, hospitalization, or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>	
b.	In the past 9 months become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
c.	Used in the past 5 years:			
1.	Alcoholic beverages? If so, to what extent?	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Barbiturates, sedatives, tranquilizers, or morphine? If yes, how often?	<input type="checkbox"/>	<input type="checkbox"/>	
3.	L.S.D., marijuana, cocaine, heroin, or any other narcotic? If Yes, how often?	<input type="checkbox"/>	<input type="checkbox"/>	
d.	In the past 10 years, been medically treated for alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>	
e.	Had a weight loss in the past year (10 pounds or more)?	<input type="checkbox"/>	<input type="checkbox"/>	
f.	Had medical treatment for AIDS, AIDS related complex (ARC) or had positive test results to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	

13 Has any person to be insured ever, to the best of your knowledge and belief, had or does any person have (answer each question by checking the appropriate box or boxes): If "Yes" give details in question 14.

A. Any Nervous, or Mental Trouble?	Yes	No	E. Any Lung or Respiratory Trouble?	Yes	No
<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Blood Spitting	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nervous Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Persistent Hoarseness or Cough	<input type="checkbox"/>	<input type="checkbox"/>
B. Any Heart or Circulatory Trouble?	Yes	No	F. Any Back, Joint, Bone, or Muscle Trouble?	Yes	No
<input type="checkbox"/> Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hemiated Disc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spine Disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Palpitations	<input type="checkbox"/>	<input type="checkbox"/>			
C. Any Endocrine or Metabolic Trouble?	Yes	No	G. Any Stomach, Digestive, Intestinal or Rectal Trouble?	Yes	No
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sugar in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Intestines	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> Liver	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> Hernia	<input type="checkbox"/>	<input type="checkbox"/>
D. Any Genito-Urinary or Breast Trouble?	Yes	No	H. Any of the following?	Yes	No
<input type="checkbox"/> Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reproductive Organ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cyst	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bye Trouble	<input type="checkbox"/>	<input type="checkbox"/>

14 List full details of any sickness above, also give full details of any other sickness, disability, medical, mental or surgical treatments or check-ups in the past five (5) years. If None, check here

Name	Conditions and Complications	Date of			Days in Hospital	Name and Addresses of Physicians/Hospitals/Clinics
		Onset Mo. Yr.	Operation Mo. Yr.	Recovery Mo. Yr.		

15	FAMILY RECORD	(Insured)			(Pavor or Joint Insured)		
		Age if Living	Age at Death	Cause of Death	Age if Living	Age at Death	Cause of Death
	Father						
	Mother						
	Brothers and Sisters	#Living	#Dead		#Living	#Dead	

16

REMARKS

ACKNOWLEDGEMENTS

- 17 THE APPLICANT, AND PROPOSED INSURED IF OTHER THAN THE APPLICANT, EACH TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF, REPRESENT AND AGREE AS FOLLOWS:
- a. I have read, or had read to me, the completed application and realize that any false material statements or misrepresentation in this application may result in loss of coverage under the policy.
 - b. The statements in this application concerning past and present health are complete, true and correct.
 - c. No agent is authorized to waive or modify any terms of this application. An agent's knowledge of any facts not disclosed in this application will not be considered knowledge by the Company nor be binding on the Company.
 - d. No agent, medical examiner or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
 - e. Any insurance policy issued as a result of this application shall, together with the application, constitute a single and entire contract of insurance.
 - f. If premium was paid with this application, I have read the receipt given to me and fully understand the conditions and limitations stated in the receipt and that no agent can waive or change such conditions and limitations.
 - g. Any insurance issued as a result of this application will either: (i) not take effect for each person proposed for insurance unless and until the full first premium is paid and the policy is delivered during such person's lifetime and while such person is in the condition of health set forth in this application; or (ii) take effect only as specified in the receipt, if any, attached to this application.
 - h. Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan applied for have been explained and are understood.
 - i. The applicant shall be the owner of any insurance applied for unless otherwise requested.

AUTHORIZATION

18 In connection with an application for insurance currently made to Bankers Life and Casualty Company (the Company), I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or any of the members of my family named in said application or of our health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization will be valid for a period of 2 years and 6 months from the date signed. I also acknowledge receipt of the Investigative Consumer Report Notice.

19 SIGNATURES Dated at City _____ State _____ Zip _____
 This _____ Day of _____ 20_____
 Signature of Applicant(s) X _____
 Social Security Number(s) _____
 or Employer Identification number, if applicable _____

If other than Applicant, Proposed Insured(s) who are of legal age must sign below. I consent to this application and confirm that the answers recorded above are complete and true.

Name	B.	C.	D.	E.	F.
Signature of Proposed Insured					
Social Security Number					

I have witnessed the signature of the Applicant and Proposed Insured(s) if different. I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for is likely, is not or is not likely to replace or change any existing policy(ies) or contract(s).

Signature of Licensed Resident Agent X _____ No. _____ B.O. _____
 Signature of Licensed Resident Agent X _____ No. _____

L-11602B-PA

(04)

NOTICE: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

MAKE ALL CHECKS PAYABLE TO BANKERS LIFE AND CASUALTY COMPANY

**APPLICATION FOR INSURANCE TO
BANKERS LIFE AND CASUALTY COMPANY
222 Merchandise Mart Plaza, Chicago, Illinois 60654-2001**

1 I hereby apply for an Insurance Policy on Plan No. _____
Policy Name _____

Print Proposed Insured's Full Name (Last, First & Middle Initial)	Sex	Date of Birth Mo. Day Yr.	Age	Principal Sum	Annual Premium
2 Y357!!!!!!!!!!!!!!!!!!!!	Y358Y	Y359!!!Y	Y360Y	\$	\$

3 RESIDENCE OF PROPOSED INSURED Street Address Y014##### City Y015##### State Y016Y Zip Y017Y Telephone Number (Y012Y) Y013###Y Occupation _____	4 BILLING ADDRESS (If different than Residence Address) Street or P.O. Box _____ City, Town _____ State _____ Zip Code _____
5 SPECIAL ISSUE DATE _____ <input type="checkbox"/> None	

6 MEDICAL QUESTIONS (If "Yes", the Proposed Insured is not eligible for coverage.)

A. Within the past year, have you:

- 1) Been in a long-term care facility; or
- 2) Been confined to a bed or required daily use of a wheelchair? Yes No

B. Within the past 2 years, to the best of your knowledge and belief, have you:

- 1) Had Angina Pectoris, a heart attack, congestive heart failure, a stroke, pacemaker surgery or any heart procedure to improve coronary circulation;
- 2) Been diagnosed as having, been treated or medically advised to receive treatment for: ALS (Lou Gehrig's disease), Alzheimers disease, brain tumor, internal cancer, leukemia or melanoma, or chronic lung disease or received oxygen for any respiratory disease; or
- 3) Been medically treated or advised by a doctor to receive treatment for: excessive use of alcohol, drug use, insulin dependent diabetes, kidney insufficiency (including dialysis), liver disease, or had an organ transplant? Yes No

C. Have you ever tested positive for antibodies to the AIDS Virus or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

7 BENEFICIARY: Primary _____, Related to me as _____
Contingent _____, Related to me as _____

8 Is the policy applied for intended to, or likely to, replace or change any existing life insurance or annuities in this or any other company? If "Yes", attach any required forms. Yes No

9 Is the Automatic Premium Loans provision to be effective? Yes No

10 I have paid a total of \$ _____ with this application to pay premiums for _____ months.

11 REMARKS _____

I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, except as may be stated by the Proposed Insured's response to Question 8 the insurance applied for: is not or is not likely to replace or change any existing policies or contracts.

_____, No. _____ Office _____
Signature of Licensed Resident Agent

_____, No. _____ Office _____
Signature of Licensed Resident Agent

Send Policy to 1. PROPOSED INSURED 2. AGENT

Subject to the terms of a receipt, if any, given in connection with this application, I understand and agree that the policy hereby applied for will not take effect until the first premium is paid and the policy is delivered during the Proposed Insured's lifetime while in the condition of health set forth in this application, and that no agent has authority to waive the answers to any questions of this application, pass on insurability, waive any of the Company's rights or requirements or to alter any contract. I have read, or had read to me, the above questions and my answers to them and, to the best of my knowledge and belief, they are complete, true and correct.

Dated at _____
This _____ Day of _____ 20 _____

X _____
Signature of Proposed Insured

Social Security Number

X _____
Signature of Owner (If other than Proposed Insured)

Social Security Number

L-12570B-PA

(04)

NOTICE: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

MAKE ALL CHECKS PAYABLE ONLY TO BANKERS LIFE AND CASUALTY COMPANY

**APPLICATION FOR INSURANCE TO
BANKERS LIFE AND CASUALTY COMPANY**
222 Merchandise Mart Plaza . Chicago, IL 60654-2001

1

Print Proposed Insured's Full Name (Last, First, & Middle Initial) _____

Male <input type="checkbox"/>	Married <input type="checkbox"/>	Date of Birth (Mo/Day/Yr)	Age (Last Birthday)	State or Country of Birth	U.S. Citizen Yes <input type="checkbox"/> No <input type="checkbox"/>	Height Ft. _____ Inches _____	Weight Pounds _____
Female <input type="checkbox"/>	Single <input type="checkbox"/>						

2 INCOME REPLACEMENT POLICY FORM NO. _____

Policy Benefit Period: 2 years 5 years
 to age 65 _____

Policy Elimination Period: 30 days 60 days 90 days
 180 days 365 days _____

Maximum Monthly Benefit Amount: \$ _____

Request for Special Issue Date: _____ No

Occupation Class: 4A 3A 2A A B _____

OPTIONAL BENEFIT RIDERS

- Indexing Benefit
- Future Purchase Option Benefit
- Compound Increases Inflation Benefit _____%
- Return Of Premium Benefit
- Extension Of Policy's Guarantee Of Renewability To Age 67
- _____

3 HOME ADDRESS

(List previous address in "REMARKS" Section 1b, if residing here less than 2 years)

Street _____
City/Town _____ State _____
Zip Code _____ Phone No. (____) _____

4 BILLING ADDRESS Same as Home Address

Name _____
Street or P.O. Box _____
City/Town _____ State _____ Zip Code _____

5 Have you used tobacco products within the last 12 months? Yes No

6 EMPLOYMENT INFORMATION (Proposed Insured)

a. Name of Employer _____
Business Address _____
City/Town _____ State _____
Zip Code _____ Phone No. (____) _____

b. Are you actively working at least 30 hours a week at your full time job? Yes No

c. Have you been working full time during the past 180 days? Yes No

If no, explain: _____

d. Business of Employer _____

e. Occupation Title _____

f. Check the box that best describes the work you do:

- Professional Technical Sales Agricultural Managerial Clerical Personal Service Construction
- Factory Other _____

g. Describe your exact duties in detail: _____

h. Do you work mostly (check boxes that apply):

- Inside Outside Heavy Manual Labor Light Manual Labor No Manual Labor

i. How many months a year do you usually work? _____ months

j. Time Employed - This Job _____ years _____ months. Time Employed - This Employer _____ years _____ months.

k. Describe duties of any other current job (include name and address of Employer): (If none, check here!) _____

7 FINANCIAL INFORMATION (Proposed Insured)

- a. If self-employed, number of full time employees _____ (If none, or not applicable, check here)
- b. Annual Income (as Reported on your Federal Tax return), Full Time Job: Current Year \$ _____
 Last Year \$ _____ 2 Years Ago \$ _____
- c. Annual Income (as Reported on your Federal Tax return), Other Job(s) \$ _____ (If none, check here)
- d. Unearned Income (as Reported on your Federal Tax return) and Sources:
 Dividends \$ _____ Interest \$ _____ Rental \$ _____ Pension \$ _____
 Other \$ _____ (Give Details) _____
-
- Total Unearned Income: \$ _____ (If none, check here)
- e. Net Worth (Assets minus Liabilities): \$ _____
- f. Are you eligible for (but not currently receiving):
 Federal Social Security? Yes No Workers Compensation? Yes No State Cash Sickness Plan? Yes No
- g. Have you declared bankruptcy in the past 7 years? Yes No

8 INSURANCE IN FORCE ON PROPOSED INSURED

Disability Income in force None (Include all Disability Benefits under Individual, Group or Association Policies; all Salary Continuation, Sick Leave, Pension and Union Welfare Plans which provide Disability benefits; Disability Riders on Life Insurance.) If more space is needed, use Section 10p.

Company or Source	Monthly Amount	Benefit Period	Elimination Period	To Be Replaced		Replacement Date
				Yes	No	

9 Will any other existing Life, Health, Accident & Sickness, Disability Income or Annuity contracts be replaced or changed if a proposed policy is issued? Yes No (If yes, show details in Section 10p.)

10 HAS THE PROPOSED INSURED:

	Yes	No	Details of Yes answers (Identify No. of question)
a. Ever been declined, postponed, rated or charged an extra premium for Life or Health or Disability Income Insurance or offered a policy different from that applied for, or been refused reinstatement or renewal of Life, Health or Disability Income Insurance?	<input type="checkbox"/>	<input type="checkbox"/>	
b. An application for any other Disability Income Insurance now pending or being considered?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Ever received or claimed disability benefits, or a pension for any injury, sickness, or impaired condition?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Made in the last 12 months, or plan to make, any flight as a pilot, student pilot, or member of the crew of any aircraft?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Engaged in the last 12 months, or plan to engage in any sport or hobby such as paragliding, parakiting, parachuting, hang gliding, vehicle racing, mountain climbing, scuba or skin diving?	<input type="checkbox"/>	<input type="checkbox"/>	
f. 1. Lived or traveled outside the U.S.A. within the past 12 months? 2. Any intention of living or working outside the U.S.A. within the next 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Had military service deferment, rejection or discharge because of a physical or mental condition?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Been under observation, or taking medical treatment, or been medically advised to have any diagnostic test, hospitalization, or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>	
i. In the past 9 months, become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
j. Had his/her drivers license been suspended, or revoked or received two (2) or more moving violations in the past 3 years? If yes, give details in 10p.	<input type="checkbox"/>	<input type="checkbox"/>	
k. Been convicted of a felony within the past 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	

10 HAS THE PROPOSED INSURED: (continued)

	Yes	No	Details of Yes answers (Identify No. of question)
i. In the past 5 years used:			
1. Alcoholic beverages? If yes, to what extent?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Barbiturates, sedatives, tranquilizers, or morphine unless prescribed by a licensed physician? If yes, to what extent?	<input type="checkbox"/>	<input type="checkbox"/>	
3. L.S.D., marijuana, cocaine, heroin, or any narcotic drug? If yes, how often?	<input type="checkbox"/>	<input type="checkbox"/>	
m. Ever had medical attention related to the use of alcohol, drugs, or the effects of their use?	<input type="checkbox"/>	<input type="checkbox"/>	
n. Had a change in weight in the past year (10 pounds or more)?	<input type="checkbox"/>	<input type="checkbox"/>	
o. Had, or been medically treated for AIDS, AIDS related complex (ARC)			
P. Additional Details to Questions 8, 9 and 10 (Identify No. of questions):			

11 Has the person to be insured ever, to the best of your knowledge and belief, had or have (answer each question by checking the appropriate box or boxes): If "Yes" give details in question 12.

A. Any Brain, Nervous, or Mental Trouble including but not limited to those listed below?		E. Any Lung or Respiratory Trouble?		Yes No
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Nervous Fatigue	<input type="checkbox"/> Blood Spitting	<input type="checkbox"/> Throat	
<input type="checkbox"/> Depression	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Emphysema	
		<input type="checkbox"/> Persistent Hoarseness or Cough		
B. Any Heart or Circulatory Trouble?		F. Any Back, Joint, Bone or Muscle Trouble?		Yes No
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Amputation	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Fracture
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Stroke	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Back	<input type="checkbox"/> Deformity	<input type="checkbox"/> Bursitis
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> High Blood Pressure	G. Any Stomach, Digestive, Intestinal or Rectal Trouble?		
C. Any Endocrine or Metabolic Trouble?		<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Liver
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sugar in Urine	<input type="checkbox"/> Colitis	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Gland Trouble	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hernia
<input type="checkbox"/> Goiter	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Hemorrhoids		
D. Any Genito-Urinary or Breast Trouble?		H. Any of the following?		Yes No
<input type="checkbox"/> Breast	<input type="checkbox"/> Reproductive Organ	<input type="checkbox"/> Allergy	<input type="checkbox"/> Eye Trouble	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Kidney	<input type="checkbox"/> Urinary Bladder	<input type="checkbox"/> Anemia	<input type="checkbox"/> Leukemia	
<input type="checkbox"/> Prostate	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Polyp	
<input type="checkbox"/> Pus in Urine		<input type="checkbox"/> Cyst	<input type="checkbox"/> Tumor	
		<input type="checkbox"/> Ear Trouble	<input type="checkbox"/> Dermatitis	

12 List full details of any condition above; also give full details of any other sickness or accident, or medical, mental or surgical treatments or check-ups in the past five (5) years. (If none, check here)

Question Number	Conditions and Complications	Date of			Days in Hosp.	Names, Addresses, Phone Numbers of Physicians/Doctors/Hospitals
		Onset Mo. Yr.	Operation Mo. Yr.	Recovery Mo. Yr.		

13 Is the proposed insured, to the best of your knowledge and belief, free from mental or physical deformity or defect except as noted above? If "No" give details in question 12. Yes No

14 FAMILY RECORD OF PROPOSED INSURED

	Age If Living	Age at Death	Cause of Death, If known
Father			
Mother			
Brothers and Sisters	#Living	#Dead	

15

REMARKS

Empty box for remarks.

ACKNOWLEDGEMENTS

16 THE APPLICANT, TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF, REPRESENTS AND AGREES AS FOLLOWS:

- a. I have read, or had read to me, the completed application and realize that any false statements or misrepresentation in this application may result in loss of coverage.
b. The statements in this application concerning past and present health are complete, true and correct.
c. No agent is authorized to waive or modify any terms of this application.
d. No agent, medical examiner or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
e. Any individual insurance policy issued as a result of this application shall, together with the application, constitute a single and entire contract of insurance.
f. If premium was paid with this application, I have read the receipt(s) for same and fully understand the conditions and limitations stated in the receipt(s) and that no agent can waive or change such conditions and limitations.
g. Any insurance issued as a result of this application will either: (i) not take effect for each person proposed for insurance unless and until the full first premium is paid and the policy or certificate is delivered during such person's lifetime and while such person is in the condition of health set forth in this application; or (ii) take effect only as specified in the receipt(s), if any, attached to this application.
h. For an exchange, the new coverage will be treated as a renewal of any current coverage. Any loss that begins before the effective date of the new coverage will be considered within the limit of benefits contained in both the new and current coverage, subject to the applicable time limits on certain defenses.
i. For upgrades, all policy waiting periods will apply to any increase in benefits. The waiting periods will start on the effective date of the increase.
j. Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan(s) applied for have been explained and are understood.
k. The applicant shall be the owner of any insurance applied for.

17 SIGNATURES Dated at City _____ State _____ Zip _____

this _____ Day of _____ 20 _____

Signature of Applicant X _____

Social Security _____

Number | | | | - | | | | Driver's License Number _____

Proposed Insured sign below, IF OTHER THAN APPLICANT, I consent to this application and confirm that the answers recorded above are, to the best of my knowledge and belief, complete and true.

Signature of Proposed Insured X _____

Relationship to Applicant _____ Social Security Number | | | | - | | | |

I have witnessed the signatures of the Applicant and Proposed Insured, if different. I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for is or is likely, is not or is not likely to replace or change any existing policy(ies) or contract(s).

Signature of Licensed Resident Agent X _____ No. _____ Branch _____

Signature of Licensed Resident Agent X _____ No. _____

(Agent's Signature Not Needed When Dealing Directly With The Home Office)

12046B-PA

NOTICE: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

MAKE ALL CHECKS PAYABLE ONLY TO BANKERS LIFE AND CASUALTY COMPANY

TO BANKERS LIFE AND CASUALTY COMPANY, Chicago, Illinois 60654-2001 (hereinafter called the Company)

1. I apply for a Policy on Form No. _____.

2. _____
 Print Applicant's Full Name (Last, First, & Middle Initial)

3. Home Address _____ Post Office Box No. _____
 (Number and Street or Distance and Direction From Town)
 City/Town _____ State _____ Zip Code _____ County _____

4. Sex	Date of Birth (Mo.) (Day) (Year)	Age (Nearest Birthday) years	Policy numbers of Bankers' policies:
--------	-------------------------------------	---------------------------------	--------------------------------------

Exact Duties of Employment	Avg. Mo. Earnings Past 12 Mo. \$ Prev. 12 Mo. \$	Occ. Class	Name and Address of Employer	Business of Employer
----------------------------	--	---------------	------------------------------	----------------------

Beneficiary (Primary) _____ Relationship/Age _____
 (Contingent) _____ Relationship _____

5. Will any other existing Life, Health, Accident & Sickness, Disability Income or Annuity contracts be replaced or changed if a proposed policy is issued? Yes No

I, to the best of my knowledge and belief, represent and agree that: (1) Any policy issued as a result of this application shall, together with the application, constitute a single and entire contract of insurance. (2) No agent or any other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements. (3) The insurance takes effect on the Issue Date of the policy if the first premium is paid.

I have paid a total of \$ _____ with this application for the initial premium to insure me for _____ months.

I have read, or had read to me, the above questions and my answers to them. To the best of my knowledge and belief, they are complete, true and correct.

Dated at _____

6. this _____ day of _____ 20 _____

 Signature of Applicant

I have witnessed the signature of the Applicant. I certify that I asked all the questions and truly and accurately recorded the answers contained herein. I also certify that the Applicant read, or had read to him/her the completed application. To the best of my knowledge and belief, the insurance applied for is or is likely, is not or is not likely to replace or change any existing policy (ies) or contract(s).

Signature of Licensed Resident Agent
 _____ No. _____ B.O. _____

Social Security Number _____
 3833-PL

 No. _____ (F-PA)

Any person who, knowingly and with intent to defraud any insurance 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 subjects such person to criminal and civil penalties.

11 Are you receiving Federal, State or Local government supported financial assistance in any form such as Supplemental Security Income or Medicaid? YES NO
 Is the State paying for your or your spouse's premium for Part B of Medicare? YES NO

12 ACKNOWLEDGEMENTS

CERTIFICATION
 THE UNDERSIGNED APPLICANT AND AGENT CERTIFY THAT THE APLICANT HAS READ OR HAD READ TO HIM/HER THE COMPLETED APPLICATION AND THAT HE/SHE REALIZES THAT ANY FALSE STATEMENTS OR MISREPRESENTATION THEREIN MAY RESULT IN LOSS OF COVERAGE UNDER THE POLICY.

The Applicant, to the best of his or her knowledge and belief, represents and agrees as follows:

1. Any policy issued as a result of this application shall constitute the entire contract of insurance.
2. No agent or any other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
3. Any insurance issued as a result of the application will either:
 - a. Not take effect unless and until the first premium is paid and the policy is delivered during such person's lifetime, or;
 - b. Take effect only as specified in the Conditional Receipt, if any, issued in conjunction with the application.
4. Policy and rider form provisions concerning exceptions, exclusions, limitations and renewal which have been applied for have been explained and are understood.
5. Ownership. The Applicant shall be the owner of any insurance applied for.
6. The Applicant can afford to pay the premium for this insurance and for all other insurance that will remain in force in this or any other company.

13 PAYMENT OF PREMIUM

READ THE CONDITIONAL RECEIPT BEFORE SIGNING. I certify that I have read or had read to me the receipt and fully understand its conditions. I understand that no agent can waive or change the conditions of this receipt.

14 SIGNATURES

Dated at City _____ State _____ Zip _____
 this _____ Day of _____ 20 _____

Signature of Applicant(s) X _____

Social Security Number(s) _____

I have witnessed the signature of the Applicant.
 I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for
 is or is likely is not or is not likely to replace or change any existing policy(ies) or contract(s).

Signature of Licensed Resident Agent X _____ No. _____ B.O. _____

Signature of Licensed Resident Agent X _____ No. _____

Any person who, knowingly and with intent to defraud any insurance 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 subjects such person to criminal and civil penalties.

MAKE CHECKS PAYABLE ONLY TO BANKERS LIFE AND CASUALTY COMPANY


BANKERS
LIFE AND CASUALTY COMPANY

We specialize in seniors

January 5, 2004

VIA SERFF

Honorable Diane Koken
Insurance Commissioner
Commonwealth of Pennsylvania
Bureau of Rates & Policies
1311 Strawberry Square
Room 1787-41921
Harrisburg, PENNSYLVANIA 17120

NAIC #: 233- BLC: 61263

RE: MEDICARE SUPPLEMENT APPLICATION
AUTHORIZATION FORM 12513-AU
AGENT STATEMENT 14119-PA (4/99)

Dear Commissioner:

We are submitting for your review and approval the above referenced forms. Your favorable consideration would be greatly appreciated. This filing contains no unusual or controversial items from normal Company or industry standards. These forms are not intended to replace any existing forms. These forms are not required to be filed in our home state of Illinois.

These forms are used with our previously approved Medicare Supplement application form 12513-PA. This application was on January 1, 1996. We are formally filing these forms for approval as a result of a recent market conduct exam conducted by your department.

Form 12513-AU is an authorization for release of medical information. Form 14119 is a form utilized to gather information on premiums and obtain the applicant's signature for receipt of mandated items.

Your consideration and approval of the above form would be appreciated.

Very truly yours,



Dan Murphy
Compliance Administrator
Product Approval and Compliance

CC Karren Leonard

DJM/
Encls

AUTHORIZATION

(Required when Application Questions 7a. through 7e. apply)

In connection with an application for insurance currently made to Bankers Life and Casualty Company, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any of the members of my family named in said application or of our health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization will be valid for a period of 2 years and 6 months from the date signed.

Date _____ Applicant _____ Spouse _____

12513-AU

AGENT STATEMENT

COMPLETE AND SUBMIT WITH ALL APPLICATIONS FOR MEDICARE SUPPLEMENT PLANS

1. TOTAL PREMIUM (life & health)

	Applicant & Spouse
a. Premium for insurance being applied for on this application	\$ _____
b. Total premium for other Health, Accident and Disability Income insurance, in force and applied for, in all companies, including Bankers Life and Casualty Company	_____ per month \$ _____
c. Total premium for Life & Annuity plans, in force and applied for, in all companies, including Bankers Life and Casualty Company	_____ per month \$ _____
	TOTAL \$ _____
	_____ per month

2. APPLICANT'S ACKNOWLEDGEMENT

The above information is complete and correct, and I acknowledge receipt of:

- Medicare Supplement Buyers Guide
- Applicable Outline of Coverage
- Supplement To Application, Form 11360A-PA
- Notice Regarding Replacement, Form 4043-SUP(96), if applicable

Applicant's Signature

Date

3. AGENT'S STATEMENT

I have questioned the proposed Insured regarding the premium(s) for all in force and applied for life insurance and other health insurance, in all companies, and recorded the appropriate information above.

(Complete for all Open Enrollment applications)

I have taken this application in the presence of all proposed insureds. No one is currently confined in a hospital or nursing home nor bedridden or confined to a wheel chair.

True False (If False, explain below)

Agent

Agent No.

Date

4. ASSOCIATION/ORGANIZATION VERIFICATION

The Applicant is an employee/member in good standing of:

Association/Organization

Account Number

5. PREMIUM CALCULATIONS

Plan _____

Total Applicant Premium \$ _____
 Total Spouse Premium \$ _____
 Total Annual Premium \$ _____
 Total Modal Premium \$ _____

MODE SELECTED

- ANNUAL x 1.00
- SEMI ANNUAL x .515 + \$1.00
- QUARTERLY x .2625 + \$1.00
- P.P.S.P. x .08583 + \$1.00
- PRD x .08583 + \$1.00

Transmittal Header SERT-5UWSWQ614/00-00/00-00/00

Transmittal Header

SERT-5UWSWQ614/00-00/00-00/00
Created by Dan Murphy on 01/05/2004
Assigned To: Yen Lucas, Jeff Russell,
[Receiver]
Company List: Bankers Life and Casualty
Comp
publicAccess
No value

Sent: 01/09/2004 03:08:46 PM
Other Authors: None
TOI: Accident and Health

SubTOI: Medicare Supplement; Individual

Filing Information:

Filing Action:	Initial	Filing Date:	01/09/2004
State:	Pennsylvania	State Instance Identifier:	None
State Domain:	stateserff	Filing Type:	Form
Type of Insurance:	Accident and Health	Sub TOI:	Medicare Supplement; Individual
Product Name:	12516-AU &14119-PA (4/99)		
Implementation Date Requested:	None	Effective Date Requested:	None
Project Name:	12516-AU &14119-PA (4/99)	Project #:	12516-AU &14119-PA (4/99)
Fee Required:	No	Fee Amount:	
Reference Filing:	No	Reference Org:	None
Reference #:	None	Advisory Org Circular #:	None

Components sent originally with filing:

SERT-5UWSWQ614/00-01/00-00/00
SERT-5UWSWQ614/00-02/00-00/00
SERT-5UWSWQ614/00-03/00-00/00
SERT-5UWSWQ614/00-04/00-00/00
SERT-5UWSWQ614/00-05/00-00/00
SERT-5UWSWQ614/00-06/00-00/00
SERT-5UWSWQ614/00-07/00-00/00
SERT-5UWSWQ614/00-08/00-00/00
SERT-5UWSWQ614/00-09/00-00/00
SERT-5UWSWQ614/00-10/00-00/00
SERT-5UWSWQ614/00-11/00-00/00
SERT-5UWSWQ614/00-12/00-00/00
SERT-5UWSWQ614/00-13/00-00/00
SERT-5UWSWQ614/00-14/00-00/00

Company Contact:

Lead Company: Bankers Life and Casualty Company

Filing Company Info	Contact Info
Bankers Life and Casualty Company 222 Merchandise Mart Plaza, Chicago, IL 60654-9988 USA Phone: 1-800-621-3724 FAX: 312-396-5907 CoCode: 61263 Group Code: 233 FEIN: 36-0770740 State of Domicile: Illinois	Dan Murphy Compliance Administrator Bankers Life and Casualty Company 222 Merchandise Mart Plaza, Chicago, IL 60654-9988 USA Phone: 312-396-6134 or 1-800-621-3724 Ext. 6134 FAX: 312-396-5907

Transmittal Header SERT-5UWSWQ614/00-00/00-00/00

State ID Number: None.

Email: d.murphy@banklife.com

Submission Requirements:

Status	Requirement
Satisfied	Transmittal Letter
Satisfied	Policy Forms
Bypassed	Listing of Forms
Bypassed	Authorization to File
Bypassed	Replacement Form with Highlighted Change
Bypassed	Variability Explanation
Bypassed	Outline of Coverage
Bypassed	Advertisements
Bypassed	Requirements for App, Replacement Covera
Bypassed	Certification of Plan A and B
Bypassed	Actuarial Memorandum and Explanatory Inf
Bypassed	Actuarial Certification
Bypassed	Rate Table
Satisfied	Filing Fee

Tracking Information:

Company Tracking #:	None	State Tracking #:	None
Company Status:	None	State Status:	None
Date Company Status Changed:	None	Date State Status Changed:	None
SERFF Tracking #:	SERT-5UWSWQ614/00	Delivery Date:	01/09/2004 03:25:08 PM
SERFF Status:	Closed - Approved	Disposition Date:	02/09/2004
Date SERFF Status Changed:	02/09/2004	Implementation Date:	None
Deemer Date:	None	Effective Date:	None
Reviewers:	Yen Lucas, Jeff Russell, [Receiver]		

Additional State Tracking Numbers
 Bankers Life and Casualty
 Company

State-Specific Fields:

Filing Fee Amount:	50.00	Filing Fee Check Number:	2527646
Date Filing Fee Mailed:	01/09/2003		

Filing Description: None

File Attachments: None

Disposition Report SERT-5UWSWQ614/00-00/00-01/00

Disposition Report

Report Type: Disposition Report

Filing Originally Sent: 01/09/2004 03:08:46 PM

Created by Jeff Russell on 02/09/2004

Sent: 02/09/2004 07:55:12 AM

State: Pennsylvania
SERFF Tracking No.: SERT-5UWSWQ614/00-00/00-01/00

Response To: TransmittalHeader
Response To No.: SERFF Tracking No.: SERT-5UWSWQ614/00-00/00-00/00

Lead Company: Bankers Life and Casualty Company
Product Name: 12516-AU & 14119-PA (4/99)
Filing Date: 01/09/2004 03:08:46 PM

Company: Bankers Life and Casualty Company
Project Name: 12516-AU & 14119-PA (4/99)
Project No.: 12516-AU & 14119-PA (4/99)

State Tracking No.: None
TOI: Accident and Health
Disposition: Approved
Reviewer Phone No.: 717-783-2852

Company Tracking No.: None
Sub TOI: Medicare Supplement; Individual
SERFF Status: None

No disposition descriptions.

Disposition: Approved
Disposition Date: 02/09/2004
Effective Date: None
Type: None
Effective Date: None
Implementation Date: None
Deemer Date: None
Comments: Form #14119-PA (4/99) & form #12513-AU are approved as of this date.

Applies to Components

CH 01/00 --- Transmittal Letter
CH 02/00 --- Policy Forms
CH 03/00 --- Listing of Forms
CH 04/00 --- Authorization to File
CH 05/00 --- Replacement Form with Highligh
CH 06/00 --- Variability Explanation
CH 07/00 --- Outline of Coverage
CH 08/00 --- Advertisements
CH 09/00 --- Requirements for App, Replacem
CH 10/00 --- Certification of Plan A and B
CH 11/00 --- Actuarial Memorandum and Expla
CH 12/00 --- Actuarial Certification
CH 13/00 --- Rate Table
CH 14/00 --- Filing Fee

File Attachments: None

ANNUITY/LIFE CLAIMS EXHIBIT

REGULATORY UPDATE

TO: ALL AGENTS
ALL BRANCH SALES MANAGERS
ALL ADMINISTRATORS
- STATE of PENNSYLVANIA -

CC: M. BUCKLEY, DVP # 1060
R. BRADY, VP Agency
G. MONROY, VP Distribution Strategy
S. PERRY, SVP Sales

FROM: G. Gresik, Manager
Agency Relations/Field Procedures

DATE: February 20, 2004

SUBJECT: LIFE/ANNUITY DEATH CLAIM INVESTIGATION TIME LIMITS

Pennsylvania Regulations 31 s 146.6 states that investigation of a claim must be completed within 30 days after notification of a loss. If an investigation cannot be reasonably completed within the allotted time, the company must provide the claimant with a reasonable written explanation for the delay. It must also state when a decision on the claim may be expected.

Because an investigation begins the date the company/agent is notified of a loss, it is extremely important that the Home Office be notified of a loss on the day that the field/agent is first notified. If notification is received on a weekend, the Home Office must be notified on the next business day. The state does not differentiate between contestable and non-contestable claims.

A copy of the Regulation is attached and should be carefully reviewed.

Please add these pages to
SPECIAL RULES AND REGULATIONS
Page VI-42 through VI-43

Pennsylvania
Insurance Regulations

PENNSYLVANIA REGULATIONS ... TITLE 31. -- INSURANCE ... PART VIII. -- MISCELLANEOUS PROVISIONS ... Chapter 146 --
UNFAIR INSURANCE PRACTICES ... Subchapter A. Unfair Claims Settlement Practices

31 S 146.6

Standards for prompt investigation of claims

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

History	Adopted 12-15-78, 8 Pa.B. 3575.
Subject Categories	010 - All/unspecified lines 300 - The policy 700 - Trade practices 940 - Model Laws
Index Information Type	Claims investigations AND Claims processing AND Time limitations TEXT

RECOMMENDATIONS EXHIBIT

RECOMMENDATION 1

LICENSING PROCEDURES

Producer Overview

RODNEY W MASON
National Producer #: 2078186

Available Data
Demographics
License/Appointment Summary
Regulatory Actions
Comments

States Only and Partially in PDB's (Some may not be in PDB)					
*AK	*AL	*AR	*AS	*AZ	*CA
*CO	*CT	*DC	*DE	*FL	*GA
*GU	*HI	*IA	*ID	*IL	*IN
*KS	*KY	*LA	*MA	*MD	*ME
*MI	*MN	*MO	*MS	*MT	*NC
*ND	*NE	*NH	*NJ	*NM	*NV
*NY	*OH	*OK	*OR	*PA	*PR
*RI	*SC	*SD	*TN	*TX	*UT
*VA	*VI	*VT	*WI	*WV	*WY

**PDB data refers to Licensing, Appointment/Termination and Certification/Clearance data only. All other available information is supplied by outside sources.

Demographics

PA

Date Updated **Business Addresses :**

06/19/2003 BANKERS LIFE & CASUALTY 3824 NORTHERN PIKE STE 600 MONROEVILLE, PA 15146

Date Updated **Mailing Addresses :**

06/19/2003 407 TWIN PONDS LANE BRIDGEVILLE, PA 15017

Date Updated **Residence Addresses :**

06/19/2003 407 TWIN PONDS LANE BRIDGEVILLE, PA 15017

License/Appointment Summary

Terminated 7-8-03

STATE: PA

License#: 154114 Issue Date: 07/16/1998 Expiration Date: 07/16/2004
 Class: Agent Residency: R Active: Yes
CE Compliance: N/S CE Renewal Date: CE Credits Needed:

<u>Line Of Authority</u>	<u>Authority Issue Date</u>	<u>Status</u>	<u>Status Reason</u>	<u>Status/Reason Date</u>	<u>CE Compliance</u>	<u>CE Renewal Date</u>	<u>CE Credits Needed</u>
<u>Accident & Health</u>	07/16/1998	<u>Active</u>		07/16/1998	N/S		
<u>Life & Fixed Annuities</u>	07/16/1998	<u>Active</u>		07/16/1998	N/S		

STATE: PA

APPOINTMENT INFO

<u>Company Name</u>	<u>FEIN/Cocode</u>	<u>Line Of Authority</u>	<u>Status</u>	<u>Termination Reason</u>	<u>Current Appt/Term Effective Date</u>	<u>Appointment Renewal Date</u>
American General Life Ins Co	25-0598210	<u>Accident & Health</u>	Appointed		09/17/2002	
American General Life Ins Co	25-0598210	<u>Life & Fixed Annuities</u>	Appointed		09/17/2002	
American Investors Life Ins Co Inc	48-0696320	<u>Life & Fixed Annuities</u>	Appointed		01/03/2003	
American Progressive Life And Health Ins Co Of New York	13-1851754	<u>Accident & Health</u>	Terminated	Not for Cause	11/21/2002	
American Progressive Life And Health Ins Co Of New York	13-1851754	<u>Life & Fixed Annuities</u>	Terminated	Not for Cause	11/21/2002	

Bankers Life And Casualty Co	36-0770740	<u>Accident & Health</u>	Terminated	Not for Cause	07/08/2003
Bankers Life And Casualty Co	36-0770740	<u>Life & Fixed Annuities</u>	Terminated	Not for Cause	07/08/2003
Canada Life Assur Co The	38-0397420	<u>Accident & Health</u>	Appointed		11/05/2002
Canada Life Assur Co The	38-0397420	<u>Life & Fixed Annuities</u>	Appointed		11/05/2002
Conseco Medical Ins Co	04-2741731	<u>Accident & Health</u>	Terminated	Not for Cause	02/14/2002
Conseco Medical Ins Co	04-2741731	<u>Life & Fixed Annuities</u>	Terminated	Not for Cause	02/14/2002
Continental Casualty Co	36-2114545	<u>Accident & Health</u>	Appointed		07/01/2002
Fidelity And Guaranty Life Ins Co	52-6033321	<u>Accident & Health</u>	Terminated	Not for Cause	05/28/2003
Fidelity And Guaranty Life Ins Co	52-6033321	<u>Life & Fixed Annuities</u>	Terminated	Not for Cause	05/28/2003
Highmark Inc	23-1294723	<u>Accident & Health</u>	Appointed		09/30/2002
John Hancock Life Ins Co	04-1414660	<u>Accident & Health</u>	Appointed		01/22/2003
John Hancock Life Ins Co	04-1414660	<u>Life & Fixed Annuities</u>	Appointed		01/22/2003
Kansas City Life Ins Co	44-0308260	<u>Accident & Health</u>	Appointed		08/28/2002
Kansas City Life Ins Co	44-0308260	<u>Life & Fixed Annuities</u>	Appointed		08/28/2002
Keystone Health Plan West Inc	25-1522457	<u>HMO</u>	Appointed		09/30/2002

Old Line Life Ins Co Of America The	39-0515140	<u>Accident & Health</u>	Terminated	Not for Cause	04/30/2003
Old Line Life Ins Co Of America The	39-0515140	<u>Life & Fixed Annuities</u>	Terminated	Not for Cause	04/30/2003
Physicians Life Ins Co	47-0529583	<u>Life & Fixed Annuities</u>	Terminated	Not for Cause	04/08/2003
Physicians Mutual Ins Co	47-0270450	<u>Accident & Health</u>	Terminated	Not for Cause	04/08/2003
Transamerica Life Ins And Annuity Co	95-6140222	<u>Life & Fixed Annuities</u>	Appointed		02/19/2003
Transamerica Occidental Life Ins Co	95-1060502	<u>Accident & Health</u>	Appointed		02/19/2003
Transamerica Occidental Life Ins Co	95-1060502	<u>Life & Fixed Annuities</u>	Appointed		02/19/2003

Regulatory Actions

No Information Available

Comments

No Information Available

The Producer Database (PDB) compiles information provided by participating state insurance departments including licensing information on insurance producers and/or registered securities brokers and regulatory actions on insurance producers, companies and other entities engaged in the business of insurance. Not every state participates actively or fully in the PDB. The Producer Database does not report adverse licensing or regulatory action information on individuals if the information is more than seven (7) years old. Users are cautioned that the absence of information on a particular individual or entity should not be taken as conclusive that no licensing or regulatory action information exists. The information is provided "AS IS" and there is no guarantee of the truth or accuracy of the information provided by the state insurance department. There is no guarantee the information in the PDB has not been modified, revised or updated and not reported by the state insurance department to the PDB.

[Help](#)

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RECOMMENDATIONS EXHIBIT

RECOMMENDATION 3

CLAIMS SETTLEMENT PRACTICES

REGULATORY UPDATE

TO: ALL AGENTS
ALL BRANCH SALES MANAGERS
ALL ADMINISTRATORS
- STATE of PENNSYLVANIA -

CC: M. BUCKLEY, DVP # 1060
R. BRADY, VP Agency
G. MONROY, VP Distribution Strategy
S. PERRY, SVP Sales

FROM: G. Gresik, Manager
Agency Relations/Field Procedures

DATE: February 20, 2004

SUBJECT: LIFE/ANNUITY DEATH CLAIM INVESTIGATION TIME LIMITS

Pennsylvania Regulations 31 s 146.6 states that investigation of a claim must be completed within 30 days after notification of a loss. If an investigation cannot be reasonably completed within the allotted time, the company must provide the claimant with a reasonable written explanation for the delay. It must also state when a decision on the claim may be expected.

Because an investigation begins the date the company/agent is notified of a loss, it is extremely important that the Home Office be notified of a loss on the day that the field/agent is first notified. If notification is received on a weekend, the Home Office must be notified on the next business day. The state does not differentiate between contestable and non-contestable claims.

A copy of the Regulation is attached and should be carefully reviewed.

Please add these pages to
SPECIAL RULES AND REGULATIONS
Page VI-42 through VI-43

Pennsylvania
Insurance Regulations

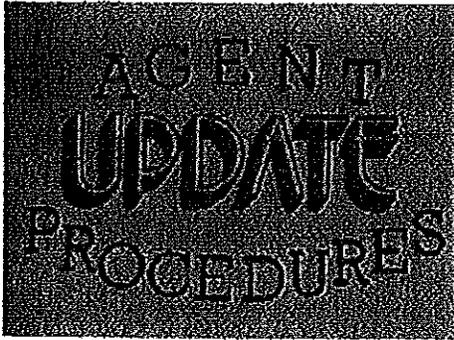
PENNSYLVANIA REGULATIONS ... TITLE 31. -- INSURANCE ... PART VIII. -- MISCELLANEOUS PROVISIONS ... Chapter 146 ...
UNFAIR INSURANCE PRACTICES ... Subchapter A. Unfair Claims Settlement Practices

31 S 146.6

Standards for prompt investigation of claims

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

History	Adopted 12-15-78, 8 Pa.B. 3575.
Subject	010 - All/unspefied lines
Categories	300 - The policy
	700 - Trade practices
	940 - Model Laws
Index	Claims investigations AND Claims processing AND Time limitations
Information Type	TEXT



TO: ALL AGENTS

CC: ALL ADMINISTRATORS
ALL BRANCH SALES MANAGERS
ALL DIVISION VICE PRESIDENTS

R. BRADY, VP AGENCY
G. MONROY, VP DISTRIBUTION STRATEGY
S. PERRY, SVP SALES

FROM: G. Gresik, Manager
Agency Relations/Field Procedures

DATE: April 28, 2004

SUBJECT: LIFE/ANNUITY DEATH CLAIM NOTIFICATION

Recent Marked Conduct exams have shown several instances of incomplete documentation of death notifications. At issue is the apparent lack of recorded dates when either the Agent or Branch Office was first notified of an insured's death. Both the Agent Information and Procedures Manual as well as the Field Office Procedure Manual contain specific instructions for Death Claim Verification and they should be carefully reviewed and strictly adhered to.

As soon as possible after receiving notification, the Branch Sales Office should send a fully completed Death Claim Notice, Form 2196, to the Home Office. On AD&D Policies, where the death was accidental, also send a completed and signed Proof of Death – Physician's Statement Form 1270 along with a newspaper clipping, if available.

The prompt submission of the completed claim forms and other required information will enable the appropriate Claim Department to quickly service most claims and prevent Market Conduct violations, possible fines and lawsuits.

Your cooperation is required and appreciated.

CLAIM NOTIFICATION TO HOME OFFICE

TO: LIFE CLAIM

CAD-A&H

GROUP & SPECIAL RISK

FROM: _____ DATE _____

OFFICE # _____ SPEED # _____

CHECK BOXES BELOW AS APPLICABLE:

Life death claim (complete A below)

Annuity claim (complete A below)

Waiver of Premium notice (see B below)

Accidental Death and Dismemberment on Health Policy (complete C below)

Group or Special Risk death notification (see D below)

A. LIFE/ANNUITY DEATH CLAIMS

1. policy number(s) _____ / _____
2. name of deceased _____
3. date of death _____
4. death certificate requested yes no
5. policy requested? yes no
6. notification by claimant
 - a) date claimant notified your office _____
 - b) claimant's name _____
address _____
day phone # _____
7. acknowledgement
 - a) date claim form given/sent claimant _____
 - b) if agent/office made acknowledgement by phone:
 - 1) telephone number called _____
 - 2) name of caller _____
 - 3) name of person who took call _____
 - 4) date and time of call _____ / _____

B. WAIVER OF PREMIUM NOTICE

1. policy number _____
2. name of insured _____

Complete items A-6 and A-7 above as applicable.

C. ACCIDENTAL DEATH AND DISMEMBERMENT ON HEALTH POLICY

1. policy number _____
2. If dismemberment, name of insured _____
 - a) describe type of dismemberment (one leg, both legs, etc.)

 - b) describe briefly how and where dismemberment occurred:

3. If death claim, complete A-2,3,4,6 and 7 above as applicable.

D. GROUP OR SPECIAL RISK

These policies are usually identified through a G or SR preceding the policy number or through use of a credit card on billings. Do not send/give claim form. Complete Sections A or C above as applicable and route to Group & Special Risk. They will send forms to the proper person.

RECOMMENDATIONS EXHIBIT

RECOMMENDATION 4

SURRENDER COMPARISON INDEX DISCLOSURE

REGULATORY UPDATE

TO: ALL AGENTS
ALL BRANCH SALES MANAGERS
ALL ADMINISTRATORS
- STATE of PENNSYLVANIA -

CC: M. KELLOUGH, DVP # 1060
R. BRADY, VP Agency
G. MONROY, V.P. Field Support
S. PERRY, SVP Sales

FROM: G. Gresik, Manager
Agency Relations/Field Procedures

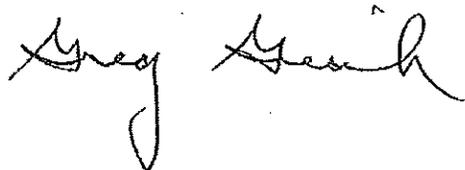
DATE: June 30, 2003

SUBJECT: SURRENDER COMPARISON INDEX DISCLOSURE FORM L-4383

The Surrender Comparison Index Disclosure Form, L-4383-PA(9/01), is generated at time of issue for applicable policies. It is important to note that a completed copy of this form is required to be left with the policyholder and a **copy is to be returned to the Home Office** as set forth in Pennsylvania Regulation Title 31. A reading of the regulation is mandatory and a copy is attached.

This is also a reminder to return all required, post-issue documents to the Home Office especially the Delivery Receipt Form #16088. The Policy Delivery Receipt is designed to benefit the policyholder, the agent and the Company and must be fully completed, **including the agent's signature.**

Please add pages VI-35 through VI-41 to your
STATE OF PENNSYLVANIA
SPECIAL RULES AND REGULATIONS



Surrender Comparison Index Disclosure
Per \$1,000 of Face Amount of Basic Insurance
Bankers Life and Casualty Company

Prepared For: _____
Name Age Sex

Base Policy Form No. _____
Description Face Amount

Policy Number _____

**TO BE COMPLETED AND LEFT WITH PROSPECT OR APPLICANT UPON REQUEST
OR AT POLICY DELIVERY, IF:**

- 1) The base policy is any of the following plans: 12X, 13M, 13N, 19A* or 20A**
AND
- 2) The face amount of the base policy is \$5,000 or over.
AND
- 3) The prospect or applicant is a standard risk.

LIFE SURRENDER VALUE COMPARISON INDEX PER \$1,000 OF BASE POLICY

	10 YEAR PERIOD	20 YEAR PERIOD
Life Surrender Value Comparison Index	_____	_____

- * For plan 19A, the above indices are based on:
(1) continuous payment of Planned Periodic Premium of _____ payable
_____; and
(2) cash values reflecting a guaranteed annual interest rate of _____ and guaranteed
expense charges and cost of insurance rates.
- ** For plan 20A, the above indices are based on:
(1) continuous payment of Planned Periodic Premium of _____ payable
_____; and
(2) cash values reflecting a current annual interest rate of _____ and current
expense charges and cost of insurance rates.

The Surrender Comparison Index was designed to measure the relative cost of life insurance protection and may be useful for comparison of similar policies offered by other companies or fraternal benefit societies. Technically, the Index shows the relationship between the amounts paid by the insured (the average annual premiums minus any average annual dividend) and the amounts paid by the insurer (the cash value of the policy in the event of surrender over periods of 10 and 20 years) all adjusted for compound interest at the rate of five percent per annum to reflect the timing of the payments.

When comparing similar policies, if all things are equal, the policy with the lower Index is generally the lower cost policy and the better buy in the event that the policy was surrendered at the end of the designated period. If death would occur during the designated period, the policy with the lower Index would not necessarily be the lower cost policy. The Index does not take into account, among other things: (1) the value of the services of an agent or company or fraternal benefit society; (2) the relative strength and reputation of the company or fraternal benefit society; and (3) small differences in policy provisions. The Index does assume that annual premiums are paid (unless otherwise noted) and that no additional benefit provisions are included.

I certify that a copy of this Surrender Comparison Index Disclosure was given to the above named applicant upon delivery of the policy or earlier at the request of the applicant.

Signature of Agent/Number Date

Pennsylvania
Insurance Regulations

PENNSYLVANIA REGULATIONS...TITLE 31. -- INSURANCE...PART IV. -- LIFE INSURANCE...Chapter 83 -- DISCLOSURES IN SOLICITATION OF LIFE INSURANCE...Subchapter B. Cost Disclosures in the Solicitation of Life Insurance

Note: A statement of policy does not constitute a rule or regulation entitled to the force and effect of law.

31 s 83.51

Purpose

The interest adjusted method at 5% shall be used to provide a ten-year and 20-year surrender comparison index per \$1,000 of face amount of basic insurance. The index shall be based on the premise that the policy will be surrendered at the end of 10 years and 20 years. This index will provide the purchaser of life insurance with a means of making a cost comparison of the same type life insurance policies having the same premium payment period and pattern. This subchapter is not intended to prohibit any life insurance agent or insurer from providing additional means to make cost comparison which are not in violation of this subchapter, applicable Pennsylvania Statutes or other applicable Insurance Department regulations set forth in this title.

History	Adopted 4-5-74, 4 Pa.B. 661; amended 6-14-75, 5 Pa.B. 1551; amended through 12-28-79, 9 Pa.B. 4251.
Subject Categories	020 - Life Insurance / Insurers 720 - Information practices
Index	Surrender value comparison Index AND Life Insurance AND Regulatory intent
Information Type	TEXT

31 s 83.52

Applicability

(a) This subchapter applies to all insurance companies authorized to transact the business of life insurance in the Commonwealth as regards any solicitation of the sale of insurance on the life of any Commonwealth resident unless excluded in subsection (b) of this section. This subchapter equally applies to all fraternal benefit societies authorized to transact the business of life insurance in this Commonwealth and employing representatives licensed as agents or brokers or selling life insurance on a direct-response or mail-order basis.

(b) This subchapter is not applicable to the following kinds of insurance:

- (1) Annuities.
- (2) Group life insurance.
- (3) Credit life insurance.
- (4) Life insurance of less than \$5,000.
- (5) Life insurance on substandard risks.

- (6) Life Insurance issued in connection with qualified funded pension plans and qualified retirement plans.
- (7) Life insurance issued as a result of a contractual policy change or conversion provision.
- (8) Life Insurance where the cost is borne in whole or in part by the employer of the insured.
- (9) Policies having a varying face amount, resulting from other than the application of dividends.
- (10) Variable life insurance.
- (11) Family policies.
- (12) Term policies.
- (13) Riders.

History	Adopted 4-5-74, 4 Pa.B. 661; amended 6-14-75, 5 Pa.B. 1551; amended through 12-28-79, 9 Pa.B. 4251.
Subject Categories	020 - Life insurance / Insurers 720 - Information practices 900 - Benefit societies / assessment plan insurers
Index	Fraternal benefit societies AND Life insurance AND Surrender value comparison index Life insurance AND Surrender value comparison index AND Applicability of insurance regulations
Information Type	TEXT

31 s 83.53

Calculation of surrender comparison Index

(a) Calculation of Surrender Comparison Index After Ten Years shall be performed in the following manner:

(1) Step 1. Accumulate the annual premiums for the basic policy, excluding all built-in benefits and riders, at 5.0% interest compounded annually for ten years. For level premium policies:

$$\text{Accumulated premiums} = \text{level annual premium} \times 13.207.$$

(2) Step 2. Accumulate the annual dividends, if any, at 5.0% interest compounded annually for ten years. Include any termination dividend after ten years.

(3) Step 3. Determine the cash value after ten years.

(4) Step 4. Step 4 shall be based on the following formula:



(b) Calculation of Surrender Comparison Index After 20 years shall be performed in the following manner:

(1) Step 1. Accumulate the annual premiums for the basic policy, excluding all built-in benefits and riders, at 5.0% interest compounded annually for 20 years. For level premium policies:

Accumulated premiums = level annual premium X 34.719

(2) Step 2. Accumulate the annual dividends, if any, at 5.0% interest compounded annually for 20 years. Include any termination dividend after 20 years.

(3) Step 3. Determine the cash value after 20 years.

(4) Step 4. This step shall be based on the following formula:



(c) Factors to be excluded from computation of the Surrender Comparison Index:

Supplemental built-in benefits -- As accurate as possible a calculation of the cost of such built-in benefits as accidental death, premium waiver, guaranteed insurability, and disability monthly income, must be subtracted from the annual premium prior to calculating the index.

History	Adopted 4-5-74, 4 Pa.B. 661; amended 6-15-75, 5 Pa.B. 1551; amended through 12-28-79, 9 Pa.B. 4251.
Subject Categories	020 - Life Insurance / Insurers 300 - The policy 720 - Information practices
Index	Life Insurance AND Surrender value comparison index AND Computation methods
Information Type	TEXT

31 s 83.54

Additional methods of comparison

In addition to the method required by Subchapter B of this chapter (relating to cost disclosures in the solicitation of life insurance), additional methods of cost comparison will be permitted provided that any method chosen takes into account an interest based on 5.0% that recognizes the times of payment. Prior to the use of any additional method, it must be filed with the Department for review. Traditional net cost comparison methods are prohibited.

History	Adopted 4-5-74, 4 Pa.B. 661; amended 6-14-75, 5 Pa.B. 1551; amended 12-14-79, 9 Pa.B. 4051.
Subject Categories	020 - Life insurance / Insurers 720 - Information practices
Index	Life insurance AND Surrender value comparison index AND Computation methods
Information Type	TEXT

31 s 83.55

Delivery

(a) The Surrender Comparison Index Disclosure must be given as a separate document upon delivery of the policy or earlier if requested by the life insurance applicant. If requested earlier, the Index disclosure must be provided as soon as reasonably possible.

(b) A disclosure that is minimally satisfactory to the Insurance Department is set forth in Appendix B of this chapter. If the Appendix B disclosure will be used, a letter to that effect, prior to use, is adequate notification to the Department. However, if a disclosure different than Appendix B will be used, it must be filed with the Department for review prior to use.

(c) The Surrender Comparison Index Disclosure shall describe:

(1) The name, age, and sex of the insured.

(2) The face amount of the policy.

(3) The descriptive title of the policy, as "whole life, 20 year decreasing term, endowment at age 65," and so forth.

(4) The policy number of policy.

(5) The 10-year Surrender Index and 20-year Surrender Index per \$1,000 of face amount of basic insurance.

(6) If applicable, the amount of the equivalent level annual dividend and termination dividend reflected in each Index.

(7) If applicable, the dividend scale on which the reflected dividends are based.

(8) An explanation of the purpose and use of the Surrender Comparison Index.

(d) Italicized material in the Appendix B disclosure statement has been included for explanatory purposes only and shall not appear in copies of Appendix B used by insurers. Insurer's Appendix B form should only indicate applicable terminology or designation in lieu of italicized material.

History	Adopted 4-5-74, 4 Pa.B. 661; amended 6-14-79, 5 Pa.B. 1551; amended through 12-28-79, 9 Pa.B. 4251.
Publisher's Note	Appendix B is set out separately. See 31 s 83.55 Appendix B.
Subject Categories	020 - Life insurance / insurers 300 - The policy 720 - Information practices
Index	Information disclosure AND Surrender value comparison index AND Life insurance Consumer information AND Surrender value comparison index AND Life insurance Policy solicitation AND Surrender value comparison index AND Life insurance
Information Type	TEXT

31 s 83.55a

Certification of surrender comparison index disclosure delivery

The agent shall submit to the Insurer a statement, signed by him, certifying that the surrender comparison index disclosure was given upon delivery of the policy or earlier at the request of the life insurance applicant.

History	Adopted 8-24-79, 9 Pa.B. 2885; amended 12-28-79, 9 Pa.B. 4251.
Subject Categories	020 - Life insurance / Insurers 300 - The policy 400 - Insurance representatives 720 - Information practices
Index	Life and health agents AND Surrender value comparison index AND Powers and duties
Information Type	TEXT

31 s 83.55b

Maintenance of surrender comparison index disclosure delivery certification

The insurer shall maintain the agent's certification of surrender comparison index disclosure delivery in its appropriate files for at least three years or until the conclusion of the next succeeding regular examination by the insurance department of its domicile, whichever is later. The absence of the agent's certification from the appropriate files of the insurer shall constitute prima facie evidence that no surrender comparison index disclosure was provided to the prospective purchaser of life insurance.

History	Adopted 8-24-79, 9 Pa.B. 2885; amended 12-28-79, 9 Pa.B. 4251.
Subject Categories	020 - Life insurance / Insurers 720 - Information practices
Index	Life insurers AND Surrender value comparison index AND Records maintenance
Information Type	TEXT

Penalties

(a) For falling to make adequate disclosure of basic information about the product being sold, after an administrative hearing as provided by law, an agent or broker may be subject to the penalties provided in section 639 of The Insurance Department Act of 1921 (40 P.S. s 279; NILS 40-25-410) for conduct that would disqualify an agent from the initial issuance of a license under section 603 of that act (40 P.S. s 233; NILS 40-25-103) and for misrepresenting the terms of an insurance policy, a violation of section 637 of The Insurance Department Act of 1921 (40 P.S. s 277; NILS 40-25-408).

(b) For falling to insure adequate disclosure of basic information about the product being sold, after a hearing as provided by law, a company may be subject to the penalties provided in section 350 of The Insurance Company Law of 1921 (40 P.S. s 475; NILS 40-3-902) for violations of the provisions of sections 347- 349 of that act (40 P.S. s s 472- 474; NILS 40-23-110- 40-3-901).

(c) For falling to insure adequate disclosure of basic information about the product being sold, after a hearing as provided by law, a fraternal benefit society may be subject to the penalties provided in sections 817(b) and 904(d) of the Fraternal Benefit Society Code (40 P.S. ss 1141-817(b) and 1141-904(d); Repealed).

(d) In addition to the provisions of subsections (a)- (c) of this section, failure to make the disclosure outlined

in this subchapter may be considered a violation of the Unfair Insurance Practices Act (40 P.S. ss 1171.1-1171.15; NILS 40-29-101- 40-29-115).

History	Adopted 4-5-74, 4 Pa.B. 661; amended 6-14-75, 5 Pa.B. 1551; amended through 12-28-79, 9 Pa.B. 4251.
Cross References	<u>40-25-410</u> ; <u>40-25-103</u> ; <u>40-25-408</u> ; <u>40-3-902</u> ; <u>40-23-110</u> ; <u>40-3-901</u> ; <u>40-29-101</u> ; <u>40-29-115</u>
Subject Categories	020 - Life Insurance / insurers 700 - Trade practices 720 - Information practices
Index	Life Insurance AND Policy solicitation AND Violations Unfair and deceptive practices AND Surrender value comparison Index
Information Type	TEXT

RECOMMENDATIONS EXHIBIT

RECOMMENDATION 7

FORM FILINGS

Transmittal Header SERT-5UWSWQ614/00-00/00-00/00

Transmittal Header

SERT-5UWSWQ614/00-00/00-00/00
Created by Dan Murphy on 01/05/2004
Assigned To: Yen Lucas, Jeff Russell,
[Receiver]
Company List: Bankers Life and Casualty
Comp
publicAccess
No value

Sent: 01/09/2004 03:08:46 PM
Other Authors: None
TOI: Accident and Health

SubTOI: Medicare Supplement; Individual

Filing Information:

Filing Action:	Initial	Filing Date:	01/09/2004
State:	Pennsylvania	State Instance:	None
State Domain:	stateserff	Identifier:	
Type of Insurance:	Accident and Health	Filing Type:	Form
Product Name:	12516-AU &14119-PA (4/99)	Sub TOI:	Medicare Supplement; Individual
Implementation Date Requested:	None	Effective Date Requested:	None
Project Name:	12516-AU &14119-PA (4/99)	Project #:	12516-AU &14119-PA (4/99)
Fee Required:	No	Fee Amount:	
Reference Filing:	No	Reference Org:	None
Reference #:	None	Advisory Org Circular #:	None

Components sent originally with filing:

SERT-5UWSWQ614/00-01/00-00/00
SERT-5UWSWQ614/00-02/00-00/00
SERT-5UWSWQ614/00-03/00-00/00
SERT-5UWSWQ614/00-04/00-00/00
SERT-5UWSWQ614/00-05/00-00/00
SERT-5UWSWQ614/00-06/00-00/00
SERT-5UWSWQ614/00-07/00-00/00
SERT-5UWSWQ614/00-08/00-00/00
SERT-5UWSWQ614/00-09/00-00/00
SERT-5UWSWQ614/00-10/00-00/00
SERT-5UWSWQ614/00-11/00-00/00
SERT-5UWSWQ614/00-12/00-00/00
SERT-5UWSWQ614/00-13/00-00/00
SERT-5UWSWQ614/00-14/00-00/00

Company Contact:

Lead Company: Bankers Life and Casualty Company

Filing Company Info	Contact Info
Bankers Life and Casualty Company 222 Merchandise Mart Plaza, Chicago, IL 60654-9988 USA Phone: 1-800-621-3724 FAX: 312-396-5907 CoCode: 61263 Group Code: 233 FEIN: 36-0770740 State of Domicile: Illinois	Dan Murphy Compliance Administrator Bankers Life and Casualty Company 222 Merchandise Mart Plaza, Chicago, IL 60654-9988 USA Phone: 312-396-6134 or 1-800-621-3724 Ext. 6134 FAX: 312-396-5907

Transmittal Header SERT-5UWSWQ614/00-00/00-00/00

State ID Number: None.

Email: d.murphy@banklife.com

Submission Requirements:

Status	Requirement
Satisfied	Transmittal Letter
Satisfied	Policy Forms
Bypassed	Listing of Forms
Bypassed	Authorization to File
Bypassed	Replacement Form with Highlighted Change
Bypassed	Variability Explanation
Bypassed	Outline of Coverage
Bypassed	Advertisements
Bypassed	Requirements for App, Replacement Covera
Bypassed	Certification of Plan A and B
Bypassed	Actuarial Memorandum and Explanatory Inf
Bypassed	Actuarial Certification
Bypassed	Rate Table
Satisfied	Filing Fee

Tracking Information:

Company Tracking #:	None	State Tracking #:	None
Company Status:	None	State Status:	None
Date Company Status Changed:	None	Date State Status Changed:	None
SERFF Tracking #:	SERT-5UWSWQ614/00	Delivery Date:	01/09/2004 03:25:08 PM
SERFF Status:	Closed - Approved	Disposition Date:	02/09/2004
Date SERFF Status Changed:	02/09/2004	Implementation Date:	None
Deemer Date:	None	Effective Date:	None
Reviewers:	Yen Lucas, Jeff Russell, [Receiver]		

Additional State Tracking Numbers
Bankers Life and Casualty
Company

State-Specific Fields:

Filing Fee Amount:	50.00	Filing Fee Check Number:	2527646
Date Filing Fee Mailed:	01/09/2003		

Filing Description: None

File Attachments: None

Disposition Report SERT-5UWSWQ614/00-00/00-01/00

Disposition Report

Report Type: Disposition Report

Filing Originally Sent: 01/09/2004 03:08:46 PM

Created by Jeff Russell on 02/09/2004

Sent: 02/09/2004 07:55:12 AM

State: Pennsylvania
SBRFF Tracking No.: SERT-5UWSWQ614/00-00/00-01/00

Response To: TransmittalHeader
Response To SBRFF Tracking No.: SERT-5UWSWQ614/00-00/00-00/00

Lead Company: Bankers Life and Casualty Company
Product Name: 12516-AU & 14119-PA (4/99)
Filing Date: 01/09/2004 03:08:46 PM

Company: Bankers Life and Casualty Company
Project Name: 12516-AU & 14119-PA (4/99)
Project No.: 12516-AU & 14119-PA (4/99)

State Tracking No.: None
TOI: Accident and Health
Disposition: Approved
Reviewer Phone No.: 717-783-2852

Company Tracking No.: None
Sub TOI: Medicare Supplement; Individual
SERFF Status: None

No disposition descriptions.

Disposition: Approved
Disposition Date: 02/09/2004
Effective Date: None
Type:
Effective Date: None
Implementation: None
Date:
Deemer Date: None
Comments: Form #14119-PA (4/99) & form #12513-AU are approved as of this date.

Applies to Components

- CH 01/00 --- Transmittal Letter
- CH 02/00 --- Policy Forms
- CH 03/00 --- Listing of Forms
- CH 04/00 --- Authorization to File
- CH 05/00 --- Replacement Form with Highligh
- CH 06/00 --- Variability Explanation
- CH 07/00 --- Outline of Coverage
- CH 08/00 --- Advertisements
- CH 09/00 --- Requirements for App, Replacem
- CH 10/00 --- Certification of Plan A and B
- CH 11/00 --- Actuarial Memorandum and Expla
- CH 12/00 --- Actuarial Certification
- CH 13/00 --- Rate Table
- CH 14/00 --- Filing Fee

File Attachments: None

AUTHORIZATION

(Required when Application Questions 7a. through 7e. apply)

In connection with an application for insurance currently made to Bankers Life and Casualty Company, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any of the members of my family named in said application or of our health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization will be valid for a period of 2 years and 6 months from the date signed.

Date _____ Applicant _____ Spouse _____

12513-AU

AGENT STATEMENT

COMPLETE AND SUBMIT WITH ALL APPLICATIONS FOR MEDICARE SUPPLEMENT PLANS

1. TOTAL PREMIUM (life & health)

	Applicant & Spouse
a. Premium for insurance being applied for on this application	\$ _____
b. Total premium for other Health, Accident and Disability Income insurance, in force and applied for, in all companies, including Bankers Life and Casualty Company	_____ per month
c. Total premium for Life & Annuity plans, in force and applied for, in all companies, including Bankers Life and Casualty Company	\$ _____ per month
	\$ _____ per month
	TOTAL \$ _____ per month

2. APPLICANT'S ACKNOWLEDGEMENT

The above information is complete and correct, and I acknowledge receipt of:

- Medicare Supplement Buyers Guide
- Applicable Outline of Coverage
- Supplement To Application, Form 11360A-PA
- Notice Regarding Replacement, Form 4043-SUP(96), if applicable

Applicant's Signature

Date

3. AGENT'S STATEMENT

I have questioned the proposed Insured regarding the premium(s) for all in force and applied for life insurance and other health insurance, in all companies, and recorded the appropriate information above.

(Complete for all Open Enrollment applications)

I have taken this application in the presence of all proposed insureds. No one is currently confined in a hospital or nursing home nor bedridden or confined to a wheel chair.

True False (If False, explain below)

Agent

Agent No.

Date

4. ASSOCIATION/ORGANIZATION VERIFICATION

The Applicant is an employee/member in good standing of:

Association/Organization

Account Number

5. PREMIUM CALCULATIONS

Plan _____

Total Applicant Premium \$ _____

Total Spouse Premium \$ _____

Total Annual Premium \$ _____

Total Modal Premium \$ _____

- MODE SELECTED
- ANNUAL x 1.00
 - SEMI ANNUAL x .515 + \$1.00
 - QUARTERLY x .2625 + \$1.00
 - P.P.S.P. x .08583 + \$1.00
 - PRD x .08583 + \$1.00


BANKERS
LIFE AND CASUALTY COMPANY

We specialize in seniors

January 5, 2004

VIA SERFF

Honorable Diane Koken
Insurance Commissioner
Commonwealth of Pennsylvania
Bureau of Rates & Policies
1311 Strawberry Square
Room 1787-41921
Harrisburg, PENNSYLVANIA 17120

NAIC #: 233- BLC: 61263

RE: MEDICARE SUPPLEMENT APPLICATION
AUTHORIZATION FORM 12513-AU
AGENT STATEMENT 14119-PA (4/99)

Dear Commissioner:

We are submitting for your review and approval the above referenced forms. Your favorable consideration would be greatly appreciated. This filing contains no unusual or controversial items from normal Company or industry standards. These forms are not intended to replace any existing forms. These forms are not required to be filed in our home state of Illinois.

These forms are used with our previously approved Medicare Supplement application form 12513-PA. This application was on January 1, 1996. We are formally filing these forms for approval as a result of a recent market conduct exam conducted by your department.

Form 12513-AU is an authorization for release of medical information. Form 14119 is a form utilized to gather information on premiums and obtain the applicant's signature for receipt of mandated items.

Your consideration and approval of the above form would be appreciated.

Very truly yours,



Dan Murphy
Compliance Administrator
Product Approval and Compliance

CC Karen Leonard

DJM/
Encls

RECOMMENDATIONS EXHIBIT

RECOMMENDATION 8

POLICY DELIVERY RECEIPT RETENTION