Filing at a Glance

Company:	Wilco Life Insurance Company
Product Name:	Wilco Reinstatement Application
State:	District of Columbia
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	07/17/2018
SERFF Tr Num:	METF-131583740
SERFF Status:	Closed-APPROVED
State Tr Num:	
State Status:	
Co Tr Num:	WILCO18P066-REINCHG-DC
Implementation Date Requested:	
Author(s):	Sande Chaffin
Reviewer(s):	Colin Johnson (primary)
Disposition Date:	07/20/2018
Disposition Status:	APPROVED
Implementation Date:	07/20/2018

State: *District of Columbia* **Filing Company:** *Wilco Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Wilco Reinstatement Application*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Sande Chaffin

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filed through the compact
Market Type: Individual
Individual Market Type:
Filing Status Changed: 07/20/2018
State Status Changed:
Created By: Sande Chaffin
Corresponding Filing Tracking Number:

Filing Description:

This reinstatement/policy change application was filed by another company to be used with both Washington National and Conseco Life insurance Company. Our parent company bought Conseco and changed the name to Wilco Life Insurance Company. We are filing this with a new form number to reflect the name change to Wilco Life Insurance Company and to update the phone number and addresses.

This form will be used in its paper version only, no electronic version.

Company and Contact

Filing Contact Information

Sande Chaffin, Sr. Associate, Compliance
900 Washington Ave
Waco, TX 76701

schaffin@texaslife.com
254-750-2435 [Phone]

Filing Company Information

Wilco Life Insurance Company
20 Glover Avenue
4th Floor

Norwalk, CT 06850
(203) 762-4401 ext. [Phone]

CoCode: 65900
Group Code: 4213
Group Name: Wilton Re Group
FEIN Number: 04-2299444

State of Domicile: Indiana
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*METF-131583740*	***State Tracking #:***		***Company Tracking #:***	*WILCO18P066-REINCHG-DC*

State:	*District of Columbia*	***Filing Company:***	*Wilco Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Wilco Reinstatement Application*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Colin Johnson	07/20/2018	07/20/2018

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Colin Johnson	07/18/2018	07/18/2018

Response Letters

Responded By	Created On	Date Submitted
Sande Chaffin	07/20/2018	07/20/2018

SERFF Tracking #:	*METF-131583740*	***State Tracking #:***		***Company Tracking #:***	*WILCO18P066-REINCHG-DC*

State:	*District of Columbia*	***Filing Company:***	*Wilco Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Wilco Reinstatement Application*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/20/2018
Implementation Date: 07/20/2018
Status: APPROVED

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Statement of Variability	APPROVED	Yes
Supporting Document	Readability	APPROVED	Yes
Form	Wilco Reinstatement/Policy Change application	APPROVED	Yes

State: District of Columbia **Filing Company:** Wilco Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Wilco Reinstatement Application
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/18/2018
Submitted Date	07/18/2018
Respond By Date	07/25/2018

Dear Sande Chaffin,

Introduction:

Please review our D.C. 31-4725 & 31-4726 (flesch reading score) and include your certificate readability score on your forms not withstanding, APPLICATIONS, ENROLLMENT FORMS, policies, certificates, amendments and endorsements.

You may combine this document with the policy if it achieves a combined readability score of 40.

Conclusion:

Sincerely,
Colin Johnson

SERFF Tracking #:	*METF-131583740*	***State Tracking #:***		***Company Tracking #:***	*WILCO18P066-REINCHG-DC*

State:	*District of Columbia*	***Filing Company:***	*Wilco Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Wilco Reinstatement Application*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/20/2018
Submitted Date	07/20/2018

Dear Colin Johnson,

Introduction:

Thank you for reviewing our filing.

Response 1

Comments:

I've attached the readability certification.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Readability
Comments:	Please see attached
Attachment(s):	Read_Cert DCdocx.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Sande Chaffin

SERFF Tracking #:	*METF-131583740*	***State Tracking #:***		***Company Tracking #:***	*WILCO18P066-REINCHG-DC*

State:	*District of Columbia*	***Filing Company:***	*Wilco Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Wilco Reinstatement Application*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	APPROVED 07/20/2018	Wilco Reinstatement/Policy Change application	Wilco18P066-REINCHG-DC	AEF	Initial			Reinstatement Policy Change Application DC.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NAP**	Network Access Plan
NOC	Notice of Coverage	**OTH**	Other
OUT	Outline of Coverage	**PJK**	Policy Jacket
POL	Policy/Contract/Fraternal Certificate	**POLA**	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider
PRC	Provider Contract/Provider Addendum/Provider Leading Agreement	**PRD**	Provider Directory

Reinstatement/Policy Change Appl**ication**

WILCO LIFE INSURANCE COMPANY

Administrative office: [(844-877-6907)]
Mailing address:
[PO Box 305017, Nashville, TN 37230-5017]

Street address:
[100 Centerview Drive, Suite 100, Nashville, TN 37214]

SECTION 1 –INSURED

A-Insured	First Name, MI Last Name *(indicate if hyphenated name)*	☐ Male ☐ Female	Ht. Wt.
Street Address	City, State, Zip Code		Phone No.
Social Security No.	Birth Date	Place of Birth	Driver's License No. & State
Occupation	Employer and Address		
B-Spouse/ Additional Insured	First Name, MI Last Name *(indicate if hyphenated name)*	☐ Male ☐ Female	Ht. Wt.
Street Address	City, State, Zip Code		
Relationship		Phone No.	
Social Security No.	Birth Date	Place of Birth	Driver's License No. & State
Occupation	Employer and Address		
C-Child	First Name, MI Last Name *(indicate if hyphenated name)*	☐ Male ☐ Female	Ht. Wt.
Birth Date	Relationship		Phone No.
Street Address	City, State, Zip Code		

If more than one child, please attach an additional sheet

POLICY NUMBER:_____

Modal Payment Changed to:
☐ Monthly/ ABC (Automatic Bank Check)- Voided check required
☐ Quarterly ☐ Semi-annual ☐ Annual ☐ List Bill _____
☐ Government Allotment

Planned Premium Amount Changed to $_____

Has this policy or any other life insurance policy in force on the Insured been transferred to an owner other than the Insured, such as a viatical, senior settlement company, viatical broker, or other third party? Has any interest, of any kind, in this policy or any other insurance policy, whether in whole or in part, been assigned, or promised to be assigned, transferred, or otherwise encumbered to any third party?

☐Yes☐No If yes, provide details (policy number, insurance company, name of owner/transferee/assignee, etc., and full address on a separate sheet and attach to application.)

SECTION 2 – REINSTATEMENT

☐ Reinstatement

If you are applying for reinstatement, return your original policy with this reinstatement application.

SECTION 3 – CHANGES **(Check all that apply).**	SECTION 4 – CONVERSIONS **(Check all that apply).**
☐ Add Decreasing Term Option	☐ Convert Term Life Policy or Rider
☐ Remove or reduce the rated premium class rating	☐ Remove or reduce the rated premium class rating
☐ Increase Face Amount to $_____	☐ Add Decreasing Term Option
☐ Decrease Face Amount to $ _____	☐ Increase Face Amount to $_____
☐ Status Change to Preferred	☐ Decrease Face Amount to $_____
☐ Tobacco to Non-Tobacco	☐ Other_____
☐ Other _____	☐ Other_____
☐ UL Death Benefit Option - Change from Option A to Option B	
☐ UL Death Benefit Option - Change from Option B to Option A	New Policy to be Dated:
New Policy to be Dated:	☐ Current Anniversary Date
☐ Current Anniversary Date	☐ Advanced Date _____
☐ Advanced Date _____	Type of Insurance: _____
Type of Insurance:_____	Product Name: _____
Product Name: _____	

RIDERS	Add	Delete
Spouse Rider $_____	☐	☐
Child Rider $_____	☐	☐
Additional Insured Rider $ _____	☐	☐
Life Insurance Protection Rider	☐	☐
Waiver of Premium	☐	☐
Accidental Death $ _____	☐	☐
Guaranteed Insurability Option	☐	☐

RIDERS	Add	Delete
Spouse Rider $_____	☐	☐
Child Rider $_____	☐	☐
Additional Insured Rider $ _____	☐	☐
Life Insurance Protection Rider	☐	☐
Waiver of Premium	☐	☐
Accidental Death $ _____	☐	☐
Guaranteed Insurability Option	☐	☐

Please Note: All riders may not be available in all states.

SECTION 5 – MEDICAL INFORMATION

All persons applying for insurance must complete this section. All persons requesting these changes must also complete this section: reinstatement, removal or reduction of a special class premium rating, increase face amount, change to preferred classification, change from tobacco to non-tobacco, change from UL Death Benefit Option A to B, addition of rider(s) or benefit(s).

Has the Proposed Insured**(s)**:	A-Insured		B-Spouse/ Additional Insured		C-Child/ Children	
	Yes	No	Yes	No	Yes	No
1. within the past 5 years had any coverage for life or health insurance denied, postponed, rated or modified?	☐	☐	☐	☐	☐	☐
2. been hospitalized within the past 6 months?	☐	☐	☐	☐	☐	☐
3. been under a Doctor's care or observation or is he/she planning to consult a Doctor, for any physical or mental symptoms experienced within the last 60 days?	☐	☐	☐	☐	☐	☐
4. within the past 10 years been diagnosed as having, or been treated for high blood pressure, heart disease or disorder, stroke, cancer or blood disorder, diabetes, kidney, lung or liver disease, respiratory disorder, or peripheral vascular disease?	☐	☐	☐	☐	☐	☐
5. within the past 10 years been treated for a mental, nervous, or neurological disorder, epilepsy, seizures, paralysis, sleep apnea, memory loss, depression, Alzheimer's or Parkinson's disease?	☐	☐	☐	☐	☐	☐
6. within the past 10 years been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC); or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐
7. been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol, or had his/her license suspended, or in the past 3 years had more than 2 moving traffic violations?	☐	☐	☐	☐	☐	☐
8. within the past 10 years been a member of Alcoholics Anonymous or been treated for or advised to seek treatment for alcoholism or drug use?	☐	☐	☐	☐	☐	☐
9. engaged in racing of a vehicle of any type, sky diving, skin or scuba diving, hang gliding, or flying as a pilot or crew member?	☐	☐	☐	☐	☐	☐
10. within the past 5 years have or had a disability, made a claim for disability, or received workers compensation?	☐	☐	☐	☐	☐	☐
11. Is the proposed insured currently: (a) Confined to a hospital, nursing home or psychiatric facility, bedridden, receiving hospice or home health care? (b) Paralyzed, confined to a wheelchair, or using oxygen to assist in breathing? (c) Diagnosed or being treated by a licensed member of the medical profession for a terminal illness?	☐	☐	☐	☐	☐	☐

	A-Insured		B-Spouse/ Additional Insured		C-Child/ Children	
	Yes	No	Yes	No	Yes	No
12. within the past 10 years been treated for any mental or physical disorder not listed above or been advised to have any tests which have not been completed?	☐	☐	☐	☐	☐	☐
13. used tobacco in any form in the past						
36 months?	☐	☐	☐	☐	☐	☐
24 months?	☐	☐	☐	☐	☐	☐
12 months? Include type of tobacco	☐	☐	☐	☐	☐	☐
14. changed occupations in the past						
36 months?	☐	☐	☐	☐	☐	☐
24 months?	☐	☐	☐	☐	☐	☐
12 months?	☐	☐	☐	☐	☐	☐

Please provide additional information to "yes" answers indicated **in Section 5, questions 1 through 14.** If more room is needed, please check (✓) here ☐, and attach an additional sheet**(s)**.

_____

_____

_____

_____

_____

SECTION 6 – PHYSICIANS *(include personal physician and all doctors/health care providers who last treated you, in response to all "yes" answers.)*

Proposed Insured's Name	Health Care Provider Name, Address, Phone Number	Date Last Visited, Reason, Results

SECTION 7 - COMMUNITY PROPERTY STATES **(This section does not apply to reinstatements).**

If you currently reside in one of the following states (or Puerto Rico) please complete the additional information below. Community Property States: ARIZONA, CALIFORNIA, IDAHO, LOUISIANA, NEW MEXICO, NEVADA, TEXAS, WASHINGTON AND WISCONSIN.

1. If you have never been married, please acknowledge by signing here:

X_____ _____

Signature Date

2. If you are currently married, your spouse must consent to the transaction by signing here:

X_____ _____

Spouse 's Signature Date

3. If your spouse is deceased, please attach a copy of the Death Certificate.

4. If you are divorced:

- and the policy was included in the Divorce Decree or Property Settlement Agreement and was awarded to you, please attach a certified copy of the document. Spouse's consent not required.
- and the policy was not included in the Divorce Decree or Property Settlement Agreement, it will be necessary for your ex-spouse to consent by signing here:

X_____ _____

Ex-Spouse's Signature Date

Unless the Company has been notified of a community property interest in this policy, the Company shall be entitled to rely on its good faith belief that no such interest exists and assumes no responsibility for inquiry. The insured and/or policy owner signing this form agree to indemnify and hold the Company harmless from the consequences of accepting this transaction.

SECTION 8 – DECLARATIONS AND AUTHORIZATION

The undersigned proposed insured(s) represent(s) that all statements and answers made in all parts of this application are full, complete and true to the best of my/our knowledge. It is understood and agreed that: (a) All such statements and answers shall be the basis for and become a part of any policy issued based on this application; (b) No agent, producer, broker or examiner has the authority to accept risks, to make or change contracts or to waive any of the Company's rights or requirements; (c) Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company.

I/We am/are requesting to upgrade or change my/our current coverage as indicated on this form. I/We understand that if for some reason the policy is not upgraded or changed as indicated, my/our remaining coverage will still be in effect. (This does not apply to reinstatements).

I/We understand that Wilco Life Insurance Company (the Company), affiliates of the Company, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me/us or any member of my/our family in regard to proposed coverage change(s) or to determine eligibility for reinstatement of insurance coverage.

Therefore, I/we authorize any: (1) life insurer; (2) reinsurer; (3) insurance support organizations, including MIB, Inc. (4) financial source; and (5) employer, and like sources, to give the types of information listed below when this Authorization is presented.

The types of information may include my/our: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV); (10) drug and alcohol treatments; (11) other personal information; (12) government records, such as motor vehicle record; and (13) prescription drug records and related information. A separate HIPAA compliant authorization is needed to authorize release of information from health care providers and related facilities.

The Company and its reinsurers will use the information in order to determine whether I/we am/are insurable pursuant to the Company's underwriting standards.

The parties authorized above, excluding insurance support organizations, may disclose this information to: (1) other insurers to which I/we have/may applied/apply for insurance; (2) reinsurers; (3) MIB, Inc; or (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose information according to any contract with a member company or organization. Information may also be disclosed as allowed by law. This Authorization will be valid for 24 months after the date of signing and cannot be revoked.

If a minor child is proposed for coverage, these statements are made by the person(s) authorized to act on behalf of the minor child named in the application.

A copy of this Authorization shall be as valid as the original. I/We understand I/we have a right to receive a copy of this Authorization. I/We acknowledge receipt of a copy of the "Notice of Information Practices," which includes pre-notification information relating to investigative consumer reports and MIB, Inc.

Signed at _____ on _____

City and State | Month, Day, Year

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

_____ _____

Proposed Insured *(sign full legal name)*
Parent or Guardian if Primary Insured is a Minor

Applicant/Owner *(sign full legal name)*
If other than the Proposed Insured

_____ _____

Spouse/Additional Insured(s) *(sign full legal name)*
(See Community Property Law Section)

Irrevocable Beneficiary

_____ _____

Officer/Trustee/Assignee Signature

Officer/Trustee/Assignee Signature

_____

Witness (n**on-related)**

SERFF Tracking #:	*METF-131583740*	***State Tracking #:***		***Company Tracking #:***	*WILCO18P066-REINCHG-DC*

State:	*District of Columbia*	***Filing Company:***	*Wilco Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Wilco Reinstatement Application*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Statement of Variability
Comments:	Please see attached.
Attachment(s):	Statement of Variability DC.pdf
Item Status:	APPROVED
Status Date:	07/20/2018

Satisfied - Item:	Readability
Comments:	Please see attached
Attachment(s):	Read_Cert DCdocx.pdf
Item Status:	APPROVED
Status Date:	07/20/2018

WILCO LIFE INSURANCE COMPANY
REINSTATEMENT AND POLICY CHANGE APPLICATION

Wilco18P066-REINCHG-DC

STATEMENT OF VARIABILITY

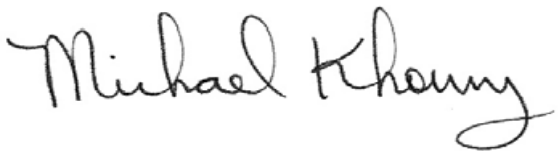
Variable Item	Variability
Administrative office phone number	To allow for possible change
Mailing address	To allow for possible change
Street address	To allow for possible change

Wilco Life Insurance Company

CERTIFICATION OF READABILITY

Reinstatement/Policy Change Application Form
Wilco18P066-REINCHG-DC

This is to certify that the WIlco Life Insurance Company form listed above achieved a Flesch Reading Ease Score of 51.3.



Senior Vice President and Chief Operating Officer
Date: July 20, 2018