

OKLAHOMA TRANSMITTAL FORM
For submission of Life, Accident and Health Forms
Check Only One

NEW SUBMISSION

RESUBMISSION ON DISAPPROVED FORM

Insurance Department Disapproval Letter Dated _____

OK Co. Number	Name of Company			Date
Form Number	Domicile	<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> Both

TYPE OF FILING (Check one item only)

- Policy Form
 Certificate Form
 Application
 Endorsement
 Rider
 Rates
 Advertisement
 Other _____

KIND OF INSURANCE (Check one item only)

- | | |
|--|---|
| <p>Annuity</p> <input type="checkbox"/> Single Premium Deferred Annuity (60)
<input type="checkbox"/> Single Premium Immediate Annuity(62)
<input type="checkbox"/> Equity Indexed Annuity (90)
<input type="checkbox"/> Annuity (64)
<input type="checkbox"/> GIC (65)
<input type="checkbox"/> Flexible Premium Deferred Variable Annuity
<input type="checkbox"/> Funding Agreement (67)
<input type="checkbox"/> Variable Annuity (68)
<input type="checkbox"/> Flexible Premium Deferred Annuity (61)
<input type="checkbox"/> Other Annuity(80)_____ <p>Credit</p> <input type="checkbox"/> Credit Life (40)
<input type="checkbox"/> Credit Accident and Health (42)
<input type="checkbox"/> Credit Life, Accident and Health (44)
<input type="checkbox"/> Credit Rider (46)
<input type="checkbox"/> Other Credit (80)_____ <p>Life</p> <input type="checkbox"/> Term Life (50)
<input type="checkbox"/> Whole Life (52)
<input type="checkbox"/> Universal/Adjustable Life (54)
<input type="checkbox"/> Endowment (56)
<input type="checkbox"/> Equity Indexed Life (71)
<input type="checkbox"/> Variable Life (71)
<input type="checkbox"/> Outline of Coverage (86)
<input type="checkbox"/> Accelerated Benefits (48)
<input type="checkbox"/> Other Life (80)_____ <p>Miscellaneous</p> <input type="checkbox"/> Viatical Settlements (85)
<input type="checkbox"/> Life Settlements (89) | <p>Health</p> <input type="checkbox"/> Hospital Expense (10)
<input type="checkbox"/> Medical Expense (12)
<input type="checkbox"/> Hospital and Medical Expense (14)
<input type="checkbox"/> Dental (03)
<input type="checkbox"/> Hospital Confinement Indemnity (16)
<input type="checkbox"/> Major Medical Expense (18)
<input type="checkbox"/> Disability Income (20)
<input type="checkbox"/> Accident Only (22)
<input type="checkbox"/> Specified Disease (24)
<input type="checkbox"/> Specified Accident (26)
<input type="checkbox"/> Long Term Care (30)
<input type="checkbox"/> Limited Benefit (32)
<input type="checkbox"/> Accident and Health Rider (36)
<input type="checkbox"/> Blanket (38)
<input type="checkbox"/> Life, Accident and Health (39)
<input type="checkbox"/> Vision (06)
<input type="checkbox"/> Prescription Drug (08)
<input type="checkbox"/> Outline of Coverage (86)
<input type="checkbox"/> Excess Loss (76)
<input type="checkbox"/> Other Health (80)_____ <p>Medicare Supplement</p> <input type="checkbox"/> Medicare Supplement (28)
<input type="checkbox"/> Medicare Select (23)
<input type="checkbox"/> Medicare Advantage
<input type="checkbox"/> Outline of Coverage (29)
<input type="checkbox"/> Other Medicare Supp (80)_____ <p>Misc. Health</p> <input type="checkbox"/> HMO (80)
<input type="checkbox"/> PPO (80)
<input type="checkbox"/> Name Change/Merger Endorsement
<input type="checkbox"/> Other _____
<input type="checkbox"/> Discount Cards/Discount Medical Plan Organization |
|--|---|

DATE HANDLED
(Ins. Dept. Use Only)

DATE RECEIVED
(Ins. Dept. Use Only)

Signature of Company Submitter

Name and Title (Company)

Telephone (Company)

