

SERFF Tracking Number: MUTM-125811516 State: Arkansas
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 40563
Company Tracking Number: WANDA HILL
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Group Life Insurance - 7684GA-VTL-EZ 08
Project Name/Number: Evidence of Insurance Application/7684GA-VTL-EZ 08

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Group Life Insurance - 7684GA-SERFF Tr Num: MUTM-125811516 State: ArkansasLH
VTL-EZ 08

TOI: L04G Group Life - Term

SERFF Status: Closed

State Tr Num: 40563

Sub-TOI: L04G.500 Other

Co Tr Num: WANDA HILL

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Authors: Wanda Hill, Stacey

Disposition Date: 10/17/2008

Payton, June Rodgers

Date Submitted: 10/15/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Evidence of Insurance Application

Status of Filing in Domicile: Authorized

Project Number: 7684GA-VTL-EZ 08

Date Approved in Domicile: 09/16/2008

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 10/17/2008

State Status Changed: 10/17/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Please see cover letter attached under the supporting documentation tab.

Company and Contact

Filing Contact Information

Wanda Hill, Senior Policy Drafting and

wanda.hill@mutualofomaha.com

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Regulatory Specialist

Regulatory Affairs (402) 351-3440 [Phone]
Omaha, NE 68175 (402) 351-5298[FAX]

Filing Company Information

United of Omaha Life Insurance Company CoCode: 69868 State of Domicile: Nebraska
Mutual of Omaha Plaza Group Code: 261 Company Type: Life Insurance
Omaha, NE 68175 Group Name: State ID Number:
(402) 351-6420 ext. [Phone] FEIN Number: 47-0322111

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Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$20.00	10/15/2008	23195276

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/17/2008	10/17/2008

SERFF Tracking Number: *MUTM-125811516* *State:* *Arkansas*
Filing Company: *United of Omaha Life Insurance Company* *State Tracking Number:* *40563*
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Disposition

Disposition Date: 10/17/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Fee Cert		Yes
Supporting Document	Cover Letter		Yes
Form	Evidence of Insurance Application		Yes

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Form Schedule

Lead Form Number: 7684GA-VTL-EZ 08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	7684GA-VTL-EZ 08	Application/ Enrollment Form	Evidence of Insurance Application	Initial		52	Life EOI_Natl w brackets.pdf

Group Life Insurance Evidence of Insurability Form



Underwritten by: United of Omaha Life Insurance Company

Home Office: Omaha, Nebraska

Section 1: Employer Information (Please print clearly. Required fields are marked with an asterisk (*).)

Employer's Name*			Group ID Number*		
			G000 _____		
Street Address				Telephone	
				(____) _____ - _____	
City*			State*	Zip Code	
			____	_____ - _____	

Section 2: Employee Contact & Employment Information (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name*		First Name*		Middle Name	
Street Address*			E-mail Address		
City*		State*	Zip Code*	Telephone*	
		____	_____ - _____	(____) _____ - _____	
Full-Time Employment Date (MM/DD/YYYY)*			Job Title/Description*		
___ / ___ / _____					

Consent to E-mail Correspondence

Check this box if you consent to receiving future correspondence regarding this form via e-mail.

Section 3: Applicant Information (Please print clearly. Required fields are marked with an asterisk (*).)

Part A – Complete if the Employee is Applying for Coverage

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*	Annual Salary*
___ / ___ / _____	____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____ Pounds	___ Ft. ___ In.	\$ _____

Part B – Complete if Your Eligible Dependent Spouse is Applying for Coverage

Last Name*		First Name*		MI
Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*
___ / ___ / _____	____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____ Pounds	___ Ft. ___ In.

Note: Use of the term "spouse" on this form refers to the person to whom you are legally married, or your domestic partner or equivalent, as recognized and allowed by federal law, or by state law in your state of residence.

Part C – Complete For Any Eligible Dependent Children Applying for Coverage

Last Name*	First Name*	Gender*	Birth Date (MM/DD/YYYY)*	Weight*	Height*
		<input type="checkbox"/> Female <input type="checkbox"/> Male	___ / ___ / _____	_____ Pounds	___ Ft. ___ In.
		<input type="checkbox"/> Female <input type="checkbox"/> Male	___ / ___ / _____	_____ Pounds	___ Ft. ___ In.
		<input type="checkbox"/> Female <input type="checkbox"/> Male	___ / ___ / _____	_____ Pounds	___ Ft. ___ In.
		<input type="checkbox"/> Female <input type="checkbox"/> Male	___ / ___ / _____	_____ Pounds	___ Ft. ___ In.
		<input type="checkbox"/> Female <input type="checkbox"/> Male	___ / ___ / _____	_____ Pounds	___ Ft. ___ In.

Section 4: Requested Coverage Amount (Please print clearly. Required fields are marked with an asterisk (*).)

	Employee (IF APPLICABLE)	Spouse (IF APPLICABLE)	Each Child (IF APPLICABLE)
(1) Current Amount of Insurance*			
(2) Additional Requested Amount*			
(3) Total Amount (1+2)*			

Section 6 Cont'd: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

- **Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- **Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Section 7: Authorization to Disclose Personal Information & Application for Insurance

Part A – Definitions of Terms Used in Section 7

- **I or me** means each person signing below in Part C of Section 7, except where otherwise noted.
- **MIB Group, Inc. (MIB)** means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.
- **Personal Information** means information about me and/or any dependent child applying for coverage, including health information such as medical history, mental and physical condition, drug and alcohol use and other information such as motor vehicle reports and criminal activity.

Part B – Authorization to Disclose Personal Information

To the MIB: I authorize you to disclose Personal Information to Mutual of Omaha Insurance Company (“Mutual of Omaha”) or a company affiliated with Mutual of Omaha. You are not authorized to disclose Personal Information to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information I have provided in my application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize Mutual of Omaha and its affiliated companies to disclose Personal Information to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it.

Name(s) used for medical records (if different than the name(s) provided on this form): _____

Part C – Application for Insurance

If I am an eligible employee applying for insurance, I apply for life insurance for me and any child identified in Section 3 of this form who is eligible for insurance. If I am an eligible spouse of the employee applying for insurance, I apply for life insurance for me. I understand that any insurance for a person applying for insurance in excess of the guaranteed issue amounts will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approves such person for such amounts. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I (the employee) permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance. I understand that insurance for new or additional coverage does not begin until the employee’s insurance certificate is issued or amended and the first premium paid.

I understand that this form is only valid for 90 days from my signature date below. If Mutual of Omaha or a company affiliated with Mutual of Omaha requests additional medical information to complete processing of this form, I understand that any delay in my response may make it necessary for me to submit a new form.

I understand that I may refuse to sign this form, and that if I refuse to sign, the insurance I am applying for will not be issued.

I will retain a copy of this form with my certificate/summary of coverage. I understand that I, or my authorized representative, may receive a copy of this form upon request. A copy of this form is as effective as the original.

By signing below, I acknowledge that (a) I understand and agree to the terms of this form; and (b) this form has been completed in accordance with the instructions provided by Mutual of Omaha or a company affiliated with Mutual of Omaha. I also acknowledge that incomplete information on this form may delay processing.

SIGNATURE OF EMPLOYEE (REQUIRED AT ALL TIMES) _____ DATE __/__/____

SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE) _____ DATE __/__/____

Section 8: Form Submission

To help ensure efficient processing, mail the completed form to:
 Attn: Group Underwriting Individual Selection
 Mutual of Omaha
 Mutual of Omaha Plaza
 Omaha, NE 68175

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 09/10/2008
Comments:
Attachment:
AR Read Cert.pdf

Review Status:
Satisfied -Name: Application 09/10/2008
Comments:
Please see Form Schedule tab.

Review Status:
Satisfied -Name: Fee Cert 10/15/2008
Comments:
Attachment:
AR Fee Schedule Cert .pdf

Review Status:
Satisfied -Name: Cover Letter 10/15/2008
Comments:
Attachment:
AR Cover Letter.pdf

CERTIFICATION

This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form</u>	<u>Description</u>	<u>Score</u>
7684GA-VTL-EZ 08	Group Life Insurance Application	52.3

United of Omaha Life Insurance Company

Date: 10-15-2008



Daniel J. Kennelly
Vice President & Chief Compliance Officer

ARKANSAS
INSURANCE
DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: United of Omaha Life Insurance Company

Company NAIC Code: 261-69868

Company Contact Person & Phone: 402-351-3440 (Collect)

402-351-5298

INSURANCE DEPARTMENT USE ONLY:

ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LIFE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.

* _____ X \$50 = \$ _____

**Retaliatory \$ _____

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.

* _____ X \$50 = _____

**Retaliatory \$ _____

Life and/or Disability Policy, Contract or Annuity Forms : Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.

* 1 X \$20 = 20.00

**Retaliatory \$ _____

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.

* _____ X \$25 = \$ _____

**Retaliatory \$ _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority

* _____ X \$400 = _____

Filing to amend Certificate of Authority.

*** _____ X \$100 = _____

***THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

****THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

*****THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SEC. 23-61-401.**

UNITED of OMAHA

UNITED of OMAHA LIFE INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
402 342 7600



October 15, 2008

Arkansas Department of Insurance
Attn: Compliance - Life & Health
1200 West Third Street
Little Rock, AR 72201-1904

RE: United of Omaha Life Insurance Company
NAIC 261-69868 FEIN 47-0322111
Group Life Insurance
Application 7684GA-VTL-EZ 08

On behalf of United of Omaha Life Insurance Company, I am submitting the captioned form in final printed format for review and approval. This form is new and is intended to replace application 7684GA-VTL-EZ 03 previously approved by your Department on March 17, 2003. To the best of my knowledge, the application complies with all applicable statutes.

Form 7684GA-VTL-EZ 08 will be used on a general basis with our Group Life Insurance coverage plans. The form is used primarily by insureds applying for coverage in excess of the guaranteed issue amount. The application was redesigned to make it more consumer friendly. In all other respects, this form remains the same as the previously approved form.

We ask that the Fraud warning section of the application be filed as variable in order to accommodate in the future any additional states that require specific insurance fraud language be added to the application. We would like to do so, without re-filing the form. The variability in the application is denoted by the use of brackets.

This form will also be a web-based application available only on the Company's website. Although form 7684GA-VTL-EZ 08 is being filed in final printed format, the web pages developed for each section may be presented to the applicant in a different order. Please accept our assurances that the application language will be identical to what is filed and approved by your department.

The Flesch readability score for this form is 52.3.

Enclosed are the required filing materials. Thank you for your consideration of this submission. Please feel free to contact me if you have any questions or concerns.

Sincerely,



Wanda Hill
Senior Product and Advertising Compliance Analyst
Regulatory Affairs

Phone: 402-351-3440 (Collect)
Fax: 402-351-5298
E-mail: wanda.hill@mutualofomaha.com