

SERFF Tracking Number: MUTM-125859952 State: Arkansas
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 40544
Company Tracking Number: WANDA HILL
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other
Product Name: Group Disability Insurance - 9273LUGC 08
Project Name/Number: Evidence of Insurance Application/9273LUGC 08

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Group Disability Insurance - 9273LUGC 08 SERFF Tr Num: MUTM-125859952 State: ArkansasLH

TOI: H11G Group Health - Disability Income

SERFF Status: Closed

State Tr Num: 40544

Sub-TOI: H11G.004 Other

Co Tr Num: WANDA HILL

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Wanda Hill, Stacey Payton, June Rodgers, Jaime Mosqueda

Disposition Date: 10/15/2008

Date Submitted: 10/15/2008

Disposition Status: Approved-Closed

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: 9273LUGC 08

Date Approved in Domicile: 09/22/2008

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: 10/15/2008

State Status Changed: 10/15/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Please see cover letter attached under the supporting documentation tab.

Company and Contact

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Filing Contact Information

Wanda Hill, Senior Policy Drafting and Regulatory Specialist
 Regulatory Affairs
 Omaha, NE 68175
 wanda.hill@mutualofomaha.com
 (402) 351-3440 [Phone]
 (402) 351-5298[FAX]

Filing Company Information

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

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	23195130

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/15/2008	10/15/2008

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Disposition

Disposition Date: 10/15/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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

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Form Schedule

Lead Form Number: 9273LUGC 08

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	9273LUGC 08	Application/Evidence of Enrollment Insurance Application Form	Initial		46	Disability EOI_Natl_brackets.pdf

Group Disability 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					
<input type="checkbox"/> Check this box if you consent to receiving future correspondence regarding this form via e-mail.					
Section 3: Employee Personal Information (Please print clearly. Required fields are marked with an asterisk (*).)					
Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*	Annual Salary*
___ / ___ / _____	____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____ Pounds	___ Ft. ___ In.	\$ _____
Section 4: Requested Coverage					
Indicate the type of coverage you are applying for:					
<input type="checkbox"/> Short-Term Disability (STD)		<input type="checkbox"/> Long-Term Disability (LTD)		<input type="checkbox"/> Both STD and LTD	
Section 5: Health Information (Please print clearly. A response is required for each health question.)					
Part A – Health Questions					
Health Question 1					
During the past seven years, have you ever been diagnosed by or received medical care from a medical professional for, or had any disease or disorder associated with, any of the following*: (Check all that apply.)					
<input type="checkbox"/> Urinary tract or kidney? <input type="checkbox"/> Liver or hepatitis? <input type="checkbox"/> Anemia or blood? <input type="checkbox"/> Skin or connective tissue? <input type="checkbox"/> Chronic Epstein-Barr? <input type="checkbox"/> Cancer or tumor? <input type="checkbox"/> Alcohol or drug abuse? <input type="checkbox"/> Spine, neck or back? <input type="checkbox"/> Fibromyalgia or myalgia?		<input type="checkbox"/> High blood pressure, arteries or veins? <input type="checkbox"/> Stroke or cerebral vascular condition? <input type="checkbox"/> Diabetes or glandular condition? <input type="checkbox"/> Stomach, upper or lower digestive tract? <input type="checkbox"/> Coronary arteries of the heart? <input type="checkbox"/> Lung or respiratory disorder? <input type="checkbox"/> Chronic fatigue syndrome? <input type="checkbox"/> Arthritis or joints (including replacements?)		<input type="checkbox"/> Breasts or reproductive organs (including implants, infertility, irregular menstruation, complications from pregnancy)? <input type="checkbox"/> Epilepsy or any nervous, mental or emotional disorder? <input type="checkbox"/> Neurological condition (including Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)? <input type="checkbox"/> Any disease of the immune system (except HIV)?	
<input type="checkbox"/> None of the Above					
Health Question 2					Response*
During the past seven years, have you been diagnosed or treated by a member of the medical profession for having: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)?					<input type="checkbox"/> YES <input type="checkbox"/> NO
Health Question 3					Response*
During the past seven years, other than questions 1 and 2 above, have you:					
<input type="checkbox"/> Been diagnosed or treated by a medical professional? <input type="checkbox"/> Had surgery or been hospitalized? <input type="checkbox"/> Had a medical or diagnostic examination or evaluation?		<input type="checkbox"/> Had or been advised to seek treatment for any illness, injury or disorder? <input type="checkbox"/> Received medical care?			<input type="checkbox"/> YES <input type="checkbox"/> NO

Section 5 Cont'd: Health Information (Please print clearly. A response is required for each health question.)

Health Question 4	Response*
Have you been absent from work for more than five consecutive working days because of illness or injury during the past five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Health Question 5	Response*
Within the past six months, have you been prescribed medication by a medical professional or taken any medication requiring a prescription?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Health Question 6	Response*
During the past seven years, have you regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics), in any form?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Health Question 7	Response*
If female, are you pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please provide anticipated delivery date (MM/DD/YYYY): ___ / ___ / _____	

Part B – If you responded YES questions 1, 2, 3 or 4 above, you must complete the following, as applicable:

Ques. #	Condition, Injury, Diagnosis, Symptom of Ill Health, Type of Operation and/or Findings of Exam	Date of Occurrence (MM/DD/YYYY)	Duration (WEEKS, MONTHS OR YEARS)	Degree of Recovery (% OF FUNCTION)

Part C – If you responded YES to question 5 above, you must complete the following, as applicable:

Medication Name (FROM PRESCRIPTION LABEL)	Dosage/Frequency	Dates Taken (MM/DD/YYYY - MM/DD/YYYY)	Reason for Taking

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

- **Fraud Warning:** 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.
- **Arkansas/Kentucky/Louisiana/New Mexico/Ohio/Tennessee:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- **District of Columbia/Pennsylvania:** 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.
- **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **New Jersey:** Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.
- **Georgia/Oregon:** 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 may be crime and may subject such person to criminal and civil penalties.
- **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between \$5,000 and \$10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.
- **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.

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

▪ **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**

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, 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 Receive and 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 about me 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 provided on the form): _____

Part C – Application for Insurance

I apply for disability insurance for me. I understand that any insurance in excess of the guaranteed issue amount will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approve the amount. 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 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 my 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 request 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 _____ 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

FORM IS NOT COMPLETE UNTIL SIGNED AND DATED – RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	10/15/2008
Comments:		
Attachment: AR Read Cert.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	10/15/2008
Comments: Please see form schedule tab.		
Satisfied -Name: Fee Schedule Cert	Review Status: Approved-Closed	10/15/2008
Comments:		
Attachment: AR Fee Schedule Cert .pdf		
Satisfied -Name: Cover Letter	Review Status: Approved-Closed	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.

Form

Description

Score

Date: _____



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:

Company NAIC Code:

Company Contact Person & Phone:

<p><u>INSURANCE DEPARTMENT USE ONLY:</u></p> <p>ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____</p>
--

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.

* _____ X \$20 = _____

**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 Disability Insurance
Application 9273LUGC 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 August 8, 2003. To the best of my knowledge, the application complies with all applicable statutes.

Form 9273LUGC 08 will be used on a general basis with our Group Disability 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 9273LUGC 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 46.3.

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