

SERFF Tracking Number: ULCC-125902966 State: Arkansas
Filing Company: The Union Labor Life Insurance Company State Tracking Number: 40861
Company Tracking Number:
TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: ULLGA-G1HIP-1108
Project Name/Number: /

Filing at a Glance

Company: The Union Labor Life Insurance Company

Product Name: ULLGA-G1HIP-1108 SERFF Tr Num: ULCC-125902966 State: ArkansasLH
TOI: L04G Group Life - Term SERFF Status: Closed State Tr Num: 40861
Sub-TOI: L04G.213 Specified Age or Duration - Co Tr Num: State Status: Approved-Closed
Fixed/Indeterminate Premium - Single Life
Filing Type: Form Co Status: Reviewer(s): Linda Bird
Authors: Karen Whitham, Carla Disposition Date: 11/19/2008
Wallace
Date Submitted: 11/14/2008 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile:
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Overall Rate Impact: Group Market Type: Association, Discretionary,
Trust, Other
Filing Status Changed: 11/19/2008
State Status Changed: 11/19/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:

Please find enclosed for your review and approval the attached Health Insurance Portability and Accountability Act (HIPPA) Authorization form. This is a new form and does not replace any existing form. This HIPPA Application Authorization Form language is designed to be marketed with our Group Life insurance products, including group application ULLGA-G1-0902 which has been approved by your department. Variable provisions are bracketed.

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Should you have any questions or require any further information, please do not hesitate to contact me at 202-962-2901 or cwallace@ullico.com.

Company and Contact

Filing Contact Information

Carla Wallace, Compliance Analyst cwallace@ullico.com
 8403 Colesville Rd (202) 962-2901 [Phone]
 Silver Spring, MD 20910

Filing Company Information

The Union Labor Life Insurance Company CoCode: 69744 State of Domicile: Maryland
 8403 Colesville Road Group Code: 781 Company Type: Life and Health
 Silver Spring, MD 20910 Group Name: State ID Number:
 (202) 682-0900 ext. [Phone] FEIN Number: 13-1423090

Filing Fees

Fee Required? Yes
 Fee Amount: \$125.00
 Retaliatory? Yes
 Fee Explanation: 1 form filed @ \$125.00 = \$125.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Union Labor Life Insurance Company	\$125.00	11/14/2008	23936509

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	11/19/2008	11/19/2008

SERFF Tracking Number: *ULCC-125902966* State: *Arkansas*
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Disposition

Disposition Date: 11/19/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *ULCC-125902966* State: *Arkansas*
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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ULLGA-G1HIP-1108	Application/Enrollment Form	HIPAA Authorization Initial Enrollment Form	Initial			ULLGA-G1HIP-1108.pdf

SERFF Tracking Number: *ULCC-125902966*

State: *Arkansas*

Filing Company: *The Union Labor Life Insurance Company*

State Tracking Number: *40861*

Company Tracking Number:

TOI: *L04G Group Life - Term*

Sub-TOI: *L04G.213 Specified Age or Duration -*

Fixed/Indeterminate Premium - Single Life

Product Name: *ULLGA-G1HIP-1108*

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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 11/13/2008

Comments:

Rule & Regulation 19 is attached.

Rule & Regulation 49, Flesch Certification and Certification of Compliance are not applicable to this application filing.

Attachment:

AR Certification Rule 19.pdf

Review Status:

Satisfied -Name: Application 11/13/2008

Comments:

The application form to be used with this filing is ULLGA-G1-0902 approved February 10, 2003.

Attachment:

ULLGA-G1-0902.pdf

THE UNION LABOR LIFE INSURANCE COMPANY
111 Massachusetts Avenue, N.W. • Washington, D.C. 20001

XXXXXXXXXX
XXXXXXXXXX

Term Life Insurance Application

1. Please tell us about yourself and your spouse or domestic partner (if applying):

Member Name _____	Spouse or Domestic Partner Name _____
Address _____ <small>STREET CITY STATE ZIP</small>	_____
Member Date of Birth ____/____/____ State of Birth _____ <small>MONTH DAY YEAR</small>	Spouse or Domestic Partner Date of Birth ____/____/____ State of Birth _____ <small>MONTH DAY YEAR</small>
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone (____) _____ <input type="checkbox"/> Day <input type="checkbox"/> Evening	Phone (____) _____ <input type="checkbox"/> Day <input type="checkbox"/> Evening <small>AREA CODE</small>
Social Security # [][][][][][][][][]	Social Security # [][][][][][][][][]
Driver's License # _____ State of Issue _____	Driver's License # _____ State of Issue _____
E-Mail Address _____	E-Mail Address _____
International Union _____	E-Mail Address _____
Have you used any tobacco or nicotine based products in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse/Domestic Partner (if applying): Have you used any tobacco or nicotine based products in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

2. Please select the benefits you would like:

<u>Member:</u> <input type="checkbox"/> \$XXXX <input type="checkbox"/> \$XXXX <input type="checkbox"/> \$XXXX	<u>Spouse or Domestic Partner:</u> <input type="checkbox"/> \$XXXX <input type="checkbox"/> \$XXXX <input type="checkbox"/> \$XXXX
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Will this insurance replace or change any life insurance or annuity contract on any proposed insured's life? ___Yes ___No
The beneficiary for your coverage and/or your spouse or domestic partner's coverage will be a spouse or domestic partner if living. Otherwise, the beneficiary will be your children, parents, brothers and sisters, or estate in that order. If you'd like to name a different beneficiary, please complete below:

Covered Person _____	Beneficiary _____	Relationship to Covered Person _____
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3. Please answer the following questions for you and your spouse or domestic partner (if applying):

MEMBER Height _____ Weight _____ <small>FEET/ INCHES LBS.</small>	SPOUSE/ DOMESTIC PARTNER Height _____ Weight _____ <small>FEET/ INCHES LBS.</small>	YOU SPOUSE/ DOMESTIC PARTNER
1. In the past 3 years have you been cited for driving while intoxicated or driving under the influence of alcohol or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. In the past 3 years have you been diagnosed or treated by a doctor for a disease or disorder of the heart or liver; cancer; stroke; diabetes requiring insulin; AIDS; the HIV virus; or drug or alcohol abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		

If you or your spouse or domestic partner answered "Yes" to question 2, please provide details in the space provided on the reverse. Attach a separate sheet if needed.

4. Read below and sign — Then return in the envelope provided:

I understand and affirm by my signature below that, to the best of my knowledge and belief, the information in this entire application is true and complete. I understand that a separate Certificate will be issued to each applicant and that no insurance is in effect until I am issued my Certificate and my first premium is paid before my effective date and during my lifetime. I understand that if I fail to give true and complete answers on this application, benefits may be denied.

To determine my insurability, or for claims purposes, I authorize any physician, medical practitioner, institution, VA Hospital, or other medically related facility, insurance company, the Medical Information Bureau, or any Consumer Reporting Agency to give any information about my physical or mental health to The Union Labor Life Insurance Company or its reinsurers. This authorization or its photocopy is valid for 30 months from the application date and I or my beneficiary may request a copy. I have read the applicable fraud notice on the back of this application and the Notice to Applicant enclosed with this form as required by the Fair Credit Reporting Act.

fraud notices on back ☞

X _____	X _____	_____
<small>YOUR SIGNATURE</small>	<small>SPOUSE'S OR DOMESTIC PARTNER'S SIGNATURE (IF APPLYING)</small>	<small>DATE</small>
<small>DATE</small>	<small>MPXXX</small>	<small>Policy Series XXX</small>

FOR COLORADO RESIDENTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FOR KENTUCKY AND PENNSYLVANIA RESIDENTS: 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.

FOR ARKANSAS, LOUISIANA, AND NEW MEXICO RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR OHIO RESIDENTS: Any person who, with 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 is guilty of insurance fraud.

FOR VIRGINIA AND MAINE RESIDENTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

FOR DISTRICT OF COLUMBIA RESIDENTS: 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 addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FOR INDIANA RESIDENTS: A person who knowingly makes any false or fraudulent statement or presentation in or with reference to any application for life insurance, or for the purpose of obtaining any fee, commission, money or benefit from or in any company transacting business under this article, commits a Class A misdemeanor.

FOR FLORIDA RESIDENTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

If you or your spouse or domestic partner responded "yes" to Question 2 on the front, please provide details below:

You: _____

Spouse or Domestic Partner: _____

Attach a separate sheet if needed.

X _____ **X** _____
YOUR SIGNATURE DATE SPOUSE'S OR DOMESTIC PARTNER'S SIGNATURE DATE
(IF APPLYING)