

SERFF Tracking Number: UNUM-125930440 State: Arkansas
Filing Company: Unum Life Insurance Company of America State Tracking Number: 41003
Company Tracking Number: C.V.D.128
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: CXC STD/LTD
Project Name/Number: Hybrid Clarification/C.V.D.128

Filing at a Glance

Company: Unum Life Insurance Company of America

Product Name: CXC STD/LTD

SERFF Tr Num: UNUM-125930440 State: ArkansasLH

TOI: H11G Group Health - Disability Income

SERFF Status: Closed

State Tr Num: 41003

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: C.V.D.128

State Status: Approved-Closed

Long Term

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Ellen Desrosiers

Disposition Date: 12/05/2008

Date Submitted: 12/04/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Hybrid Clarification

Status of Filing in Domicile: Pending

Project Number: C.V.D.128

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Maine is our domicile

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association, Trust

Filing Status Changed: 12/05/2008

Deemer Date:

State Status Changed: 12/05/2008

Corresponding Filing Tracking Number:

Filing Description:

Additional general variables for use with C.FP-1

Company and Contact

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 Project Name/Number: Hybrid Clarification/C.V.D.128

Filing Contact Information

Ellen Desrosiers, Contract Analyst EllenDesrosiers@unum.com
 2211 Congress Street (800) 974-2266 [Phone]
 Portland, ME 04122 (423) 785-2914[FAX]

Filing Company Information

Unum Life Insurance Company of America CoCode: 62235 State of Domicile: Maine
 2211 Congress Street Group Code: 416 Company Type: L&H
 Portland, ME 04122 Group Name: State ID Number:
 (207) 575-2211 ext. [Phone] FEIN Number: 01-0278678

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: 1 form for review @ \$50.00 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unum Life Insurance Company of America	\$50.00	12/04/2008	24320485

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/05/2008	12/05/2008

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Disposition

Disposition Date: 12/05/2008

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	Cover Letter	Approved-Closed	Yes
Supporting Document	Flesch Score	Approved-Closed	Yes
Supporting Document	NAIC Transmittal	Approved-Closed	Yes
Form	Hybrid Clarification	Approved-Closed	Yes

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Form Schedule

Lead Form Number: C.FP-1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	C.V.D.128	Policy/Cont	Hybrid Clarification ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51	C V D 128.pdf

UNUM Life Insurance Company of America
Portland, Maine

Additional general Policy/Certificate variables to be used with our previously approved C.FP-1 series for Short Term and Long Term Disability plans.

1. The provision entitled "WHEN DOES YOUR COVERAGE BEGIN?" found in the GENERAL PROVISIONS section of the policy/certificate may be changed to include one of the following options.

WHEN DOES YOUR COVERAGE BEGIN?

(Option 1)

[Your coverage will begin at 12:01 a.m. on the [plan effective date if you are eligible for coverage on or before that date, otherwise, on the] [first of the month [coincident with or next] following the] date you are eligible for coverage.]

(Option 2)

[Your coverage will begin at 12:01 a.m. on [the plan effective date if you are eligible for coverage and have been approved for coverage on or before that date, otherwise, on] [the first of the month [coincident with or next] following] the latest of:

- the date you are eligible for coverage;
- the date you apply for coverage; or
- the date Unum approves your application, if **evidence of insurability** is required.]

(Option 3)

[You will automatically be covered for Employer Paid Coverage at 12:01 a.m. on [the plan effective date if you are eligible for coverage on or before that date, otherwise, on the] [first of the month [coincident with or next] following the] date you are eligible for coverage.

If you apply for a **higher level of coverage**, that coverage will begin at 12:01 a.m. on [the first of the month [coincident with or next] following] the latest of:

- the date you are eligible for that coverage;
- the date you apply for that coverage; or
- the date Unum approves your application, if evidence of insurability is required.]

(Option 4)

[[Your coverage will begin at 12:01 a.m. on [the plan effective date if you are eligible for coverage and have been approved for coverage on or before that date, otherwise, on] [the first of the month [coincident with or next] following]

- the first day after the scheduled enrollment period; or
- the date Unum approves your application, if evidence of insurability is required.]

2. The provision entitled "WHEN DO CHANGES IN YOUR COVERAGE TAKE EFFECT? found in the GENERAL PROVISIONS section of the policy/certificate may be changed to include one of the following options.

WHEN DO CHANGES IN YOUR COVERAGE TAKE EFFECT?

(Option 1)

[A change in your coverage will begin at 12:01 a.m. on [the first of the month [coincident with or next] following] the latest of:

- the date you are eligible for that change in coverage;
- the date you apply for the change in coverage; or
- the date Unum approves your application, if evidence of insurability is required.]

[Once your coverage begins, any decrease in coverage you make at other than [an annual] [or] [a] [scheduled] enrollment, will take effect on [the first of the month [coincident with or next] following] the date the change is reported to us by your Employer or, if later, the [first of the month] [date] specified by your Employer.

Any decrease in coverage will not affect a **payable claim** that occurs prior to the decrease.]

[If you are not in active employment due to injury or sickness, [or if you are on a covered [layoff] [or] [leave of absence]] any increased or additional coverage will begin on the date you return to active employment.]

[A change in coverage due to a change in status will begin at 12:01 a.m. on [the first of the month [coincident with or next] following] the latest of:

- the date you are eligible for that change in coverage;
- the date you apply for the change in coverage[;
- the date Unum approves your application, if evidence of insurability is required;] or
- the date of your change in status.

Changes in coverage must be consistent with the change in status.]

(Option 2)

[A change in coverage that is made during [an annual] [a scheduled] enrollment period will begin at 12:01 a.m. on [the first of the month [coincident with or next] following] [the later of]:

- [the first day of the next plan year] [the first day [of the [first] month] after the scheduled enrollment period]; or
- the date Unum approves your application, if evidence of insurability is required.]

[Once your coverage begins, any decrease in coverage you make at other than [an annual] [or] [a] [scheduled] enrollment, will take effect on [the first of the month [coincident with or next] following] the date the change is reported to us by your Employer or, if later, the [first of the month] [date] specified by your Employer.

Any decrease in coverage will not affect a **payable claim** that occurs prior to the decrease.]

[If you are not in active employment due to injury or sickness, [or if you are on a covered [layoff] [or] [leave of absence]] any increased or additional coverage will begin on the date you return to active employment.]

[A change in coverage due to a change in status will begin at 12:01 a.m. on [the first of the month [coincident with or next] following] the latest of:

- the date you are eligible for that change in coverage;
- the date you apply for the change in coverage[;
- the date Unum approves your application, if evidence of insurability is required;] or
- the date of your change in status.

Changes in coverage must be consistent with the change in status.]

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TOI: H11G Group Health - Disability Income *Sub-TOI:* H11G.005 Combined Short Term and Long Term
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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	12/05/2008
Comments:		
Attachment: AR - Rule 19 Cert Form for C.V.D.128.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	12/05/2008
Bypass Reason: Only a variable is being filed.		
Comments:		
Satisfied -Name: Cover Letter	Review Status: Approved-Closed	12/05/2008
Comments:		
Attachment: C V D 128 Cover Letter.pdf		
Satisfied -Name: Flesch Score	Review Status: Approved-Closed	12/05/2008
Comments:		
Attachment: Flesch Score C V D 128.pdf		
Satisfied -Name: NAIC Transmittal	Review Status: Approved-Closed	12/05/2008
Comments:		
Attachment: AR - Transmittal C.V.D.128.pdf		

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Unum Life Insurance Company of America

Form Number(s): C.V.D.128

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Nancy Johnson
Name

Vice President
Title

December 3, 2008

Date



December 3, 2008

Ms. Rosalinda Minor
Senior Rate and Form Analyst
Group and Individual Health Insurance
Arkansas Insurance Department
1200 W 3rd Street
Little Rock, AR 72201-1903

Re: Unum Life Insurance Company of America
Group Disability Insurance
C.V.D. 128 - Additional Variables

Dear Ms. Minor,

Enclosed for your review and approval is the above named form to be used with our previously approved C.FP-1 modular contract/certificate series. Form C.V.D.128 provides additional variables for clarification of when coverage begins and when changes to coverage will take effect.

We request that any of our previously filed variables be applied to this filing.

If anything further is needed to complete this submission, please do not hesitate to contact me at (800) 974-2266 extension 54505 or fax (423) 785-2914.

Sincerely,

A handwritten signature in cursive script that reads "Ellen J. Desrosiers".

Ellen J. Desrosiers
Contract Analyst, Contract Compliance and Filing
Unum Life Insurance Company of America

Name of Company: UNUM Life Insurance Company of America

This is to certify that the forms listed below meet the minimum score required by the Flesch Reading Ease Test.

Form and Form Number to which the Certification is Applicable

<u>Form</u>	<u>Form No.</u>	<u>Flesch Score</u>
Policy/Certificate	C.V.D.128	50.9

Nancy M Johnson

Officer's Name

Vice President
Officer's Title

Date: December 3, 2008

Life, Accident & Health, Annuity, Credit Transmittal Document (Revised 1/1/06)

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #
	UNUM LIFE INSURANCE COMPANY OF AMERICA 2211 CONGRESS ST PORTLAND, ME 04122	ME	A+H	416	62235	01-278678

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Ellen Desrosiers Unum 2211 Congress Street Portland, Maine	(207) 575-4505	423-785-2914	EllenDesrosiers@unum.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	C.V.D.128
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input checked="" type="checkbox"/> Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input checked="" type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input checked="" type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9.	Type of Insurance	Group Health – Disability Income – Long term / Short term
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10.	Product Coding Matrix Filing Code	H11G.005
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11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input checked="" type="checkbox"/> Other: ADDITIONAL VARIABLES Rates <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum
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		<input type="checkbox"/> Other _____
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LHTD-1, Page 1 of 2

12.	Filing Submission Date	December 3, 2008
13	Filing Fee (If required)	Amount <u> \$50.00 </u> Check Date _____ Retaliatory <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	Filing has been submitted to Domiciliary state.
15.	Filing Description:	
	<p>Form C.V.D.128 provides additional variables, in addition to those already approved by your Department, for our C.FP-1 contract/certificate series. These variables address clarification of when coverage begins and when changes to coverage will take effect.</p>	

16.	Certification (If required)	
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas_____.</p>		
Print Name <u> Ellen Desrosiers </u>		Title <u> Contract Analyst </u>
Signature <u> Ellen J. Desrosiers </u>		Date: <u> December 3, 2008 </u>

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		C.V.D.128
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Additional Variables	C.V.D.128	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		N/A		
This filing corresponds to form filing company tracking number		N/A		
Overall percentage rate impact for this filing		N/A %		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1