

SERFF Tracking Number: AULD-125638664 State: Arkansas
Filing Company: American United Life Insurance Company State Tracking Number: 38894
Company Tracking Number: APP G 869(04)
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Stop Loss application
Project Name/Number: /

Filing at a Glance

Company: American United Life Insurance Company

Product Name: Stop Loss application

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: AULD-125638664

SERFF Status: Closed

Co Tr Num: APP G 869(04)

Co Status:

Authors: Bridget McGill, Angie
Neville

Date Submitted: 05/07/2008

State: ArkansasLH

State Tr Num: 38894

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 05/07/2008

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Overall Rate Impact:

Filing Status Changed: 05/07/2008

State Status Changed: 05/07/2008

Corresponding Filing Tracking Number:

Filing Description:

Stop Loss application

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 01/27/2000

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Employer

Deemer Date:

Company and Contact

Filing Contact Information

Bridget McGill, Sr. Contract Analyst

Bridget.McGill@oneamerica.com

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One American Square (317) 285-1809 [Phone]
Indianapolis, IN 46206

Filing Company Information

American United Life Insurance Company CoCode: 60895 State of Domicile: Indiana
One American Square Group Code: 619 Company Type:
P.O. Box 7127
Indianapolis, IN 46206 Group Name: State ID Number:
(877) 285-7660 ext. [Phone] FEIN Number: 35-0145825

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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 #
American United Life Insurance Company	\$20.00	05/07/2008	20150133

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/07/2008	05/07/2008

SERFF Tracking Number: *AULD-125638664* *State:* *Arkansas*
Filing Company: *American United Life Insurance Company* *State Tracking Number:* *38894*
Company Tracking Number: *APP G 869(04)*
TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *Stop Loss application*
Project Name/Number: /

Disposition

Disposition Date: 05/07/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AULD-125638664 State: Arkansas
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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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes

SERFF Tracking Number: *AULD-125638664* *State:* *Arkansas*
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TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *Stop Loss application*
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AULD-125638664 State: Arkansas
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 Company Tracking Number: APP G 869(04)
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
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Supporting Document Schedules

Bypassed -Name: Certification/Notice	Review Status: Approved-Closed	05/07/2008
Bypass Reason: N/A		
Comments:		
Satisfied -Name: Application	Review Status: Approved-Closed	05/07/2008
Comments:		
Attachment: 869 Ark APPLICATION.pdf		
Bypassed -Name: Health - Actuarial Justification	Review Status: Approved-Closed	05/07/2008
Bypass Reason: N/A		
Comments:		
Bypassed -Name: Outline of Coverage	Review Status: Approved-Closed	05/07/2008
Bypass Reason: N/A		
Comments:		
Satisfied -Name: Cover letter	Review Status: Approved-Closed	05/07/2008
Comments:		
Attachment: '08 869 Ark App1.pdf		

STOP LOSS INSURANCE APPLICATION



American United Life Insurance Company®
One American Square
P.O. Box 368
Indianapolis, Indiana 46268

[Application is hereby made for Stop Loss Insurance including Specific Stop Loss Coverage and Aggregate Stop Loss Coverage through American United Life Insurance Company®(AUL). This Application must be accepted and approved by AUL or its authorized representative prior to any Contract being in existence.

Full Legal Name of the Policyholder _____
Address _____
City _____ State _____ Zip _____
Key Contact Person at Policyholder _____

Affiliated or Subsidiary Companies _____
Other Locations _____
Nature of Business _____ Primary SIC Code _____

Proposed Effective Date _____ Deposit Premium \$ _____ Total Eligible Employees _____
Name and address of Utilization Review Firm _____

Name and address of PPO _____

Has the Policyholder ever voluntarily applied for relief in the Bankruptcy Court within the last 5 years? () Yes () No If Yes, explain:

Mail Contract, Reimbursement Checks, and General Correspondence to _____
Other mail instructions: _____

Writing Agent or Agent of Record _____
SS No. or Tax ID. _____
Address _____
Commissions are payable to: _____

Name and address of Policyholder's Third Party Administrator _____

GENERAL SCHEDULE OPTIONS

AGGREGATE STOP LOSS COVERAGE () Yes () No

[Covered Expenses are limited to those Incurred from _____ through _____, and Paid from _____ through _____.

Aggregate Stop Loss Coverage includes: (not included unless checked):

- () Medical only
- () Medical with a separate prescription drug benefit
- () Dental () Vision Care
- () Weekly Indemnity (Disability Income)
- () Other

Aggregate Percentage Reimbursable _____%

Maximum Aggregate Benefit \$ _____

Optional Provisions Desired:

- Aggregate Terminal Liability Endorsement () Yes () No
- Aggregate Accommodation Reimbursement Endorsement () Yes () No

SPECIFIC STOP LOSS COVERAGE Yes No

[Covered Expenses are limited to those Incurred from _____ through _____, and Paid from _____ through _____.

Specific Stop Loss Coverage includes: **(not included unless checked):**

- Medical only
- Medical with a separate prescription drug benefit
- Other _____

Specific Deductible Per Person Per Family \$ _____

Specific Percentage Reimbursable Per Person (in excess of the Specific Deductible) _____ %

Maximum Specific Benefit \$ _____

Optional Provisions Desired:

- Family Deductible Endorsement Yes No
- Specific Terminal Liability Endorsement Yes No
- Aggregated Specific Deductible Endorsement Yes No

POLICYHOLDER ACKNOWLEDGMENTS

It is understood and agreed as conditions precedent to the approval of this Application that:

- a) the Policyholder is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;
- b) the Third Party Administrator retained by the Applicant will be considered the Applicant's Agent, and not AUL's Agent in connection with its duties under the separate agreement between the Applicant and the Third Party Administrator;
- c) all documentation, including the Plan Document, requested by AUL must be submitted prior to any approval of the Application and must be received by AUL within ninety (90) days of the Policy Effective Date as applied for by the Policyholder;
- d) AUL will evaluate the Policyholder's risk, and may require adjustments of rates, factors, and/or Additional Provisions to accommodate for non-standard risks;
- e) AUL premiums are not considered Paid until the premium check is received by AUL or its designated representative and at the rates set forth in the Schedule of Stop Loss; and
- f) coverage is not in effect unless and until this Application is approved and the Applicant receives written confirmation of that acceptance and the effective date from AUL or its representative. Current coverage should be retained until written approval has been received from AUL.

[THE FOLLOWING FRAUD NOTICE DOES NOT APPLY TO RESIDENTS OF VA

Fraud Notice: 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 be guilty of the crime of insurance fraud as determined by a court of competent jurisdiction. In Florida: any person who knowingly and with intent to injure files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. In New Jersey: any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties. In 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. In Washington: a person who knowingly makes a false or misleading statement or impersonation, or who willfully fails to reveal a material fact in or relative to an application for insurance, to an insurer, is guilty of a gross misdemeanor.]

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Guaranty Association does not cover claims reimbursable under a stop loss policy.

In providing these Specifications and making these Disclosures, I hereby represent, to the best of my knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Policy.

[Dated at _____ this _____ day of _____, 20_____]

Policyholder (Type or Print)

Signed By _____
Policyholder (Signature of Authorized Person)

TAX ID: _____

Title _____

By: _____ Licensed Agent (if applicable)

Agent License Number _____ in the state of _____ (if applicable)]

USE THIS SPACE FOR ADDITIONAL INFORMATION



May 7, 2008

Honorable Mike Pickens
Commissioner of Insurance
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: Filing of Stop Loss Insurance Application
American United Life Insurance Company - NAIC #60895
APP G 869(04)

Dear Commissioner Pickens:

Attached for your review and approval is our revised Stop Loss Application. This form will replace the existing form, APP 869, approved by your Department on December 17, 2000. The form was approved by our domiciliary state, Indiana, on January 27, 2000.

This application has been amended in order to add the notice required in Arkansas Insurance Department Bulletin 6-2008. The notice is on the bottom half of the second page of the application under the Fraud notice. We certify that the only addition to the application is the Notice required in the bulletin. The application questions, coverages, acknowledgments and fraud notices match the language approved by your department on December 17, 2000.

Variable language has been marked with brackets which generally indicate optional benefits or provisions. If the language is changed, it will never be less favorable than your state's laws allow. American United Life also reserves the right to change the color, font, sequential order and layout of the enclosed forms. These forms may be disseminated via electronic media.

In conjunction with this filing, the filing fee of \$20.00 which is an EFT.

Please acknowledge the approval of this form via SERFF.

You may call me at 1-877-285-7660 (ext 1809) or contact me by e-mail at productcompliance.corporatecompliance@oneamerica.com if you have any questions. Thank you for your assistance with this filing.

Sincerely,

A handwritten signature in cursive script that reads "Bridget McGill".

Bridget McGill
Senior Contract Analyst
Corporate Compliance and Market Conduct

encls.

*OneAmerica
Financial Partners, Inc.
One American Square
P.O. Box 368
Indianapolis, IN 46206-0368
(317) 285-1111*