

SERFF Tracking Number: LSVX-125685877 State: Arkansas
Filing Company: USAbLe Life State Tracking Number: 39226
Company Tracking Number: GLDAR0003101F01
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Group Trust Participation Application, GRPAPPLYLIF
Project Name/Number: Group Trust Policy, GTP/GLDAR0003101F01

Filing at a Glance

Company: USAbLe Life

Product Name: Group Trust Participation
Application, GRPAPPLYLIF

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: LSVX-125685877 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39226

Co Tr Num: GLDAR0003101F01

State Status: Approved-Closed

Co Status:

Reviewer(s): Linda Bird

Author: SPI Life and Specialty
Ventures

Disposition Date: 06/10/2008

Date Submitted: 06/06/2008

Disposition Status: Approved

Implementation Date Requested: 07/04/2008

Implementation Date:

State Filing Description:

General Information

Project Name: Group Trust Policy, GTP

Project Number: GLDAR0003101F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/10/2008

State Status Changed: 06/10/2008

Corresponding Filing Tracking Number:

Filing Description:

This letter is being sent to designate Blue Cross and Blue Shield of North Carolina as our agent for filing this joint application.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Group Market Type: Employer

Deemer Date:

The application will be used by groups applying for our group life, accidental death and dismemberment, dependent life, and short-term disability benefits. These benefits are written through the following policy forms which are already approved in NC:

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Policy Forms	Description	NCDOI Approval Date
GPOL (11-99) NC	Group Life & Health Policy	February 8, 2000
GPOL (11-99) Rev. 9-04	Group Life & Health Policy	February 20, 2005
GPOL (7-05)	Group Life & Health Policy	May 24, 2005

Company and Contact

Filing Contact Information

Tiffany Bradley, Product Compliance Analyst II tbradley@usablelife.com
 PO Box 1650 (501) 212-8876 [Phone]
 Little Rock, AR 72203-1650 (501) 378-3333[FAX]

Filing Company Information

USable Life	CoCode: 94358	State of Domicile: Arkansas
PO Box 1650	Group Code: 876	Company Type: Life & Health
Little Rock, AR 72203-1650	Group Name: Life and Speciality Ventures (LSV)	State ID Number:
(501) 375-7200 ext. [Phone]	FEIN Number: 71-0505232	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
USable Life	\$20.00	06/06/2008	20711289

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/10/2008	06/10/2008

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Disposition

Disposition Date: 06/10/2008

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	Application		Yes
Supporting Document	Certification/Notice		No
Form	Group Application for Coverage		Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GRPAPPL	Application/Group	Application for Initial			0	GRPAPPLYLI
		YLIFE, 5/08	Enrollment Coverage				FE, 5_08.PDF
		Form					

Group [Health Carrier] Coverage

<input type="checkbox"/> New Group	Prospect Number: _____	<input type="checkbox"/> Renewal Group	Group Number: _____	Effective Date: _____
1. Name of Group: _____			Tax ID No (EIN): _____	
2. Type of Organization: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____				
3. Physical Address:				
ADDRESS 1		ADDRESS 2		
CITY	STATE	ZIP CODE	COUNTY	
Billing Address: (if different from above) ADDRESS 1				
ADDRESS 2				
CITY	STATE	ZIP CODE		
Group Administrator: _____	Telephone Number: _____	Fax Number: _____	Email Address: _____	
4. Divisions/Subsidiaries/Affiliates to be covered (attach list if necessary):				
Name: _____		Relationship: _____		
Address: _____		Nature of Business: _____		
5. Industry Type (NAICS Code): _____	6. Are 50% of eligible employees employed in the State of North Carolina? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list states: _____			
7. GROUPS OF 1-50: The Group certifies that it meets the definition of Small Employer Group as follows: any individual or entity actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for the purpose of taxation by the State of North Carolina, shall be considered one employer. The Group further certifies that all individuals enrolling for coverage meet the following definition of eligible employee: An eligible employee is an individual working 30 hours or more per week on a full-time basis with the employer reporting the FICA withheld by W2 Form on an annual basis. Persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible. An individual who is a "statutory employee" as that term is defined under Internal Revenue Code Section 3121(d)(3) and works on a full-time basis for the Group may be considered eligible for coverage. Documentation of "statutory employee" status is required. Elected Official Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No				
8. GROUPS OF 51+: [Health Carrier] standard eligibility allows for persons to be covered who are active, full-time employees, working 30 hours or more per week and their eligible dependents. Underwriting approval is required for any additional eligibility requests.				
[Domestic Partner Coverage Options (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Same Sex <input type="checkbox"/> Opposite Sex		Retiree Coverage: (New Groups Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	Elected Official Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Special Eligibility (please specify):]
9. Health and USable Life Products: Eligibility requirements to be applicable to future employees Note: "0 day probationary period" is only available for health coverage for groups of 6 or more eligible employees:				
<input type="checkbox"/> 1st of the month following 30 days		<input type="checkbox"/> Next day following 90 days		
<input type="checkbox"/> Next day following 30 days		<input type="checkbox"/> 0 day probationary period, effective 1st of the month following the date of hire		
<input type="checkbox"/> 1st of the month following 60 days		<input type="checkbox"/> 0 day probationary period, effective on date of hire		
<input type="checkbox"/> Next day following 60 days				

[Tagline]

Group Name: _____

10. Choose one of the following to be applicable to employees terminating health coverage:

End of the contract month following employment termination

Last day of employment (only available to groups of 6 or more eligible employees)

11a. For Health Coverage: Number of Eligible Employees: _____ Number of Enrolled Employees: _____	11b. Group Health Contribution (percentage): Employees: _____ % Dependents: _____ %
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12. All employer-sponsored group health plans must offer COBRA continuation coverage unless the employer is exempt from COBRA. (An employer is exempt if the group (i) employed fewer than 20 employees (including all full-time, part-time, and seasonal employees) on at least 50% of its working days during the preceding calendar year; or (ii) is a church plan or governmental plan as defined under the Internal Revenue Code.)

Is your group health plan exempt from COBRA?
 Yes No

13. The Employee Retirement Income Security Act of 1974 (ERISA) regulates employee health benefit plans sponsored by most employers. Governmental Plans and church-sponsored plans (as defined by federal law) are exempt.

Will this coverage insure an Employee Welfare Benefit Plan that is regulated by ERISA? Yes No

If you checked yes, please identify a contact person for ERISA plan information.

Name and Title: _____

Address: _____ Phone: _____

14. Under federal law, the Plan Administrator may be required to provide a notice to Plan Participants who do not read English but are literate in another language, advising them of where they can get information and assistance concerning their benefits and member rights. The notice must be in their primary language and appear in the summary plan description (member booklet). The following information is being requested to determine if such a notice will be necessary. It may also assist [health carrier] in meeting special customer service needs.

<p>For Groups 1-99: Do 25% or more of the persons covered by your plan meet the following criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Literate only in a foreign (non-English) language? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, what is their primary language (e.g., Spanish)? _____</p> <p>If more than one language is listed, state percentages of members literate in each language: _____</p>	<p>For Groups 100+: Do 10%, or 500 of the persons covered by your plan, whichever is less, meet the following criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Literate only in a foreign (non-English) language? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, what is their primary language (e.g., Spanish)? _____</p> <p>If more than one language is listed, state percentages of members literate in each language: _____</p>
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15. The Group acknowledges that it agrees to pay [health carrier] the following rates for the benefits below.

[Please check the benefit plan(s) you have selected for your group. If you will be contributing to an HSA/HRA during the benefit period, please verify benefit plans, annual contribution amounts, and the HSA/HRA administrator you will be contributing through. If the [health carrier] chosen HSA/HRA administrator has been selected for the HSA/HRA, please also verify if fees should be included in the premium or deducted from the employee's HSA/HRA account.]

[HRA product is not currently available to Groups] [1 to 99]

[Health Plans]

[Product and quote numbers will display here.]

[Health Plans

		ANNUAL FUND CONTRIBUTION AMOUNT (in dollars)								
Quote Number	LOB	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family	Employee + 1 Other	HSA/HRA Administrator	Include in Premium	Deduct from Employee's HSA Account
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										

[Please write in quote information, if existing quotes do not reflect the Group's final choices. Please note that any change in the amounts you listed above could result in a change to the rate you were quoted.]

Group Name: _____

16. **Certification of Compliance with Federally Mandated Coverages:** Federal Social Security laws require employers to provide primary health care benefits under employer group health plans to certain individuals who are entitled to Medicare. The Group certifies and agrees that individuals eligible for Medicare, who are required to receive primary health care benefits under the Group's employee group health plan pursuant to federal Social Security laws, will be enrolled in a manner consistent with such laws. The Group hereby agrees to indemnify [health carrier], hold it harmless against and reimburse it for any and all expenses paid or incurred by [health carrier] due to any act or omission of the Group or the employer inconsistent with the relevant Social Security laws, as amended.
17. In applying for this coverage, the Group further understands that the Group's tender of this application and fees as required by [health carrier] (or by [health carrier]'s chosen HSA/HRA administrator, if HSA/HRA services are being purchased), in no way binds [health carrier] and the HSA/HRA administrator to contract with the Group. Submission of this application and requisite fees, constitutes an offer by the Group, which may be accepted by [health carrier] and the HSA/HRA administrator as signified by the earlier of the following events: [health carrier]'s issuance of the Group Contract and the HSA/HRA administrator's issuance of its group contract, or issuance of identification cards to the Group's members. The Group Contract issued by [health carrier] (and the group contract issued by the HSA/HRA administrator) shall set out the terms of the agreement between the parties, and this application shall be incorporated therein by reference. Group agrees that [health carrier]'s Group Contract and the HSA/HRA administrator's group contract shall be binding upon the parties as issued, without necessity of signature by the Group. References to the HSA/HRA administrator in this document shall apply only if HSA/HRA services are being purchased by Group.

Life/AD&D/STD:

Underwritten by USAbLe Life, an independent life insurance company, that does not provide [health carrier] products or services and is solely responsible for the life insurance coverage below.

<p>18a. Number of Employees:</p> <p>Eligible: _____ Enrolled: _____</p>	<p>18b. Employer Contribution:</p> <p>Life and AD&D _____ % Supplemental _____ %</p> <p>Dependent Life _____ % STD _____ %</p>																				
<p>19.</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Class Descriptions</th> <th style="width:25%;">Life/AD&D* <input type="checkbox"/> Amount of Insurance</th> <th style="width:25%;">Supplemental <input type="checkbox"/> Life <input type="checkbox"/> AD&D Amount of Insurance</th> <th style="width:25%;">Short Term Disability <input type="checkbox"/> Salary Multiple <input type="checkbox"/> Flat Schedule Maximum Weekly Benefit</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>1. _____</td> <td>1. _____</td> <td>1. _____</td> </tr> <tr> <td>2. _____</td> <td>2. _____</td> <td>2. _____</td> <td>2. _____</td> </tr> <tr> <td>3. _____</td> <td>3. _____</td> <td>3. _____</td> <td>3. _____</td> </tr> <tr> <td>4. _____</td> <td>4. _____</td> <td>4. _____</td> <td>4. _____</td> </tr> </tbody> </table> <p>* If Life and AD&D benefit is a multiple of salary, the amount will be rounded to the next higher \$1,000.</p>		Class Descriptions	Life/AD&D* <input type="checkbox"/> Amount of Insurance	Supplemental <input type="checkbox"/> Life <input type="checkbox"/> AD&D Amount of Insurance	Short Term Disability <input type="checkbox"/> Salary Multiple <input type="checkbox"/> Flat Schedule Maximum Weekly Benefit	1. _____	1. _____	1. _____	1. _____	2. _____	2. _____	2. _____	2. _____	3. _____	3. _____	3. _____	3. _____	4. _____	4. _____	4. _____	4. _____
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2. _____	2. _____	2. _____	2. _____																		
3. _____	3. _____	3. _____	3. _____																		
4. _____	4. _____	4. _____	4. _____																		
<p>20. Short Term Disability (non-occupational):</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Accident _____ Days/</td> <td style="width:25%;">Sickness _____ Days/</td> <td style="width:25%;">Duration _____ Weeks</td> <td style="width:25%;">The maximum weekly and the benefit STD benefits is \$ _____ may not exceed _____ % of an insured's weekly income (excluding bonuses, overtime or any form of extra pay).</td> </tr> </table>		Accident _____ Days/	Sickness _____ Days/	Duration _____ Weeks	The maximum weekly and the benefit STD benefits is \$ _____ may not exceed _____ % of an insured's weekly income (excluding bonuses, overtime or any form of extra pay).																
Accident _____ Days/	Sickness _____ Days/	Duration _____ Weeks	The maximum weekly and the benefit STD benefits is \$ _____ may not exceed _____ % of an insured's weekly income (excluding bonuses, overtime or any form of extra pay).																		
<p>21. Dependent Life Insurance (Benefit amounts are limited in some states): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Children: <input type="checkbox"/> from birth to 6 months \$ _____ Spouse: \$ _____</p> <p> <input type="checkbox"/> 6 months to 19 years* \$ _____</p> <p><small>*To age 26 if full-time student</small></p>																					
<p>22. Reductions and Termination (Benefit reduction due to age will be effective on the insured's birthday.)</p> <p>Employee Life and AD&D benefits reduce by the following percent or to the amount shown. Benefits terminate when an employee is no longer eligible as an active employee or at retirement.</p> <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width:25%;">At Age 65</td> <td style="width:25%;">At Age 70</td> <td style="width:25%;">Terminates</td> <td style="width:25%;">Other</td> </tr> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		At Age 65	At Age 70	Terminates	Other																
At Age 65	At Age 70	Terminates	Other																		
<p>23. Guaranteed Issue Amount \$ _____ (Life and AD&D amounts over Guaranteed Issue are subject to evidence of insurability.)</p>																					

COMPLIANCE NOTICE: USAbLe Life does not provide legal or tax advice. Based upon information you have provided USAbLe about your group, USAbLe Life will notify you if USAbLe Life perceives any obvious deficiency in your plan, but you must consult your own legal counsel for definitive advice and opinions regarding your plan's compliance.

WARNING: It is or may be a crime to knowingly provide false, incomplete or misleading information to USAbLe Life for the purposes of defrauding USAbLe Life or other person. Penalties may include imprisonment, fines or a denial of insurance benefits in accordance with applicable state law. It is further understood and agreed that this application shall be made a part of the USAbLe Life policy or policies applied for and that no insurance shall be effective until approved by USAbLe Life's home office.

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Rate Information

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Supporting Document Schedules

Review Status:

Satisfied -Name: Application

06/06/2008

Comments:

Attached under forms tab