

SERFF Tracking Number: UNUM-125963764 State: Arkansas  
Filing Company: Unum Life Insurance Company of America State Tracking Number: 41222  
Company Tracking Number: AE-1077-AR, ET AL  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: CXC STD/LTD  
Project Name/Number: 2008 Evidence of Insurability Forms/2008 Evidence of Insurability Forms/AE-1077-AR, et al

## Filing at a Glance

Company: Unum Life Insurance Company of America

Product Name: CXC STD/LTD

SERFF Tr Num: UNUM-125963764 State: ArkansasLH

TOI: H11G Group Health - Disability Income

SERFF Status: Closed

State Tr Num: 41222

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: AE-1077-AR, ET AL

State Status: Approved-Closed

Long Term

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Ellen Desrosiers

Disposition Date: 01/12/2009

Date Submitted: 12/23/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: 2008 Evidence of Insurability Forms

Status of Filing in Domicile: Authorized

Project Number: 2008 Evidence of Insurability Forms/AE-1077-AR, et al

Date Approved in Domicile: 12/19/2008

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: 01/12/2009

State Status Changed: 01/12/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

2008 Evidence of Insurability Forms

## Company and Contact

SERFF Tracking Number: UNUM-125963764 State: Arkansas  
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**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	

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$60.00  
 Retaliatory? Yes  
 Fee Explanation: 3 forms @ \$20.00 per form = \$60.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unum Life Insurance Company of America	\$60.00	12/23/2008	24695913

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/12/2009	01/12/2009

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## Disposition

Disposition Date: 01/12/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UNUM-125963764 State: Arkansas  
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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	No
<b>Supporting Document</b>	Application	Approved-Closed	No
<b>Form</b>	Application for Worksite STD Insurance	Approved-Closed	No
<b>Form</b>	Application for Group STD Insurance	Approved-Closed	No
<b>Form</b>	Application for Group LTD Insurance	Approved-Closed	No

SERFF Tracking Number: UNUM-125963764 State: Arkansas  
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## Form Schedule

**Lead Form Number:** AE-1077

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AE-1077-AR	Application/ Enrollment Form Application for Worksite STD Insurance	Initial			AE-1077-AR.pdf
Approved-Closed	AE-1078-AR	Application/ Enrollment Form Application for Group STD Insurance	Initial			AE-1078-AR.pdf
Approved-Closed	AE-1079-AR	Application/ Enrollment Form Application for Group LTD Insurance	Initial			AE-1079-AR.pdf



**APPLICATION FOR  
WORKSITE SHORT TERM  
DISABILITY INSURANCE**  
Evidence of Insurability  
**Unum Life Insurance Company of America**  
2211 Congress Street  
Portland, Maine 04122

**Application Type:**     Newly Eligible                       Replace Existing Unum Coverage                       Rehire  
                                  Change to Existing Coverage                       Late Applicant

**SECTION 1: Employee (Applicant) Information – Always Complete**

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender <input type="checkbox"/> F <input type="checkbox"/> M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
[Email Address]		Employee ID/Payroll #
Employer Name	Customer Number	Date of Hire (mm/dd/yyyy)
St/PO Box		Occupation
City		Annual Salary \$
State	Zip Code	Work Phone #
Are you Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Scheduled Number of Work Hours/week

**SECTION 2: Other Coverage**

2. Do you have any group or individual disability insurance now in force with us or any other company that *will not* be replaced or modified? .....  Yes    No  
If "Yes," give details below.

Insurance Company Name	Monthly Benefit	Elimination Period/Benefit Period

Employee Name: \_\_\_\_\_  
(Applicant)

Employee SSN: \_\_\_\_\_  
(Applicant)

**SECTION 3: Plan Information**

[Weekly Benefit Amount \$ \_\_\_\_\_]

Benefit Period: \_\_\_\_\_

Elimination Period: \_\_\_\_\_ days injury / \_\_\_\_\_ days sickness

Cost Per Pay Period: \$ \_\_\_\_\_]

**SECTION 4: Medical Profile**

**Employee (Applicant)**

1. Current height and weight .....\_\_\_\_\_ ft. \_\_\_\_\_ in. \_\_\_\_\_ lbs.
  2. Have you (Applicant) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)?.....  Yes  No
  3. In the past 12 months, other than colds, flu or pregnancy, have you taken time off from work or taken vacation for 5 or more consecutive days due to an accident, sickness, back, knee, neck, shoulder, joint or muscular disorder? .....  Yes  No
  4. In the past 12 months have you received medical advice, sought treatment, including medication, or been hospitalized for any of the following:.....  Yes  No
    - Heart Attack/Heart Surgery
    - Congestive Heart Failure
    - Stroke/Transient Ischemic Attack (TIA)
    - High blood pressure treated with 3 or more medications
    - Diabetes (except gestational or diet controlled)
    - Cancer (except basal cell carcinoma)
    - Hepatitis B or C
    - Cirrhosis
    - [Schizophrenia, psychosis, major depressive disorder, bipolar disorder or post traumatic stress disorder]
    - [Fibromyalgia, chronic fatigue syndrome]
    - [Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig’s disease), or Parkinson’s Disease]
    - [Alcohol or drug abuse]
    - [Carpal Tunnel Syndrome]
-

Employee Name: \_\_\_\_\_  
(Applicant)

Employee SSN: \_\_\_\_\_  
(Applicant)

**SECTION 5: Employee (Applicant) Statements**

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter Unum) and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. If I pay part or all of the cost of my coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

All statements and answers provided on this application are true and complete, and are given to obtain insurance.

**CAUTION:** Unum will rely on the information provided in order to evaluate this application. If the answers provided are incorrect or untrue, Unum may deny benefits or rescind insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

Employee (Applicant) Signature

Date (mm/dd/yyyy)

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Unum Life Insurance Company of America.



**APPLICATION FOR  
GROUP SHORT TERM DISABILITY INSURANCE**  
Evidence of Insurability  
**Unum Life Insurance Company of America**  
2211 Congress Street  
Portland, Maine 04122

**Application Type:**     Newly Eligible                       Late Applicant                       Rehire  
                                  Change to Existing Coverage

**SECTION 1: Employee (Applicant) Information – Always Complete**

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender <input type="checkbox"/> F <input type="checkbox"/> M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
[Email Address]		Employee ID/Payroll #
Employer Name	Customer Number	Date of Hire (mm/dd/yyyy)
St/PO Box		Occupation
City		Annual Salary \$
State	Zip Code	Work Phone #
Are you Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Scheduled Number of Work Hours/week

**SECTION 2: Coverage Information**

Weekly Benefit Amount:  
\$ \_\_\_\_\_ / week or \_\_\_\_\_% of salary

Cost per Paycheck: \$	Elimination Period: _____ days injury / _____ days sickness
--------------------------	--

Employee Name: \_\_\_\_\_  
(Applicant)

Employee SSN: \_\_\_\_\_  
(Applicant)

**SECTION 3: Medical Profile – Complete as required for all underwritten coverage**

**Employee (Applicant)**

1. Current height and weight ..... \_\_\_\_\_ ft. \_\_\_\_\_ in. \_\_\_\_\_ lbs.
  2. Have you (Applicant) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)? .....  Yes  No
  3. In the past 12 months, other than colds, flu or pregnancy, have you taken time off from work or taken vacation for 5 or more consecutive days due to an accident, sickness, back, knee, neck, shoulder, joint or muscular disorder? .....  Yes  No
  4. In the past 12 months have you received medical advice, sought treatment, including medication, or been hospitalized for any of the following: .....  Yes  No
    - Heart Attack/Heart Surgery
    - Congestive Heart Failure
    - Stroke/Transient Ischemic Attack (TIA)
    - High blood pressure treated with 3 or more medications
    - Diabetes (except gestational or diet controlled)
    - Cancer (except basal cell carcinoma)
    - Hepatitis B or C
    - Cirrhosis
    - Schizophrenia, psychosis, major depressive disorder, bipolar disorder or post traumatic stress disorder
    - Fibromyalgia, chronic fatigue syndrome
    - [Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig’s disease), or Parkinson’s Disease]
    - [Alcohol or drug abuse]
    - [Carpal Tunnel Syndrome]
-

Employee Name: \_\_\_\_\_  
(Applicant)

Employee SSN: \_\_\_\_\_  
(Applicant)

**SECTION 4: Employee (Applicant) Statements**

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter Unum) and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. If I pay part or all of the cost of my coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

All statements and answers provided on this application are true and complete, and are given to obtain insurance.

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Employee (Applicant) Signature	Date (mm/dd/yyyy)
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Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Unum Life Insurance Company of America.



**APPLICATION FOR  
GROUP LONG TERM DISABILITY INSURANCE**  
Evidence of Insurability  
**Unum Life Insurance Company of America**  
2211 Congress Street  
Portland, Maine 04122

**Application Type:**     Newly Eligible                       Late Applicant                       Rehire  
                                  Change to Existing Coverage

**SECTION 1: Employee (Applicant) Information – Always Complete**

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender <input type="checkbox"/> F <input type="checkbox"/> M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
[Email Address]		Employee ID/Payroll #
Employer Name	Customer Number	Date of Hire (mm/dd/yyyy)
St/PO Box		Occupation
City		Annual Salary \$
State	Zip Code	Work Phone #
Are you Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Scheduled Number of Work Hours/week

**SECTION 2: Coverage Information**

Monthly Benefit Amount:  
\$ \_\_\_\_\_ / month or \_\_\_\_\_ % of salary

Cost per Paycheck: \$	Elimination Period:
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Employee Name: \_\_\_\_\_  
(Applicant)

Employee SSN: \_\_\_\_\_  
(Applicant)

**SECTION 3: Medical Profile – Complete as required for all underwritten coverage**

**Employee (Applicant)**

1. Current height and weight ..... \_\_\_\_\_ ft. \_\_\_\_\_ in. \_\_\_\_\_ lbs.
  
  2. Have you (Applicant) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)? .....  Yes  No
  
  3. In the past 12 months, other than colds, flu or pregnancy, have you taken time off from work or taken vacation for 5 or more consecutive days due to an accident, sickness, back, knee, neck, shoulder, joint or muscular disorder? .....  Yes  No
  
  4. In the past 5 years have you received medical advice, sought treatment, including medication, or been hospitalized for any of the following: .....  Yes  No
    - Diabetes (except gestational or diet controlled)
    - High blood pressure treated with 3 or more medications
    - Cancer (except basal cell carcinoma)
    - Atrial fibrillation, angina, heart attack, coronary artery disease, heart surgery, congestive heart failure or cardiomyopathy
    - Stroke, Transient Ischemic Attack (TIA), or Peripheral Vascular Disease
    - Chronic Obstructive Pulmonary Disease (COPD), emphysema, chronic lung disease (excluding asthma)
    - Cirrhosis, hepatitis B or C, Crohn’s disease or ulcerative colitis
    - Systemic lupus or other connective tissue disease, fibromyalgia, chronic fatigue syndrome, rheumatoid arthritis, disc disease or joint replacements
    - Kidney disease (excluding stones) or failure
    - Alcohol or drug abuse
    - Schizophrenia, psychosis, major depressive disorder, bipolar disorder or post traumatic stress disorder
    - Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig’s disease), or Parkinson’s Disease
-

Employee Name: \_\_\_\_\_  
(Applicant)

Employee SSN: \_\_\_\_\_  
(Applicant)

**SECTION 4: Employee (Applicant) Statements**

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter Unum) and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. If I pay part or all of the cost of my coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin.

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Employee (Applicant) Signature	Date (mm/dd/yyyy)
--------------------------------	-------------------

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*SERFF Tracking Number:* UNUM-125963764      *State:* Arkansas  
*Filing Company:* Unum Life Insurance Company of America      *State Tracking Number:* 41222  
*Company Tracking Number:* AE-1077-AR, ET AL  
*TOI:* H11G Group Health - Disability Income      *Sub-TOI:* H11G.005 Combined Short Term and Long Term  
*Product Name:* CXC STD/LTD  
*Project Name/Number:* 2008 Evidence of Insurability Forms/2008 Evidence of Insurability Forms/AE-1077-AR, et al

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: UNUM-125963764 State: Arkansas  
Filing Company: Unum Life Insurance Company of America State Tracking Number: 41222  
Company Tracking Number: AE-1077-AR, ET AL  
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Product Name: CXC STD/LTD  
Project Name/Number: 2008 Evidence of Insurability Forms/2008 Evidence of Insurability Forms/AE-1077-AR, et al

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice **Review Status:** Approved-Closed 01/12/2009  
**Comments:**  
**Attachments:**  
AR - Rule 19 Cert Form for E of I Filing.pdf  
AR - Transmittal Evidence of Insurability.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 01/12/2009  
**Bypass Reason:** We are not filing a policy at this time. This filing consists of applications only.  
**Comments:**

## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Unum Life Insurance Company of America

Form Number(s): AE-1077, AE-1078, AE-1079

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



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Signature of Company Officer

Nancy Johnson  
Name

Vice President  
Title

December 23, 2008

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Date

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

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

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

<b>5.</b>	<b>Requested Filing Mode</b>	<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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<b>6.</b>	<b>Company Tracking Number</b>	AE-1077, AE-1078, AE-1079
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<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b> Previous file # _____
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<b>8.</b>	<b>Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input checked="" type="checkbox"/> <b>Group</b>	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> <b>Small and Large</b> <input checked="" type="checkbox"/> <b>Employer</b> <input checked="" type="checkbox"/> <b>Association</b> <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input checked="" type="checkbox"/> <b>Trust</b> <input type="checkbox"/> Other: _____
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<b>9.</b>	<b>Type of Insurance</b>	Group Health – Disability Income – Long term / Short term
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<b>10.</b>	<b>Product Coding Matrix Filing Code</b>	H11G.005
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<b>11.</b>	<b>Submitted Documents</b>	<p><b>xFORMS</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Policy</td> <td><input type="checkbox"/> Outline of Coverage</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input checked="" type="checkbox"/> Application/Enrollment</td> <td><input type="checkbox"/> Rider/Endorsement</td> <td><input type="checkbox"/> Advertising</td> </tr> <tr> <td><input type="checkbox"/> Schedule of Benefits</td> <td colspan="2"><input checked="" type="checkbox"/> Other: ADDITIONAL VARIABLES</td> </tr> </table> <p><b>Rates</b></p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate	<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input checked="" 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	
<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate									
<input checked="" 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										
		<input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____									
		<p><b>SUPPORTING DOCUMENTATION</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Articles of Incorporation</td> <td><input type="checkbox"/> Third Party Authorization</td> </tr> <tr> <td><input type="checkbox"/> Association Bylaws</td> <td><input type="checkbox"/> Trust Agreements</td> </tr> <tr> <td><input type="checkbox"/> Statement of Variability</td> <td><input type="checkbox"/> Certifications</td> </tr> <tr> <td><input type="checkbox"/> Actuarial Memorandum</td> <td></td> </tr> </table>	<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"/> Statement of Variability	<input type="checkbox"/> Certifications										
<input type="checkbox"/> Actuarial Memorandum											

		<input type="checkbox"/> Other _____
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LHTD-1, Page 1 of 2

12.	<b>Filing Submission Date</b>	<b>December 23, 2008</b>	
13	<b>Filing Fee (If required)</b>	Amount <u>\$60.00</u>	Check Date _____
		Retaliatory <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	<b>Date of Domiciliary Approval</b>	<b>December 19, 2008</b>	
15.	<b>Filing Description:</b>		
<p>AE-1077, AE-1078 and AE-1079 are a new series of std and ltd group insurance applications which have been designed and drafted to the extent possible to reflect a uniform look and contain consistent language to streamline the application process.</p>			

16.	<b>Certification (If required)</b>		
<p><b>I HEREBY CERTIFY</b> 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 23, 2008</u>	

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		<b>AE-1077, AE-1078, AE-1079</b>
<b>This filing corresponds to rate filing company tracking number</b>		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	<b>Application for Worksite STD Insurance</b>	<b>AE-1077</b>	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
02	<b>Application for Group STD Insurance</b>	<b>AE-1078</b>	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
03	<b>Application for Group LTD Insurance</b>	<b>AE-1079</b>	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
04			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
05			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
06			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
07			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
08			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
09			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
10			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	

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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 _____	

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