

SERFF Tracking Number: CLTR-126352518 State: Arkansas  
 Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43839  
 Company Tracking Number: 10634GA-EZ-0110  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group Dental Application  
 Project Name/Number: United 0110 App/10634GA-EZ-0110

## Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Group Dental Application SERFF Tr Num: CLTR-126352518 State: Arkansas  
 TOI: H10G Group Health - Dental SERFF Status: Closed-Approved- State Tr Num: 43839  
 Closed

Sub-TOI: H10G.000 Health - Dental Co Tr Num: 10634GA-EZ-0110 State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Rosalind Minor  
 Authors: Frank Cripps, Stephanie Disposition Date: 10/29/2009  
 Young, Susan Kalmus  
 Date Submitted: 10/21/2009 Disposition Status: Approved-Closed  
 Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: United 0110 App  
 Project Number: 10634GA-EZ-0110  
 Requested Filing Mode: Review & Approval  
 Explanation for Combination/Other:  
 Submission Type: New Submission  
 Overall Rate Impact:  
 Filing Status Changed: 10/29/2009

Status of Filing in Domicile: Authorized  
 Date Approved in Domicile: 09/16/2009  
 Domicile Status Comments:  
 Market Type: Group  
 Group Market Size: Small and Large  
 Group Market Type: Employer, Association  
 Explanation for Other Group Market Type:  
 State Status Changed: 10/29/2009  
 Created By: Frank Cripps  
 Corresponding Filing Tracking Number:

Deemer Date:  
 Submitted By: Frank Cripps  
 Filing Description:

On August 13, 2009 the Alabama Insurance Department approved a group dental filing (SERFF Tracking No. CLTR-126251763) for United of Omaha. Among the forms approved was group application form 10634GA-EZ 04. In processing this approval we discovered that the form number used to identify the group application - 10634GA-EZ 04 - was already being used by another application form that was previously submitted and approved. Accordingly, we need to re-designate the application form to be used with the approved group dental forms.

The new form number is 10634GA-EZ 0110. No other changes have been made to the approved form other than the form designation. Please withdraw the approval on form 10634GA-EZ 04 and replace it with form 10634GA-EZ 0110.

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Thank you for your attention to this matter, and please accept our apologies for any inconvenience this situation may cause.

Please do not hesitate to contact me should you have any questions or require any additional information.

## Company and Contact

### Filing Contact Information

Frank Cripps, Consultant frank@coulter-and-associates.com  
 379 Princeton-Hightstown Rd 609-443-7540 [Phone]  
 Cranbury, NJ 08512 609-443-4103 [FAX]

### Filing Company Information

(This filing was made by a third party - coulterandassociatesinc)

United of Omaha Life Insurance Company	CoCode: 69868	State of Domicile: Nebraska
Mutual of Omaha Plaza	Group Code: 261	Company Type: life and health
Omaha, NE 68175	Group Name:	State ID Number:
(609) 443-7540 ext. [Phone]	FEIN Number: 47-0322111	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$20.00
Retaliatory?	No
Fee Explanation:	AR Fee for Addition/Change to Previously Approved Filing = \$20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$20.00	10/21/2009	31441231

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/29/2009	10/29/2009

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*Product Name:* Group Dental Application  
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## **Disposition**

Disposition Date: 10/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter and Authorization	Approved-Closed	Yes
<b>Form</b>	Group Application	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: 10634GA-EZ 0110

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 10/29/2009	10634GA- EZ 0110	Application/ Group Application Enrollment Form		Initial		40.500	10634GA-EZ 0110_Master App.pdf



Mutual of Omaha  
 Home Office Use Only  
 Policy Number(s): \_\_\_\_\_

**Group Insurance Application**

**Applicant** (Full Legal Name) \_\_\_\_\_ (the Policyholder)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Requested Effective Date:** \_\_\_\_\_, subject to our acceptance of this application and payment of premium on or before such date.

<u>Coverage(s) being applied for:</u>	<u>GROUP</u> (Contributory / Non-Contributory)	<u>VOLUNTARY</u> (100% Employee Paid)
<input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AD&D	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>

**Active at work requirement:** An employee must meet an Active at Work requirement to become insured. Will all proposed insureds meet the Active at Work requirement?  Yes  No If "No," please provide the name of the individual, date of birth, date of disability or confinement and nature of disability or confinement on a separate page.

Certain states have enacted legislation that requires insurers to provide specific coverage for people residing in their states. Do you have employees residing in or working in other states?  Yes  No  
 If "Yes," which states: \_\_\_\_\_

**Financial Risk** (If "Yes," to any part, please explain below)

1. Has the applicant ever filed for bankruptcy?  Yes  No
  2. Does the applicant anticipate ceasing or materially reducing active business operations?  Yes  No
- Explanation: \_\_\_\_\_

Application is made on the basis of the proposal, any available experience data and the information contained in this application.

The applicant signing below agrees to accept the terms and provisions of the Master Policy for the coverages applied for above. Insurance will become effective on the requested effective date shown above, unless we send written notice of a different effective date. If this application is not approved by an officer at the Home Office of the underwriting company, no insurance is in effect at any time and any advance payment received will be returned.

This application is submitted with the following advance payment \$ \_\_\_\_\_

**REQUIRED FRAUD WARNINGS (State Specific Warnings Apply to the Resident of Such State)**

**[Fraud Warning:** 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, may be guilty of a crime and may subject such person to criminal and civil penalties.]

**[Arkansas/District of Columbia/Louisiana/New Mexico/West Virginia:** 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.]

**[California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

**[Colorado:** 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.]

**[Delaware/Florida/Oklahoma:** 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.]

**[Maine/Tennessee/Virginia/Washington:** 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 or a denial of insurance benefits.]

**[Maryland/Oregon:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**[New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

**[New York:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

**[Ohio** 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 Applicant:**

By \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

**Name of broker, agent and/or insurance agency  
soliciting this coverage:**

\_\_\_\_\_

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	10/29/2009
<b>Comments:</b>		
<b>Attachment:</b> AR 0110 Group App Readability Cert.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	10/29/2009
<b>Bypass Reason:</b> N/A - New app to replace previously approved form.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter and Authorization	Approved-Closed	10/29/2009
<b>Comments:</b>		
<b>Attachments:</b> 20091021 AR 0110 App Filing Letter.pdf Letter of Authority- United.pdf		

## READABILITY CERTIFICATION

This is to certify that the form(s) below has (have) been subject to the Flesch Reading Ease Test.

A. Option Selected

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is \_\_\_\_\_.
2. Policy and riders are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

<u>Form</u>	<u>Form Number</u>	<u>Flesch</u>
Group Application	10634GA-EZ 0110	40.5

B. Test Option Selected

1. Test was applied to entire form(s).
2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of forms enclosed indicating word samples tested.

Company Name: United Mutual of Omaha America Insurance Company

Signature of Certifying Officer



Martin F. Traynor  
Vice President of Voluntary Benefits

October 19, 2009



Frank D. Cripps, Senior Consultant  
Contracts and Compliance

379 Princeton-Hightstown Rd.  
Cranbury, NJ 08512  
Phone: 609-443-7540  
Fax: 609-443-4103  
frank@coulter-and-associates.com

October 21, 2009

Arkansas Insurance Department  
Via SERFF

RE: United of Omaha Life Insurance Company • NAIC #69868 • FEIN 47-0322111  
Group Dental Coverage Form Filing  
Group Application Form 10634GA-EZ 0110  
Filing Authorization Letter  
Readability Certification

Dear Sir or Madam:

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Thank you for your attention to this matter, and please accept our apologies for any inconvenience this situation may cause.

Please do not hesitate to contact me should you have any questions or require any additional information.

Sincerely,

Frank D. Cripps  
Consultant

FDC/c  
Attachment

MUTUAL of OMAHA INSURANCE COMPANY  
Mutual of Omaha Plaza  
Omaha, NE 68175  
402 351 2840 fax 402 351 6666  
Scott.Ault@mutualofomaha.com

**SCOTT AULT**  
Senior Vice President  
Group Insurance Division  
Group Benefit Services



Date: July 1, 2009  
To: State Insurance Departments  
From: United of Omaha Life Insurance Company  
Re: Filing Authority for Coulter & Associates, Inc.

I, Scott Ault, have authorized Coulter and Associates, to make state filings and to correspond to insurance departments on our behalf.

A handwritten signature in black ink, appearing to read "Scott Ault", with a long horizontal line extending to the right.

T. Scott Ault  
Senior Vice President  
Group Insurance Division