

SERFF Tracking Number: GRTT-126260941 State: Arkansas
Filing Company: United National Life Insurance Company of America State Tracking Number: 43220
Company Tracking Number: URA09-10
TOI: MS05I Individual Medicare Supplement - Standard Plans Sub-TOI: MS05I.001 Plan A
Product Name: Amendment Filing
Project Name/Number: Amendment Filing /URA09-10

Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: Amendment Filing SERFF Tr Num: GRTT-126260941 State: Arkansas
TOI: MS05I Individual Medicare Supplement - Standard Plans SERFF Status: Closed-Approved-Closed State Tr Num: 43220
Sub-TOI: MS05I.001 Plan A Co Tr Num: URA09-10 State Status: Approved-Closed
Filing Type: Form/Rate/Advertisement Reviewer(s): Stephanie Fowler
Author: Joan Jannotta Disposition Date: 10/01/2009
Date Submitted: 08/13/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date: 10/01/2009

State Filing Description:

General Information

Project Name: Amendment Filing
Project Number: URA09-10
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/01/2009

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filing concurrently
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 10/01/2009
Created By: Joan Jannotta
Corresponding Filing Tracking Number: GRTT-126261802, GRTT-126261809, GRTT-126261840

Deemer Date:

Submitted By: Joan Jannotta

Filing Description:

Re: Individual Medicare Supplement Insurance
Amendment Rider URA09-10
Application UAPPH7-08
Brochure UADH2-09
Actuarial Memorandum and Rates

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NAIC #92703 903

Dear Sir or Madam:

We are submitting the above referenced forms for your review and approval. They are new and not intended to replace any forms currently on file in your Department.

The purpose of Rider URA09-10 is to add language pertaining to the suspension of benefits due to group insurance to our previously approved Medicare Supplement policy forms U9740A, U9740D, U9740F and U9740G. These forms were approved by your Department on June 15, 1998.

We are asking for general approval of this application. It will be used with our currently approved, as well as future generations of Medicare Supplement plans. The applicant section and items 1, 2 and 3 on the application are variable.

Brochure UADH2-09 will be used to interest prospects one of the above referenced Medicare Supplement forms.

These forms have been printed by our computer and laser printer. We reserve the right to change the font (typeset) when and if a new font becomes available.

We are also submitting revised rates for policy form U9740A to be used with the new application. We are submitting the rates for policy forms U9740D, U9740F and U9740G under separate serff filings. The serff filing numbers for these rates are shown in the corresponding filing number section on the General Information tab.

We would appreciate any consideration you could extend toward the prompt approval of this submission. If I can be of further assistance in the approval process, please contact me directly or at our toll-free number shown below.

Sincerely,

Joan Jannotta

Product Manager

Product Approval and Compliance (PAC)

Direct Phone: 1-847-904-5730

Toll-Free: 1-800-338-7452, extension #5730

E-mail: jjannotta@gtlic.com

Fax: 847-699-0093

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Company and Contact

Filing Contact Information

Joan Jannotta, jjannotta@gtlic.com
 1275 Milwaukee Ave. 847-904-5730 [Phone]
 Glenview, IL 60025 847-699-0093 [FAX]

Filing Company Information

United National Life Insurance Company of America CoCode: 92703 State of Domicile: Illinois
 1275 Milwaukee Ave. Group Code: 903 Company Type:
 Glenview, IL 60025 Group Name: State ID Number:
 (847) 803-5252 ext. [Phone] FEIN Number: 37-1095206

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? Yes
 Fee Explanation: Illinois requires \$50 per form, no charge for rates

3 forms = \$150.00
 1 rates = \$ 50.00
 Total \$200.00

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United National Life Insurance Company of America	\$200.00	08/13/2009	29830168

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	10/01/2009	10/01/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	09/18/2009	09/18/2009	Joan Jannotta	09/28/2009	09/28/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Brochure	Joan Jannotta	08/21/2009	08/21/2009
Supporting Document	Commission Schedule	Joan Jannotta	08/21/2009	08/21/2009

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Disposition

Disposition Date: 10/01/2009

Implementation Date: 10/01/2009

Status: Approved-Closed

Comment: The requested rate increase has been approved to be implemented on or after October 1, 2009. This approval is subject to the following:

- Increases will not be given more frequently than once in a twelve-month period
- Both the insured and agent shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

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 Product Name: Amendment Filing
 Project Name/Number: Amendment Filing /URA09-10

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Accepted for Informational Purposes	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage		Yes
Supporting Document	Commission Schedule	Accepted for Informational Purposes	Yes
Supporting Document	Monthly Premium Rates	Accepted for Informational Purposes	Yes
Form	Amendment Rider	Approved	Yes
Form	Application	Approved	Yes
Form (revised)	Brochure	Filed	Yes
Form	Brochure	Replaced	Yes
Rate	Plan A Rates	Approved	Yes

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TOI: MS05I Individual Medicare Supplement - Standard Plans Sub-TOI: MS05I.001 Plan A
Product Name: Amendment Filing
Project Name/Number: Amendment Filing /URA09-10

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/18/2009
Submitted Date 09/18/2009
Respond By Date 10/19/2009

Dear Joan Jannotta,

This will acknowledge receipt of the captioned filing.

The filing has been reviewed and will be approved upon receipt of a rate sheet with they monthly premiums.

Please feel free to contact me if you have questions.

Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/28/2009
Submitted Date 09/28/2009

Dear Stephanie Fowler,

Comments:

Thank you for your comments.

Response 1

Comments: Attached are the monthly rates you requested.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Monthly Premium Rates

Comment:

No Form Schedule items changed.

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Amendment Letter

Submitted Date: 08/21/2009

Comments:

I've attached our commission schedule.

I replaced brochure UADH2-09 with brochure UADH2-09-A

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
UADH2-09-AA	Advertising	Brochure	Initial					Brochure UADH2-09-A.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Commission Schedule

Comment:

Commission Schedule.pdf

SERFF Tracking Number: GRTT-126260941 State: Arkansas
 Filing Company: United National Life Insurance Company of America State Tracking Number: 43220
 Company Tracking Number: URA09-10
 TOI: MS051 Individual Medicare Supplement - Standard Plans Sub-TOI: MS051.001 Plan A
 Product Name: Amendment Filing
 Project Name/Number: Amendment Filing /URA09-10

Form Schedule

Lead Form Number: URA09-10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/01/2009	URA09-10	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Amendment Rider	Initial		43.420	URA09-10.pdf
Approved 10/01/2009	UAPPH7-08	Application/ Enrollment Form	Application	Initial		69.900	UAPPH7-08.pdf
Filed 10/01/2009	UADH2-09-A	Advertising Brochure	Advertising Brochure	Initial			Brochure UADH2-09- A.pdf

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

P. O. Box 1154, Glenview, Illinois 60056-1154
(847) 803-5252

AMENDMENT RIDER

This rider is made a part of your Policy effective _____, or your Policy's issue date, whichever is later.

The following is added to the Suspension of Benefits provision:

If you are entitled to benefits under Section 226(b) of the Social Security Act and covered under a group health plan, we will suspend benefits and premiums under this policy at your request. This suspension of coverage can last as long as the period provided by federal regulation. Upon receipt of your timely notification, we will refund any unearned premium for the period of time you are covered under the group health policy. Your refunded premium will be reduced by the amount of any claims paid for the period you are eligible. If you lose coverage under the group health plan during this suspension of coverage, your policy will be automatically reinstated as long as you notify us of such loss of coverage within 90 days after it occurs. Automatic reinstatement of your policy's coverage will be effective as of the date of group health plan termination. You must pay the applicable policy premium. Upon reinstatement, we will;

- (a) provide coverage substantially equivalent to the coverage in effect prior to the date of suspension;
and
- (b) charge a premium at least as favorable as if coverage had not been suspended.

This Rider is subject to all terms, provisions, limitations and exclusions of the Policy except when specifically changed by this rider.

Signed at United National Life Insurance Company of America in Glenview, Illinois by



President



Secretary

Licensed Resident Agent (If Required): _____

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

[APPLICANT Last Name		First Name				M.I.
Soc. Security #	Age	Date of Birth / /	Sex	Height /	Weight lbs	Phone Number () Email
ADDRESS Number & Street			City	State	Zip Code	
MAILING ADDRESS (if different from above)			City	State	Zip Code	

PLAN & PAYMENT INFORMATION

<p>1. Requested Effective Date or Replacement Date: _____</p> <p>2. I am applying for: a. Medicare Supplement Plan: Plan: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> G b. <input type="checkbox"/> Medicare Supplement High Deductible Plan F</p>	<p>3. Premium Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft*</p> <p>Requested Draft Date _____</p> <p>Application Fee: \$ _____</p> <p>Total Modal Premium: \$ _____</p> <p>Premium Paid with Application: \$ _____</p> <p>* (1 month's premium required for bank draft)</p>
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MEDICARE COVERAGE QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER QUESTIONS 4 THROUGH 9 COMPLETELY.

Please mark Yes or No with an "X". To the best of your knowledge:

<p>4. Are you covered or will you be covered under Medicare Parts A & B? (If the answer is "No", do not submit the application) If yes, what is your Medicare claim number? (exactly as it appears on your Medicare Card) _____</p> <p>5. a. Did you turn age 65 in the last 6 months? b. Did you enroll in Medicare Part B in the last 6 months or will you enroll in Medicare Part B in the next 6 months?.... If yes, what is/was the effective date? _____</p> <p>6. Are you covered for medical assistance through the state Medicaid program? (If the answer to 6a. or 6b. is "yes", do not submit the application.) NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. If you answer yes, a. Will Medicaid pay your premiums for this Medicare supplement policy? b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....</p> <p>7. a. Do you have another Medicare supplement policy in force?..... b. If so, with what company and what plan do you have? _____ c. If so, do you intend to replace your current Medicare supplement policy with this policy?..... d. If yes, what is the Termination Date of your other Medicare Supplement Policy? _____</p> <p>8. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____ b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? c. Was this your first time in this type of a Medicare plan? d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? e. If your coverage has not ended please fill in a planned termination date? ____/____/____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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9. Have you had coverage under any other health insurance within the past 63 days?.....
 (For example, Railroad Retirees, teachers plans, an employer union, group major medical or individual plan)
 a. If so, with what company and what kind of policy?

 b. What are your dates of coverage under the other policy?
 START _____/_____/_____ END _____/_____/_____
 (If you are still covered under the other policy, leave the "END" blank.
 c. If your coverage has not ended, please fill in a planned termination date? _____/_____/_____

Yes No

HEALTH QUESTIONS

You do not have to answer questions 10 through 24 if you have enrolled in Medicare Part B within the past 6 months or are in a guarantee issue period. If not, and you answer "yes" to questions 10 through 23 below, you are not eligible for coverage

10. Are you currently hospitalized or confined to a nursing facility, or, are you bedridden or confined to a wheelchair? Yes No

11. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? Yes No

12. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, degenerative bone disease, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? Yes No

13. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? Yes No

14. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

15. Do you have diabetes, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, congestive heart failure, heart disease, or high blood pressure with three or more medications? Yes No

16. Do you have diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral)? Yes No

17. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation? Yes No

18. Within the past two years have you been treated, been advised to have treatment, been prescribed new medication or had changes in existing medication(s) for coronary or carotid artery disease, heart rhythm disorders including pacemakers or a defibrillator, a heart attack, congestive heart failure, or enlarged heart, stroke, transient ischemic attack (TIA), heart valve surgery, or peripheral vascular disease? Yes No

19. Within the past two years have you been treated for crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes No

20. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? Yes No

21. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes No

22. Have you been hospital confined three or more times in the last two years? Yes No

23. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No

24. Have you used any tobacco products in the past 12 months? Yes No

25. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes No
 If, "YES", please list the drug and the condition in the following table.

Applicant (please attach a separate sheet if needed)	
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition

DISCLOSURE & AUTHORIZATION

DISCLOSURE: You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy, (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for the outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

APPLICANT'S AUTHORIZATION & AGREEMENT: I authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc.. This Authorization includes all information about drugs, alcoholism, and mental illness. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by the Company in accordance with federal or state law. I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

ACKNOWLEDGEMENTS: The Applicant represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete. 2) Any coverage issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No agent or any other person is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of the application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime. 5) Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan which has been applied for, have been explained and are understood. 6) The applicant shall be owner of any insurance applied for. 7) The applicant acknowledges receipt of the Outline of Coverage, and has read the authorization and received copies of the "Notice to Applicant, Parts 1 and 2" describing the Medical Information Bureau and explaining the rights of the applicant under the Fair Credit Reporting Act.

AGREEMENT: I have read, or had read to me, the completed application. I hereby agree that: 1) all the statements and answers in this application are complete and true to the best of my knowledge and belief; and 2) **no insurance will be effective until my policy is issued.**

Caution: If your answers on this application are incorrect or untrue, United National Life Insurance Company of America may deny benefits or rescind your policy.

We are required to give you this notice: Any person who, with the intent to defraud or knowledge that he is facilitating a fraud against the insurer, submits an application or files a claim containing false, incomplete, or deceptive statements of material fact may be guilty of insurance fraud.

Applicant's Signature

City & State signed

Date

MAIL POLICY TO: Agent Insured

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

SENIOR SELECT

Medicare
Supplement
Protection

Pick the

Plan that

Best Meets

Your Needs





Medicare Supplement Insurance Plan



United National Life Insurance Company's Medicare Supplement Insurance Plan is designed to work with the Federal Medicare program. Since Medicare Part A Hospital Deductibles are constantly rising, you may become responsible for paying a large amount of out-of-pocket health care expenses. Medicare Supplement Insurance from UNL can help cover health care costs that you must pay.

Features:

- *No Pre-Existing Limitations*

Coverage is available immediately.

- *Guaranteed Renewable*

Medicare Supplement Insurance is renewable for life. This means that as long as premiums are paid on time, your policy can never be canceled.

- *Premiums*

Your premiums cannot be changed due to declining health. Your premium can only be changed if we change premiums for all policies like yours in the state. If your premium changes, we will notify you in advance.

- *30-Day Free Look*

If you are not completely satisfied with your Medicare Supplement policy, simply return your policy within 30 days after you receive it for a complete refund of all premiums paid.

- *Grace Period*

Your Medicare Supplement policy provides a 31-day grace period. Premium notices are mailed to you well in advance of due dates.

- *Automatic Adjustment of Benefits*

Your Medicare Supplement Insurance policy will increase your covered deductibles and copayment benefits whenever these Medicare Deductibles and copayment amounts are increased by Medicare. Your premiums may change as your benefits change.

Your Basic Benefit Package provides the following:

Part A — Inpatient Care Benefits

Your Medicare Supplement Insurance Plan will provide benefits for the expenses you incurred due to an injury or sickness:

1. All copayment expenses incurred after the Medicare Part A Deductible during a hospital stay covered by Medicare. This includes the Medicare lifetime reserve co-payment amount.
2. Upon exhaustion of Medicare benefits, including lifetime reserve days, we will pay 100% of the Medicare Eligible Expenses incurred due to inpatient hospital care. This benefit starts on the day following the last day of coverage by Medicare. These expenses must be of the type Medicare would have covered if Medicare benefits were not exhausted. This benefit is subject to a lifetime maximum benefit of an additional 365 days.
3. The expense incurred for the first three pints of blood furnished on an inpatient basis (or the equivalent in packed red blood cells) which have not been replaced.

Part B — Medical Care Benefits

Your Medicare Supplement Insurance Plan will provide the following benefits for the expenses you incur due to an injury or illness.

1. The Medicare Part B copayment amount of the Medicare Eligible Expenses incurred, which exceed the Medicare Part B Annual Deductible.
2. The copayment for each Hospital Outpatient service and supply.
3. The Actual Charge for the first three pints of blood furnished on an outpatient basis (or the equivalent in packed red blood cells) which have not been replaced.

Choose from the following options:

U9742A

- Basic Benefit Package

U9742D

- Basic Benefit Package
- Coverage for the Medicare Part A Deductible, as determined by Medicare
- Skilled Nursing copayment expense incurred while Medicare is paying Skilled Nursing Home benefits
- Covered expenses for Emergency Medical Care Outside the U.S., not covered by Medicare
- Home Care Benefit - up to \$40.00 per visit, with a calendar maximum of \$1,600.

U9742F

- Basic Benefit Package
- Coverage for the Medicare Part A Deductible, as determined by Medicare
- Medicare Part B Annual Deductible, as determined by Medicare
- Skilled Nursing copayment expense incurred while Medicare is paying Skilled Nursing Home benefits
- 100% of the Excess Charge you incurred for health care services and supplies of the type covered under Part B of Medicare, which exceeds the Medicare Eligible Expenses
- Covered expenses for Emergency Medical Care Outside the U.S., not covered by Medicare

U9742G

- Basic Benefit Package
- Coverage for the Medicare Part A Deductible, as determined by Medicare
- Skilled Nursing copayment expense incurred while Medicare is paying Skilled Nursing Home benefits
- Covered expenses for Emergency Medical Care Outside the U.S., not covered by Medicare
- 80% of the Excess Charge you incurred for health care services and supplies of the type covered under Part B of Medicare, which exceeds the Medicare Eligible Expenses
- Home Care Benefit - up to \$40 per visit, with a calendar maximum of \$1,600.

You can select your Medicare Supplement Insurance Plan based on your individual needs.

FORM U9742A	FORM U9742D	FORM U9742F	FORM U9742G
BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS
	SKILLED NURSING CO-INSURANCE	SKILLED NURSING CO-INSURANCE	SKILLED NURSING CO-INSURANCE
	PART A DEDUCTIBLE	PART A DEDUCTIBLE	PART A DEDUCTIBLE
		PART B DEDUCTIBLE	
		PART B EXCESS (100%)	PART B EXCESS (80%)
	FOREIGN TRAVEL EMERGENCY	FOREIGN TRAVEL EMERGENCY	FOREIGN TRAVEL EMERGENCY
	AT HOME RECOVERY		AT HOME RECOVERY

Exclusions

Unless specifically stated otherwise, this policy does not cover or consider for payment any service or supply, or any portion of a service or supply that is not a Medicare Eligible Expense, nor will this policy duplicate any benefit paid by medicare. This policy has exclusions. For costs and complete details of the coverage, call your insurance agent or the company.



1275 Milwaukee Ave. Glenview, IL
1.800.207.8050

This is a solicitation of insurance. An agent may be in contact with you. United National Life Insurance Company of America and its representatives are independent and are not connected with or endorsed by the United States Government or the federal Medicare program.

SERFF Tracking Number: GRTT-126260941 State: Arkansas
 Filing Company: United National Life Insurance Company of America State Tracking Number: 43220
 Company Tracking Number: URA09-10
 TOI: MS05I Individual Medicare Supplement - Standard Plans Sub-TOI: MS05I.001 Plan A
 Product Name: Amendment Filing
 Project Name/Number: Amendment Filing /URA09-10

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 10/01/2009	Plan A Rates	U9740A	New		AR Rates.pdf

United National Life Insurance Company
Standardized Medicare Supplement Premium Rates
Annual Rates

ARKANSAS

	Preferred					Standard			
Age	Plan A	Plan D	Plan F	Plan G		Plan A	Plan D	Plan F	Plan G
All Ages	1,268.40	1,666.80	1,814.40	1,701.60		1,409.30	1,852.00	2,016.00	1,890.70

A discount factor of 0.93 is applied for married applicants

Zip Codes

720-722
 716-719, 723-729

Area Factors

0.93
 0.80

SERFF Tracking Number: GRTT-126260941 State: Arkansas
 Filing Company: United National Life Insurance Company of America State Tracking Number: 43220
 Company Tracking Number: URA09-10
 TOI: MS05I Individual Medicare Supplement - Standard Plans Sub-TOI: MS05I.001 Plan A
 Product Name: Amendment Filing
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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	10/01/2009

Comments:

Attachments:

AR_sub-Cert for UNL.pdf
 GANT_AR(Rev1_04).pdf
 readcert.pdf
 UNOT-03-AR (Rev. 7-04).pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Accepted for Informational Purposes	10/01/2009

Comments:

The application for approval is attached to the forms tab. This is a John Doe version for your reference.

Attachment:

John Doe Application.pdf

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		

Bypass Reason: This is not a policy form filing. We will use our outline of coverage which was approved with policy U9740A.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Commission Schedule	Accepted for Informational Purposes	10/01/2009

SERFF Tracking Number: GRTT-126260941 State: Arkansas
Filing Company: United National Life Insurance Company of America State Tracking Number: 43220
Company Tracking Number: URA09-10
TOI: MS05I Individual Medicare Supplement - Standard Plans Sub-TOI: MS05I.001 Plan A
Product Name: Amendment Filing
Project Name/Number: Amendment Filing /URA09-10

Comments:

Attachment:

Commission Schedule.pdf

		Item Status:	Status
Satisfied - Item:	Monthly Premium Rates	Accepted for Informational Purposes	Date: 10/01/2009

Comments:

Attachment:

Monthly rates.pdf

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Re: Policy Form URA09-10, UAPPH7-08, UADH2-09

The United National Insurance Company of America, Glenview, Illinois does hereby certify that this policy form submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements for this category of insurance pursuant to the Arkansas Department of Insurance.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA



Thomas Dunkin
President

Date August 11, 2009

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the **Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association")**. The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals).
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

CERTIFICATE OF READABILITY

Form Number(s): URA09-10, UAPPH7-08

Flesch Test Score(s): 43.42, 69.90

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA



Thomas Dunkin
President

Date August 11, 2009

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA
P. O. Box 1154, Glenview, IL 60025-1154
(847) 803-5252 or Toll-free 1-800-207-8050

Agent _____

Address _____

Telephone Number _____

IMPORTANT NOTICE

You may file a complaint with your state's Department of Insurance by writing:

Consumer Services Division
Arkansas Insurance Department
Room 120, First Floor
1200 West Third Street
Little Rock, AR 72201-1904

You may also contact the Consumer Services Division by telephone or fax at:

Telephone: (501) 371-2640
Toll-Free: 1-800-852-5494
Fax: (501) 371-2618

If you have Internet access, you may file an on-line complaint at the following email address:

Insurance.Consumers@mail.state.ar.us

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

[APPLICANT Last Name <u>Doe</u>		First Name <u>John</u>		M.I. <u>A</u>	
Soc. Security # <u>326-10-1000</u>	Age <u>64</u>	Date of Birth <u>9 11 5 11944</u>	Sex <u>M</u>	Height <u>518</u>	Weight <u>140 lbs</u>
ADDRESS Number & Street <u>123 Main St.</u>			City <u>Any City</u>	State <u>Any State</u>	Zip Code <u>70000</u>
MAILING ADDRESS (if different from above)			City	State	Zip Code

PLAN & PAYMENT INFORMATION 1. Requested Effective Date or Replacement Date: <u>9-1-09</u>		3. Premium Mode: <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft* Requested Draft Date _____ Application Fee: \$ _____ Total Modal Premium: \$ <u>000.00</u> Premium Paid with Application: \$ <u>000.00</u> *(1 month's premium required for bank draft)]	
2. I am applying for: a. Medicare Supplement Plan: Plan: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> G b. <input type="checkbox"/> Medicare Supplement High Deductible Plan F			

MEDICARE COVERAGE QUESTIONS If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER QUESTIONS 4 THROUGH 9 COMPLETELY. Please mark Yes or No with an "X". To the best of your knowledge:	
4. Are you covered or will you be covered under Medicare Parts A & B? (If the answer is "No", do not submit the application) If yes, what is your Medicare claim number? (exactly as it appears on your Medicare Card) <u>326-10-1000A</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5. a. Did you turn age 65 in the last 6 months? b. Did you enroll in Medicare Part B in the last 6 months or will you enroll in Medicare Part B in the next 6 months?.... If yes, what is/was the effective date? <u>9-1-09</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you covered for medical assistance through the state Medicaid program? (If the answer to 6a. or 6b. is "yes", do not submit the application.) NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. If you answer yes, a. Will Medicaid pay your premiums for this Medicare supplement policy? b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. a. Do you have another Medicare supplement policy in force?..... b. If so, with what company and what plan do you have? _____ c. If so, do you intend to replace your current Medicare supplement policy with this policy?..... d. If yes, what is the Termination Date of your other Medicare Supplement Policy? _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____ b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? c. Was this your first time in this type of a Medicare plan? d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? e. If your coverage has not ended please fill in a planned termination date? ____/____/____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

9. Have you had coverage under any other health insurance within the past 63 days?..... Yes No
 (For example, Railroad Retirees, teachers plans, an employer union, group major medical or individual plan)
 a. If so, with what company and what kind of policy?

 b. What are your dates of coverage under the other policy?
 START _____/_____/_____ END _____/_____/_____
 (If you are still covered under the other policy, leave the "END" blank.)
 c. If your coverage has not ended, please fill in a planned termination date? _____/_____/_____

HEALTH QUESTIONS

You do not have to answer questions 10 through 24 if you have enrolled in Medicare Part B within the past 6 months or are in a guarantee issue period. If not, and you answer "yes" to questions 10 through 23 below, you are not eligible for coverage

10. Are you currently hospitalized or confined to a nursing facility, or, are you bedridden or confined to a wheelchair? Yes No

11. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? Yes No

12. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, degenerative bone disease, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? Yes No

13. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? Yes No

14. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

15. Do you have diabetes, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, congestive heart failure, heart disease, or high blood pressure with three or more medications? Yes No

16. Do you have diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral)? Yes No

17. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation? Yes No

18. Within the past two years have you been treated, been advised to have treatment, been prescribed new medication or had changes in existing medication(s) for coronary or carotid artery disease, heart rhythm disorders including pacemakers or a defibrillator, a heart attack, congestive heart failure, or enlarged heart, stroke, transient ischemic attack (TIA), heart valve surgery, or peripheral vascular disease? Yes No

19. Within the past two years have you been treated for crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes No

20. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? Yes No

21. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes No

22. Have you been hospital confined three or more times in the last two years? Yes No

23. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No

24. Have you used any tobacco products in the past 12 months? Yes No

25. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes No
 If, "YES", please list the drug and the condition in the following table.

Applicant (please attach a separate sheet if needed)	
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition

DISCLOSURE & AUTHORIZATION

DISCLOSURE: You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy, (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for the outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

APPLICANT'S AUTHORIZATION & AGREEMENT: I authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc.. This Authorization includes all information about drugs, alcoholism, and mental illness. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by the Company in accordance with federal or state law. I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

ACKNOWLEDGEMENTS: The Applicant represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete. 2) Any coverage issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No agent or any other person is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of the application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime. 5) Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan which has been applied for, have been explained and are understood. 6) The applicant shall be owner of any insurance applied for. 7) The applicant acknowledges receipt of the Outline of Coverage, and has read the authorization and received copies of the "Notice to Applicant, Parts 1 and 2" describing the Medical Information Bureau and explaining the rights of the applicant under the Fair Credit Reporting Act.

AGREEMENT: I have read, or had read to me, the completed application. I hereby agree that: 1) all the statements and answers in this application are complete and true to the best of my knowledge and belief; and 2) **no insurance will be effective until my policy is issued.**

Caution: If your answers on this application are incorrect or untrue, United National Life Insurance Company of America may deny benefits or rescind your policy.

We are required to give you this notice: Any person who, with the intent to defraud or knowledge that he is facilitating a fraud against the insurer, submits an application or files a claim containing false, incomplete, or deceptive statements of material fact may be guilty of insurance fraud.

John Doe
Applicant's Signature

Ang City
City & State signed

8-15-09
Date

MAIL POLICY TO: Agent Insured

UAPPH7-08 3 7/09/09

Arkansas (Community Rated)

Attained Age	Plan A		Plan D		Plan F		Plan G	
	65-74	75+	65-74	75+	65-74	75+	65-74	75+
Years 1-6	25.0%	12.5%	25.0%	12.5%	25.0%	12.5%	25.0%	12.5%
Years 7-10	8.0%	4.0%	8.0%	4.0%	8.0%	4.0%	8.0%	4.0%
Years 11+	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Net Loss Ratio	70.8%	70.8%	71.0%	71.0%	71.0%	71.0%	71.0%	71.0%

¹Commissions are paid on original premium only

United National Life Insurance Company
Standardized Medicare Supplement Premium Rates
Monthly Rates

ARKANSAS

	Preferred					Standard			
Age	Plan A	Plan D	Plan F	Plan G		Plan A	Plan D	Plan F	Plan G
All Ages	105.70	138.90	151.20	141.80		117.44	154.33	168.00	157.56

A discount factor of 0.93 is applied for married applicants

<u>Zip Codes</u>	<u>Area Factors</u>
720-722	0.93
716-719, 723-729	0.80

SENIOR SELECT

Medicare
Supplement
Protection

Pick the

Plan that

Best Meets

Your Needs





Medicare Supplement Insurance Plan



United National Life Insurance Company's Medicare Supplement Insurance Plan is designed to work with the Federal Medicare program. Since Medicare Part A Hospital Deductibles are constantly rising, you may become responsible for paying a large amount of out-of-pocket health care expenses. Medicare Supplement Insurance from UNL can help cover health care costs that you must pay.

Features:

- *No Pre-Existing Limitations*

Coverage is available immediately.

- *Guaranteed Renewable*

Medicare Supplement Insurance is renewable for life. This means that as long as premiums are paid on time, your policy can never be canceled.

- *Premiums*

Your premiums cannot be changed due to declining health. Your premium can only be changed if we change premiums for all policies like yours in the state. If your premium changes, we will notify you in advance.

- *30-Day Free Look*

If you are not completely satisfied with your Medicare Supplement policy, simply return your policy within 30 days after you receive it for a complete refund of all premiums paid.

- *Grace Period*

Your Medicare Supplement policy provides a 31-day grace period. Premium notices are mailed to you well in advance of due dates.

- *Automatic Adjustment of Benefits*

Your Medicare Supplement Insurance policy will increase your covered deductibles and copayment benefits whenever these Medicare Deductibles and copayment amounts are increased by Medicare. Your premiums may change as your benefits change.

United National Life Insurance Company and its representatives are independent and are not connected to or endorsed by Medicare, the Social Security Administration, or any other state or federal government agency.

Your Basic Benefit Package provides the following:

Part A — Inpatient Care Benefits

Your Medicare Supplement Insurance Plan will provide benefits for the expenses you incurred due to an injury or sickness:

1. All copayment expenses incurred after the Medicare Part A Deductible during a hospital stay covered by Medicare. This includes the Medicare lifetime reserve co-payment amount.
2. Upon exhaustion of Medicare benefits, including lifetime reserve days, we will pay 100% of the Medicare Eligible Expenses incurred due to inpatient hospital care. This benefit starts on the day following the last day of coverage by Medicare. These expenses must be of the type Medicare would have covered if Medicare benefits were not exhausted. This benefit is subject to a lifetime maximum benefit of an additional 365 days.
3. The expense incurred for the first three pints of blood furnished on an inpatient basis (or the equivalent in packed red blood cells) which have not been replaced.

Part B — Medical Care Benefits

Your Medicare Supplement Insurance Plan will provide the following benefits for the expenses you incur due to an injury or illness.

1. The Medicare Part B copayment amount of the Medicare Eligible Expenses incurred, which exceed the Medicare Part B Annual Deductible.
2. The copayment for each Hospital Outpatient service and supply.
3. The Actual Charge for the first three pints of blood furnished on an outpatient basis (or the equivalent in packed red blood cells) which have not been replaced.

Choose from the following options:

U9742A

- Basic Benefit Package

U9742D

- Basic Benefit Package
- Coverage for the Medicare Part A Deductible, as determined by Medicare
- Skilled Nursing copayment expense incurred while Medicare is paying Skilled Nursing Home benefits
- Covered expenses for Emergency Medical Care Outside the U.S., not covered by Medicare
- Home Care Benefit - up to \$40.00 per visit, with a calendar maximum of \$1,600.

U9742F

- Basic Benefit Package
- Coverage for the Medicare Part A Deductible, as determined by Medicare
- Medicare Part B Annual Deductible, as determined by Medicare
- Skilled Nursing copayment expense incurred while Medicare is paying Skilled Nursing Home benefits
- 100% of the Excess Charge you incurred for health care services and supplies of the type covered under Part B of Medicare, which exceeds the Medicare Eligible Expenses
- Covered expenses for Emergency Medical Care Outside the U.S., not covered by Medicare

U9742G

- Basic Benefit Package
- Coverage for the Medicare Part A Deductible, as determined by Medicare
- Skilled Nursing copayment expense incurred while Medicare is paying Skilled Nursing Home benefits
- Covered expenses for Emergency Medical Care Outside the U.S., not covered by Medicare
- 80% of the Excess Charge you incurred for health care services and supplies of the type covered under Part B of Medicare, which exceeds the Medicare Eligible Expenses
- Home Care Benefit - up to \$40 per visit, with a calendar maximum of \$1,600.

You can select your Medicare Supplement Insurance Plan based on your individual needs.

FORM U9742A	FORM U9742D	FORM U9742F	FORM U9742G
BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS
	SKILLED NURSING CO-INSURANCE	SKILLED NURSING CO-INSURANCE	SKILLED NURSING CO-INSURANCE
	PART A DEDUCTIBLE	PART A DEDUCTIBLE	PART A DEDUCTIBLE
		PART B DEDUCTIBLE	
		PART B EXCESS (100%)	PART B EXCESS (80%)
	FOREIGN TRAVEL EMERGENCY	FOREIGN TRAVEL EMERGENCY	FOREIGN TRAVEL EMERGENCY
	AT HOME RECOVERY		AT HOME RECOVERY

Exclusions

Unless specifically stated otherwise, this policy does not cover or consider for payment any service or supply, or any portion of a service or supply that is not a Medicare Eligible Expense, nor will this policy duplicate any benefit paid by medicare. This policy has exclusions. For costs and complete details of the coverage, call your insurance agent or the company.



1275 Milwaukee Ave. Glenview, IL
1.800.207.8050