

SERFF Tracking Number: TAPK-126424787 State: Arkansas
Filing Company: Central United Life Insurance Company State Tracking Number: 44370
Company Tracking Number:
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: Accident Additional Units
Project Name/Number: /

Filing at a Glance

Company: Central United Life Insurance Company

Product Name: Accident Additional Units SERFF Tr Num: TAPK-126424787 State: Arkansas
TOI: H02I Individual Health - Accident Only SERFF Status: Closed-Approved- State Tr Num: 44370
Closed

Sub-TOI: H02I.000 Health - Accident Only Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Suzanne Heasley Disposition Date: 12/21/2009
Date Submitted: 12/17/2009 Disposition Status: Approved-Closed
Implementation Date: Implementation Date:

Implementation Date Requested:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile:
Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type:
Submission Type: Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 12/21/2009 Explanation for Other Group Market Type:
State Status Changed: 12/21/2009
Deemer Date: Created By: Suzanne Heasley
Submitted By: Suzanne Heasley Corresponding Filing Tracking Number:
Filing Description:
See attached submission letter

Company and Contact

Filing Contact Information

Suzanne Heasley, Uheas@aol.com
2325 Havard Oak Drive 972-398-3733 [Phone]
Plano, TX 75074 972-398-3733 [FAX]

Filing Company Information

SERFF Tracking Number: TAPK-126424787 State: Arkansas
 Filing Company: Central United Life Insurance Company State Tracking Number: 44370
 Company Tracking Number:
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: Accident Additional Units
 Project Name/Number: /

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

Central United Life Insurance Company	CoCode: 61883	State of Domicile: Texas
10700 Northwest Freeway	Group Code: 1117	Company Type: Life and Health
Houston, TX 77092	Group Name:	State ID Number:
(713) 529-0045 ext. [Phone]	FEIN Number: 42-0884060	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Central United Life Insurance Company	\$50.00	12/17/2009	32879338

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/21/2009	12/21/2009

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Disposition

Disposition Date: 12/21/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Submission Letter	Approved-Closed	Yes
Supporting Document	Authorizations	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 12/21/2009	CUL- ESAE-AR- 1109	Application/ Enrollment Form	Application	Initial			CUL-ESAE- AR-1109.pdf
Approved- Closed 12/21/2009	EAP-SCH- 1109	Schedule Pages	Schedule of Benefits	Initial			Policy Schedule generic revised.pdf

CENTRAL UNITED LIFE INSURANCE COMPANY

10700 Northwest Freeway, Houston, Texas 77092

Application for: Enhanced Supplemental Accident Expense Policy

Requested Effective/Draft Date: _____

PART 1 - GENERAL INFORMATION

1. PERSONS TO BE COVERED

Name (Please PRINT Full Name)	Relationship	Gender	Date of Birth	Age	Height Ft. In.	Weight Lbs.	Social Security Number
1.	Applicant						- -
2.	Spouse						- -
3.	Child						- -
4.	Child						- -
5.	Child						- -

2. APPLICANT'S HOME ADDRESS

Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: (_____) _____
 Work Phone: (_____) _____
 Email Address: _____

3. PREMIUM PAYOR ADDRESS (if different than Applicant)

Premium Payor Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: (_____) _____

4. EMPLOYMENT INFORMATION (All adult applicants)

Employer's Name: _____
 Occupation/Duties: _____
 Spouse's Employer's Name (if applying): _____
 Spouse's Occupation/Duties: _____

5. BENEFIT INFORMATION: Accident Policy

Benefit Amount: Medical Expense Benefit
 .5 Unit 1.0 Unit 1.5 Unit 2.0 Units
 \$1,000 \$2,000 \$2,500 \$3,000
 Plan Type: Individual Individual & Spouse
 Single Parent Family Child(ren) Only
 Billing Method: Monthly Bank Draft Direct Bill List Bill
 Billing Mode: Monthly Quarterly Semi-Annual Annual

6. OPTIONAL RIDER: Accident Disability Rider Yes No

Occupation: Type 1 Type 2
 Benefit Amount: Accident Disability Monthly Income Benefit
 .5 Unit 1.0 Unit 1.5 Unit 2.0 Units
 \$500 \$1,000 \$1,500 \$2,000
 Units elected for Optional Accident Disability Rider may be less than or equal to but cannot exceed the number of units elected for the Accident Policy.

7. BENEFICIARY

Name: _____
 Relationship: _____

8. PRIMARY PHYSICIAN

Name: _____
 Address: _____
 Phone: _____

PART 2 - REPRESENTATION & QUESTIONS OF THE APPLICANT

	YES	NO
1. Are all persons to be insured to the best of your knowledge and belief in good health and free from physical impairment or abnormality?	<input type="checkbox"/>	<input type="checkbox"/>
2a. Is any person to be insured engaged in any hazardous sports or activities including racing, but not limited to parachuting, rodeo riding, motorcycling, mountain climbing, scuba diving or intend to do so?	<input type="checkbox"/>	<input type="checkbox"/>
2b. Is any person to be insured a member/participant in a semi-professional or professional sport?	<input type="checkbox"/>	<input type="checkbox"/>
3a. Have you had a driver's license suspended or revoked within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
3b. Have you had a DWI or DUI within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
3c. Is any person to be insured currently under treatment or has any person to be insured been under treatment for drug or alcohol abuse in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are all persons to be insured ages 19 to 25 years old enrolled as a full time student in an accredited school or college?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there any other health, accident or disability insurance in force on the proposed insured?	<input type="checkbox"/>	<input type="checkbox"/>
6. Will the insurance applied for replace or change any existing insurance?	<input type="checkbox"/>	<input type="checkbox"/>

If YES, give name of Company and type of insurance: _____

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Central United Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

Date _____ X _____ Signature (as it appears on bank records) _____

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____ Name of Employer

to deduct from my salary and pay to Central United Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____, 20____ \$ _____ each month.

Signature of Employee _____ Date _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

- A. I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Central United Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in the circumstances permitted by 28 TAC § 21.704.
- B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer, the Medical Information Bureau, Inc. ("MIB") or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Central United Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy.
- C. Central United Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply.
- D. This authorization will be valid from the date signed for a period of two and one half years.
- E. I authorize Central United Life Insurance Company to obtain an investigative consumer report on me.

Dated: _____ Dated at: _____

Signed X _____ Signature of Proposed Insured Signed X _____ Signature of Spouse

APPLICANT'S STATEMENT

I hereby apply to Central United Life Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; and (d) no change to the policy will be valid until approved by an officer of the Company which must be noted on or attached to the policy. I have read, or have read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief. I acknowledge I have received an Outline of Coverage for the policy applied for.

WARNING: 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.

I understand that if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income.

Dated at _____ on _____ 20____

Signature of Applicant: _____ Signature of Spouse: _____

AGENT'S STATEMENT

I Certify: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) I have given an outline of coverage for the policy applied for to the Applicant. 3) This does does not replace other insurance.

Dated _____ on _____ 20____

Agent Name (Print) _____ Agent Signature _____ Agent Number _____

CENTRAL UNITED LIFE INSURANCE COMPANY

10700 Northwest Freeway
Houston, Texas 77092

POLICY SCHEDULE

SUPPLEMENTAL ACCIDENT EXPENSE POLICY

Primary Insured:	Issue Age:
Insured Dependents:	Mode of Payment:
Policy Number:	First Renewal Date:
Effective Date:	Initial Premium:

POLICY

Units Purchased	[.5; 1; 1.5; 2]
Accidental Death Benefit	[\$25,000; \$50,000; \$75,000; \$100,000]
Medical Expense Benefit	[\$1,000; \$2,000; \$3,000; \$4,000]
Daily Hospital Confinement Benefit	[\$75; \$150; \$225; \$300]
Air or Ground Ambulance Benefit	[\$2,500; \$5,000; \$7,500; \$10,000]
Accidental Dismemberment Benefit	
Loss of Finger or Toe	
Single Loss Benefit	[\$250; \$500; \$750; \$1,000]
Multiple Loss Benefit	[\$500; \$1,000; \$1,500; \$2,000]
Loss of Hand, Arm, Foot, Leg	
Single Loss Benefit	[\$2,500; \$5,000; \$7,500; \$10,000]
Multiple Loss Benefit	[\$5,000; \$10,000; \$15,000; \$20,000]
Loss of Sight	
Single Loss Benefit	[\$2,500; \$5,000; \$7,500; \$10,000]
Multiple Loss Benefit	[\$5,000; \$10,000; \$15,000; \$20,000]
Maximum Dismemberment Per Accident	[\$5,000; \$10,000; \$15,000; \$20,000]

OPTIONAL BENEFIT FOR ACCIDENT DISABILITY INCOME RIDER [Yes; No]

Units Purchased	[.5; 1; 1.5; 2]
Monthly Income Benefit	[\$500; \$1,000; \$1,500; \$2,000]
Elimination Period	30 Days
Maximum Benefit Period	[6; 12; 18; 24] Months

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	12/21/2009
Comments:		
Attachment: Readability certificate for revised additional units.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	12/21/2009
Bypass Reason: Application is included in the form schedule		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	12/21/2009
Bypass Reason: This submission is for an application and schedule only. The outline of coverage previously approved will be used with these forms as outlined in the submission letter.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Submission Letter	Approved-Closed	12/21/2009
Comments:		
Attachment: Submission letter for revised additional units AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Authorizations	Approved-Closed	12/21/2009
Comments:		
Attachments:		

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Product Name: Accident Additional Units
Project Name/Number: /
Central United Authorization.pdf
2009L&EauthorizationformHeasley.pdf

Readability Certification

Insurance Company: Central United Life Insurance Company

<u>Form Number</u>	<u>Description of Form</u>
CUL-ESAE-AR-1109 EAP-SCH-1109	Application for Enhanced Supplemental Accident Expense Policy Schedule of Benefits

I hereby certify that the above referenced form complies with the readability requirements of this State.

Mary Lou Rainey

Authorized Signature

Mary Lou Rainey

Name

Secretary

Title

December 17, 2009

Date



T. ALLEN PARK & ASSOCIATES, INC.

2325 Havard Oak Drive Plano, TX 75074
(972) 398-3733 Uheas@aol.com

December 17, 2009

Arkansas Department of Insurance
Life and Health Section
1200 West Third Street
Little Rock, AR 72201

RE: Central United Life Insurance Company NAIC # 61883

CUL-ESAE-AR-1109 Application for Enhanced Supplemental Accident Expense Policy
EAP-SCH-1109 Alternate Schedule of Benefits

Dear Sir or Madam:

This filing is being submitted on behalf of Central United Life Insurance Company. The above referenced forms are submitted for your review and approval. These forms are new and not intended to replace any previously approved forms.

These forms provide additional options of coverage to the Policyholder by adding the choice of .5 Unit of coverage as well as a 1.5 Unit of coverage, making the total choices of 4 options of coverage. Form CUL-ESAE-AR-1109 is an additional alternate application to application form CUL-ESAE-AR and EAP-APP-AR approved by your office on April 7, 2008 and March 19, 2008, respectively. This application includes the additional unit options.

Form EAP-SCH-1109 is an additional alternate schedule of benefits to form EAP-SCH approved by your office on March 19, 2008. This schedule of benefits will be used in connection with the additional unit options.

Attached is the actuarial memorandum which has been revised to address the additional unit options.

When approved, these forms will be used with the following forms approved by your office as shown below:

FORM NUMBER	FORM DESCRIPTION	APPROVAL DATE
EAP-AR	Supplemental Accident Expense Policy	March 19, 2008
EAP-OC-AR	Outline of Coverage	March 19, 2008
EAP-DR	Accident Income Disability Benefit Rider	March 18, 2008
EAP-DR 07/08-AR	Accident Income Disability Benefit Rider	August 28, 2008
EAP-AR-Notice	Required Notice	March 19, 2008

Should you have any questions or need additional information, please do not hesitate to call me at (972) 398-3733.

Sincerely,

Suzanne Heasley, FLMI, CLU
Legal Assistant and Compliance Specialist

CENTRAL UNITED LIFE

January 12, 2009

Filing Authorization
Lewis & Ellis, Inc.
2929 N. Central Expressway, Suite 200
P.O. Box 851857

RE: Central United Life Insurance Company

To Whom It May Concern:

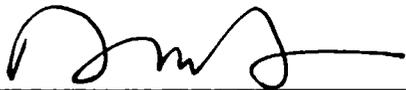
We hereby authorize Lewis & Ellis, Inc. to submit state filings of insurance forms/rates/products on behalf of Central United Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Central United Life Insurance Company.

Sincerely,

CENTRAL UNITED LIFE INSURANCE COMPANY



Signature of Company Officer/Representative

Dallas

Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Steven D. Bryson, F.S.A.
Michael A. Mayberry, F.S.A.
Gregory S. Wilson, F.C.A.S.
David M. Dillon, F.S.A.
Bonnie S. Albritton, F.S.A.
Brian D. Rankin, F.S.A.
Robert E. Gove, A.S.A.
Alexis M. Bash, A.S.A.
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)



Kansas City

Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
David L. Batchelder, A.S.A.
Leon L. Langlitz, F.S.A.
Gary R. McElwain, FLMI
Christopher H. Davis, F.S.A.
Thomas L. Handley, F.S.A.
Anthony G. Proulx, F.S.A.
Karen E. Elsom, F.S.A.

London

Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

January 19, 2009

Re: Filing Authorization
T. Allen Park & Associates, Inc.
9441 LBJ Freeway, Suite 102
Dallas, TX 75074

Re: Central United Life Insurance Company

To Whom It May Concern:

I hereby authorize Suzanne Heasley and Vicki Rowe to submit state filings of insurance forms/rates/products on behalf of Lewis & Ellis, Inc. regarding the Central United Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Lewis & Ellis, Inc.

A handwritten signature in cursive script that reads 'David M. Dillon'. The signature is written in black ink and is positioned above a horizontal line.

David M. Dillon, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.