

SERFF Tracking Number: GRTT-126010524 State: Arkansas  
Filing Company: United National Life Insurance Company of America State Tracking Number: 41928  
Company Tracking Number: UAPPH2-08  
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
Product Name: UAPPH2-08  
Project Name/Number: Malin Application (Individual)/

## Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: UAPPH2-08 SERFF Tr Num: GRTT-126010524 State: ArkansasLH  
TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed State Tr Num: 41928  
Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: UAPPH2-08 State Status: Approved-Closed  
Filing Type: Form/Rate Co Status: Reviewer(s): Rosalind Minor  
Author: Ann Ryan Disposition Date: 02/02/2009  
Date Submitted: 01/28/2009 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: Malin Application (Individual)  
Project Number:  
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 02/02/2009  
State Status Changed: 02/02/2009  
Corresponding Filing Tracking Number:

Filing Description:

Re: Individual Accident and Sickness  
Application UAPPH2-08  
Actuarial Memorandum and Rates

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: Filed in IL, our  
state of domicile, on 1-26-09  
Market Type: Individual  
Group Market Size:  
Group Market Type:  
Deemer Date:

Dear Sir or Madam:

SERFF Tracking Number: GRTT-126010524 State: Arkansas  
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We are submitting the above referenced application for your review and approval.

It is new and will be used with policy form U0552-AR, which was approved by your Department on 3-23-07.

The application will be used by licensed agents appointed by our company to sell our approved products.

For your approval, we are also enclosing the actuarial memorandum and rates for additional benefit options for the above referenced policy.

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. Any variable information is bracketed.

Your consideration and approval of this filing would be appreciated.

## Company and Contact

### Filing Contact Information

Ann Ryan, aryan@gtlic.com  
1275 Milwaukee Ave. (847) 904-5587 [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  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$150.00

SERFF Tracking Number: GRTT-126010524 State: Arkansas  
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Retaliatory? Yes  
Fee Explanation: IL, our state of domicile, filing fee is \$50 per form, no fee for rates. AR filing fee is \$20 per form, \$50 for rates per form.  
Per Company: Filing fee for this filing will equal \$150 (\$50 form, \$100 rate)  
No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United National Life Insurance Company of America	\$150.00	01/28/2009	25334503

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/02/2009	02/02/2009

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## Disposition

Disposition Date: 02/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	No
Supporting Document	Statement of Variability	Approved-Closed	No
Form	Application	Approved-Closed	No
Rate	Policy Rate Sheet	Approved-Closed	No
Rate	Rider Rate Sheet	Approved-Closed	No

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## Form Schedule

Lead Form Number: UAPPH2-08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	UAPPH2-08	Application/Enrollment Form	Application/ Enrollment Form	Initial		49	UAPPH2-08.pdf

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
**P.O. BOX 1154, GLENVIEW, ILLINOIS 60025-1154**

**APPLICATION FOR A HOSPITAL CONFINEMENT INDEMNITY POLICY - FORM U0552**

**APPLICANT INFORMATION**

Person(s) Applying for Coverage	Age	Date of Birth	Sex	Height	Weight	Occupation	Social Security Number
Applicant (A):							
Spouse (S):							
Child 1 (C):							
Child 2 (C):							
Child 3 (C):							
Child 4 (C):							

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**BENEFITS BEING APPLIED FOR**

[Hospital Benefit To 365 Days	Child Rider	Doctor's Per Visit Benefit	Outpatient Benefit (Per Visit)	Ambulance Benefit
<input type="checkbox"/> \$1,000 Daily, <input type="checkbox"/> \$500 Daily or <input type="checkbox"/> \$100 Daily	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$75.00	\$250.00	\$200.00]

**QUALIFYING MEDICAL QUESTIONS**

1. Within the past 12 months has any person to be insured been confined to a hospital, nursing home or other medical facility or been disabled or been advised to have surgery but have not yet done so? .....  Yes  No  
 If yes, indicate which person, condition, diagnosis, dates and types of treatment: \_\_\_\_\_
2. In the past 24 months has any person to be insured been diagnosed or treated by a medical professional for a heart condition, stroke, internal cancer or malignant melanoma, chronic obstructive lung disease, insulin dependent diabetes chronic liver or chronic kidney disease or drug or alcohol use? .....  Yes  No  
 If yes, indicate which person, condition, diagnosis, dates and types of treatment: \_\_\_\_\_
3. Has any person to be insured been medically diagnosed or receiving or been advised by a doctor to seek treatment for being HIV-positive or having AIDS or AIDS-Related Complex?.....  Yes  No  
 If yes, indicate which person, condition, diagnosis, dates and types of treatment: \_\_\_\_\_

**OTHER HEALTH COVERAGE**

4. Please list all existing or pending coverage and indicate who is covered and if this coverage is to be replaced by this policy. (Attach additional signed & dated sheet if more room needed.)

Who Covered?	Replacing?	Company Name	Type of Coverage
<input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
<input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

**PREMIUM**

Insurance Coverage	\$ _____
Association Dues	\$ _____
<b>TOTAL PAYMENT DUE</b>	<b>\$ _____</b>

Please make check/money order payable to:

**United National Life Insurance Co.**

Billing Method:  Bank Draft  Direct Bill  List Bill  
 Payment Mode:  Annual  Semi-Annual  Monthly

**APPLICANT'S STATEMENTS**

I HEREBY APPLY for an insurance policy as indicated on this Application. I have read or had read to me the completed application. To the best of my knowledge and belief, the answers to the above questions are true and complete.

I UNDERSTAND AND AGREE that: (1) this coverage will be issued based solely and entirely upon my answers to the above questions; (2) no coverage will exist until a Policy is issued, and will be in force only as of the Policy effective date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my Policy; (4) any loss for a pre-existing condition will not be covered for the first 12 months my coverage is in force.

**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, which is a crime and may subject such person to criminal and civil penalties.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

I certify that I have accurately recorded the information supplied by the Applicant. I further certify that I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it.

Witness - Agent's Signature: \_\_\_\_\_

Agent's Name: \_\_\_\_\_ Agent's Number(s): \_\_\_\_\_

Agent's Email Address: \_\_\_\_\_



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## Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed	Policy Rate Sheet	U0552-AR	New		Policy Rates.pdf
Approved-Closed	Rider Rate Sheet	RU060552-AR	New		Child Rider Rate .pdf

Premium Tables - G0551, GC2005, U0552, UC2005

Table 1		BENEFIT OPTION									
Daily Hospital Indemnity	\$100	\$200	\$300	\$400	\$500	\$600	\$700	\$800	\$900	\$1,000	
Elimination period	None	None	None	None	None	None	None	None	None	None	None
Lifetime Maximum	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days
Doctor Office Visit	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week
Maximum per Calendar Year	\$750	\$750	\$750	\$750	\$750	\$750	\$750	\$750	\$750	\$750	\$750
Hospital Outpatient Visit	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250
Ambulance	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200
	Issue Age	Annual Premium									
	18-39	\$ 393.26	\$ 431.32	\$ 469.37	\$ 507.43	\$ 545.49	\$ 583.55	\$ 621.61	\$ 659.66	\$ 697.72	\$ 735.78
	40-44	\$ 393.26	\$ 438.93	\$ 484.60	\$ 530.27	\$ 575.94	\$ 621.61	\$ 667.27	\$ 712.94	\$ 758.61	\$ 804.28
	45-49	\$ 438.20	\$ 497.57	\$ 556.94	\$ 616.31	\$ 675.68	\$ 735.05	\$ 794.42	\$ 853.79	\$ 913.16	\$ 972.53
	50-54	\$ 606.74	\$ 668.66	\$ 730.58	\$ 792.50	\$ 854.42	\$ 916.34	\$ 978.26	\$ 1,040.17	\$ 1,102.09	\$ 1,164.01
	55-59	\$ 606.74	\$ 698.37	\$ 789.99	\$ 881.62	\$ 973.24	\$ 1,064.87	\$ 1,156.49	\$ 1,248.12	\$ 1,339.74	\$ 1,431.37
	60-64	\$ 853.93	\$ 975.92	\$ 1,097.91	\$ 1,219.90	\$ 1,341.89	\$ 1,463.88	\$ 1,585.87	\$ 1,707.86	\$ 1,829.85	\$ 1,951.84

Table 2	Annual Premium
Issue Ages	Per 100/day
18-39	38.06
40-44	45.67
45-49	59.37
50-54	61.92
55-59	91.63
60-64	121.99

Mode	Factor
Annual	1.000
Quarterly	0.259
Semi-An	0.509
PAC	0.089
Dir Mo	0.100

Table 2 is the premium for the optional additional 100/day Hosp Confinement benefit  
 Table 2 is reflected in the premium table #1. It is shown here for clarity

Premium Tables - RG06551, RG062005, RU062005, RU060552

Child Rider - Option 1	RIDER BENEFIT OPTION 1 (\$50 Dr Office Visit)									
Daily Hospital Indemnity	\$100	\$200	\$300	\$400	\$500	\$600	\$700	\$800	\$900	\$1,000
Elimination period	None	None	None	None	None	None	None	None	None	None
Lifetime Maximum	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days
Doctor Office Visit	\$50/Week	\$50/Week	\$50/Week	\$50/Week	\$50/Week	\$50/Week	\$50/Week	\$50/Week	\$50/Week	\$50/Week
Maximum per Calendar Year	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250
Hospital Outpatient Visit	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250
Ambulance	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200
Annual Premium 1st Child	\$449.44	\$464.61	\$479.78	\$494.95	\$510.12	\$525.29	\$540.46	\$555.63	\$570.80	\$585.97
Annual Premium Per Child - Each Additional Child	\$0.00	\$15.17	\$30.34	\$45.51	\$60.68	\$75.85	\$91.02	\$106.19	\$121.36	\$136.53

Child Rider - Option 2	RIDER BENEFIT OPTION 2 (\$75 Dr Office Visit)									
Daily Hospital Indemnity	\$100	\$200	\$300	\$400	\$500	\$600	\$700	\$800	\$900	\$1,000
Elimination period	None	None	None	None	None	None	None	None	None	None
Lifetime Maximum	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days	365 Days
Doctor Office Visit	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week	\$75/Week
Maximum per Calendar Year	375	375	375	375	375	375	375	375	375	375
Hospital Outpatient Visit	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250
Ambulance	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200
Annual Premium 1st Child	\$561.80	\$576.97	\$592.14	\$607.31	\$622.48	\$637.65	\$652.82	\$667.99	\$683.16	\$698.33
Annual Premium Per Child - Each Additional Child	\$0.00	\$15.17	\$30.34	\$45.51	\$60.68	\$75.85	\$91.02	\$106.19	\$121.36	\$136.53

The optional additional 100/day Hosp Confinement benefit annual premium is \$15.17/100/per child and is reflected in the above tables

Mode Factors							
Annual	1.000	Quarterly	0.259	Semi-An	0.509	PAC	0.089

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## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 02/02/2009  
**Comments:**  
 Flesch Certification and Certificate of Compliance.  
 The Guarantee Association Notice and Consumer Information Notices are not applicable to this application filing.  
**Attachments:**  
 Readcert for UAPPH2-08.pdf  
 AR\_sub-Cert for UNL.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 02/02/2009  
**Bypass Reason:** See Form Schedule. We are filing a new application only.  
**Comments:**

**Bypassed -Name:** Outline of Coverage **Review Status:** Approved-Closed 02/02/2009  
**Bypass Reason:** Not applicable.  
**Comments:**

**Satisfied -Name:** Statement of Variability **Review Status:** Approved-Closed 02/02/2009  
**Comments:**  
 Statement of variability for UAPPH2-08  
**Attachment:**  
 AR Statement of Variability.pdf

**CERTIFICATE OF READABILITY**

Form Number(s): UAPPH2-08

Flesch Test Score(s): 49.25

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: January 28, 2009

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Re: Policy Form UAPPH2-08

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



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Thomas Dunkin  
President

Date 1/28/09

**United National Life Insurance Company of America**

**Statement of Variability  
For  
UAPPH2-08 (Application)**

The bracketing of variable text in Application form UAPPH2-08 is limited to the following:

**Under the section entitled Benefits Being Applied For**

1. The Daily benefits range from \$100 a day to \$1,000 a day
2. The doctor office visits can be \$50 or \$75
3. The other benefits don't vary.

Variability is limited to changing these portions only in context that remains compliant with Arkansas regulatory requirements. Any new benefit plans, benefit periods, or premium rates will be filed with the Arkansas Department of Insurance before use. The Company reserves the right to discontinue marketing benefit riders not mandated under state law.



Thomas Dunkin, President  
United National Life Insurance Company of America  
January 28, 2009