

SERFF Tracking Number: UHLC-126075491 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 41828
Company Tracking Number: A42805USMMAR01 01A
TOI: MS05G Group Medicare Supplement - Standard Sub-TOI: MS05G.001 Plan A
Plans
Product Name: Medicare Supplement
Project Name/Number: Co-Marketing Enrollment Application/A42805USMMAR01 01A

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: Medicare Supplement SERFF Tr Num: UHLC-126075491 State: ArkansasLH

TOI: MS05G Group Medicare Supplement - Standard Plans SERFF Status: Closed State Tr Num: 41828

Sub-TOI: MS05G.001 Plan A Co Tr Num: A42805USMMAR01 State Status: Approved-Closed
01A

Filing Type: Form Co Status: Reviewer(s): Stephanie Fowler
Author: Tammy Frederick Disposition Date: 03/19/2009
Date Submitted: 03/16/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Co-Marketing Enrollment Application

Project Number: A42805USMMAR01 01A

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/19/2009

Deemer Date:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 03/19/2009

Corresponding Filing Tracking Number:
A42805USMMAR01 01A

Filing Description:

We enclose for your information and review, proof copies of an enrollment application for use in connection with the AARP group health insurance program. This enrollment application replaces previously filed enrollment application A4282605USMMAR0101A which was approved by the Department on February 5, 2009 under the Department's File No: 41461 and SERFF File No: UHLC-126021865

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The definitions, disclosures, eligibility requirements, exclusions, limitations, Group Policy Form No. GRP 79171 GPS-1, as well as, the statement, "...not connected with, or endorsed by, the U.S. Government or the federal Medicare program," can be found in BA8982 DIS AR (02/06) which was approved by your Department on March 20, 2006 under the Department's File No: 30566.

Members who enroll in the AARP Medicare Supplement Plans will be issued certificates with Certificate Form Nos. MSA 1959, et al which were approved by your Department on September 1, 2005.

ARKANSAS

LIST OF ENCLOSURES

MEDICARE SUPPLEMENT

CO-MARKETING ENROLLMENT APPLICATION

2009

A42805USMMAR01 01A ENROLLMENT APPLICATION

BA8982 DIS AR (02/06) WRAP*

CV463 COVER PAGE**

FA528 – FA529, FA572 – FA581 OUTLINE OF COVERAGE***

*THIS COMPONENT WAS APPROVED BY THE DEPARTMENT ON 3/20/06 UNDER FILE NUMBER BA8982 DIS AR (02/06) AND YOUR DEPARTMENT FILE NUMBER 30566.

**THESE COMPONENTS WERE APPROVED BY THE DEPARTMENT ON 9/1/05 UNDER FILE NUMBER MSA 1959.

*** THIS COMPONENT WAS APPROVED BY THE DEPARTMENT ON 9/5/07 UNDER FILE NUMBER CV463.

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Company and Contact

Filing Contact Information

Susan Cipollo, Director Susan_J_Cipollo@uhc.com
 680 Blair Mill Rd. (215) 902-8444 [Phone]
 Horsham, PA 19044 (215) 902-8813[FAX]

Filing Company Information

UnitedHealthcare Insurance Company CoCode: 79413 State of Domicile: Connecticut
 450 Columbus Boulevard Group Code: 707 Company Type: Life and Health
 PO Box 150450
 Hartford, CT 06115-0450 Group Name: State ID Number:
 (860) 702-5000 ext. [Phone] FEIN Number: 36-2739571

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: \$20.00 per Enrollment Form - 1 form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$20.00	03/16/2009	26437264

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	03/19/2009	03/19/2009

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Disposition

Disposition Date: 03/19/2009

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	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Enrollment Application	Approved	Yes

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Form Schedule

Lead Form Number: A42805USMMAR01 01A

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	A42805USMMAR01 01A	Application/ Enrollment Form	Enrollment Application	Initial		40	A42805USMMAR01 01A_file3.6.pdf

PERSONALIZED APPLICATION FOR <JOE SAMPLE>



**AARP® MedicareRx Plans and AARP Medicare Supplement Insurance Plans
Insured by United HealthCare Insurance Company.**

<AARP Membership Number: 000000000000>

<Joe Sample>
<123 Main Street>
<Anytown, USA 12345-6789>

Please make any corrections to your name and address below. Please do not use P.O. boxes.

The plans and rates described in this package are good only for the address indicated.

LET'S GET STARTED—SEND NO MONEY NOW

For Medicare prescription drug coverage (Part D)—COMPLETE SECTIONS IA–8

For Medicare supplement coverage—COMPLETE SECTIONS IB–3, 9 AND 10

For both—COMPLETE SECTIONS I–10

Please check boxes in INK.

I Select the coverage(s) that best meets your needs	
IA Medicare prescription drug coverage (Part D) I wish to apply for the (select only one) See the “Summary of Benefits” insert for more information.	<input type="checkbox"/> AARP MedicareRx Preferred <input type="checkbox"/> AARP MedicareRx Enhanced <input type="checkbox"/> AARP MedicareRx Saver
IB Medicare supplement coverage I wish to apply for the following AARP Medicare Supplement Insurance Plan (select only one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan H <input type="checkbox"/> Plan I <input type="checkbox"/> Plan J <input type="checkbox"/> Plan K <input type="checkbox"/> Plan L See the “Outline of Medicare Supplement Coverage” – cover page insert for more information.	



If return envelope is lost or misplaced, please mail this application to:
<United HealthCare Insurance Company, c/o AARP Health, P.O. Box 105331, Atlanta, GA 30348-5331>

Keep space clear for barcode

CONTINUE ON NEXT PAGE

AARP MedicareRx Plans Application page 1 of 3

4 Prescription drug coverage—please answer the following questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to one of our AARP MedicareRx Plans? Yes No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

Note: If you already have creditable coverage, as good as a standard Medicare Part D plan, you do not have to sign up for a Medicare Part D plan.

2. Do you, on your own or through your spouse, have any additional primary, supplemental, or liability plan other than Medicare that includes prescription drug coverage? Yes No

If "no," you may have to pay a Medicare late enrollment penalty. The AARP MedicareRx Plans may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If MedicareRx Plans asks you to provide proof of your previous coverage and you do not provide it, your premium may be increased because of late enrollment penalty. If you have questions about the late enrollment penalty, call the AARP MedicareRx Plans at 1-888-867-5564 <TTY: 1-877-730-4192, 24 hours a day, 7 days a week.> You may also visit www.medicare.gov or call 1-800-MEDICARE 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

AARP MedicareRx Plan information is available in different formats, including Spanish and large print. Please call UnitedHealthcare Customer Care at <1-XXX-XXX-XXXX> <TTY: 1-XXX-XXX-XXXX, 24 hours a day, 7 days a week> if you need plan information in another format or language.

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If "yes," please provide the following information:

Name of Facility: _____

Address & Phone Number of Facility: _____

5 Prescription drug coverage—your plan premium payment options

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check, or you can pay through Electronic Funds Transfer from your checking, savings account, or choose a payment coupon book.

Please select one monthly payment option by checking the appropriate box below.

If you select Electronic Funds Transfer, please include the requested information.

Electronic Funds Transfer from your bank account
(Please enclose a blank check with VOID written on the front.)

Account Holder Name: _____

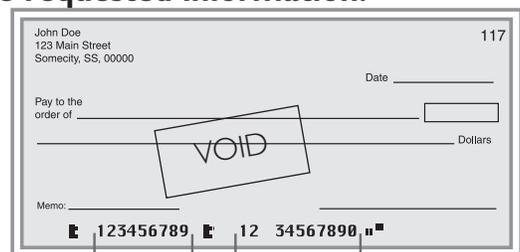
Bank Routing Number: _____

Bank Account Number: _____

Account type: Checking Savings

Payment coupon book for monthly payments by check

Monthly Social Security Administration Benefit Check Deduction



Bank Account Number
Bank Routing Number

The Social Security deduction may take two or more months to begin.

In most cases, the first deduction from your Social Security benefit check

will include all premiums due from your enrollment effective date up to the point withholding begins.

If no option is chosen, you will receive a payment coupon book. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. If Medicare pays only a portion of this premium, please choose an option above for the remaining premium.

6 Prescription drug coverage—please read this important information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage Plan that will meet your needs. By joining one of the AARP MedicareRx Plans, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage Plan sends you and, if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from a plan sponsor (former employer, union, or trust administrator), joining one of the AARP MedicareRx Plans could affect your employer or union health benefits. If you have health coverage from a plan sponsor, joining one of the AARP MedicareRx Plans may change how your current coverage works. Read the communications your plan sponsor sends you. If you have questions, visit their web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help. For AARP Medicare Enhanced plan, please note: you cannot enroll in this plan if your current or former employer helps pay for your prescription drugs.

7 Prescription drug coverage—please read and sign below

By completing this Enrollment Application, I agree to the following:

The AARP MedicareRx Plans are Medicare drug plans and have a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform the AARP MedicareRx Plans of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare prescription drug plan, my enrollment in the AARP MedicareRx Plans will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15–December 31), unless I qualify for certain special circumstances.

The AARP MedicareRx Plans serve specific service areas. If I move out of the area that the AARP MedicareRx Plans serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies to access the AARP MedicareRx Plans benefits, except under limited, non-routine circumstances when I cannot reasonably use the AARP MedicareRx Plans network pharmacies. Once I am a member of the AARP MedicareRx Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the AARP MedicareRx Plans when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with AARP MedicareRx Plans, he/she may be compensated based on my enrollment in the AARP MedicareRx Plans. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

If you are enrolling in the AARP MedicareRx Enhanced Plan:

By joining this plan, I attest that I am not receiving any financial support from my current or former plan sponsor (or my spouse's current or former plan sponsor) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

CONTINUE ON NEXT PAGE 

7 Continued

Release of Information:

By joining this Medicare prescription drug plan, I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I acknowledge that the AARP MedicareRx Plans will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that (PDP name) will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this Enrollment Form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by the AARP MedicareRx Plans or by Medicare.

Signature: _____	Date: _____
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If applicant is unable to sign, one witness signature is required.

Witness Signature: _____	Telephone Number: _____	Date: _____
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8 Prescription drug coverage—authorized representative information

If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign below and provide the following information:

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Signature: _____ **Phone:** _____

Relationship to Enrollee: _____

AARP MedicareRx Plans Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Employer ID #: _____ Branch ID #: _____

Marketing ID #: _____ Source Code: _____

Plan Representative/Agent/Broker Signature: _____

CONTINUE ON NEXT PAGE

AARP Medicare Supplement Insurance Plans
Application page 1 of 4

Insured by United HealthCare Insurance Company, Horsham, PA 19044

9 Medicare supplement coverage—choose your start date

- **You are eligible to enroll if you are an AARP member, turning age 65, enrolling in Medicare Parts A and B, and not duplicating Medicare supplement coverage.**
(You may apply using this form only if you are turning age 65 or first enrolling in Medicare Part B at age 65 or older.)
- Please refer to the enclosed cover page for the monthly cost of the plan you have selected.
SEND NO MONEY NOW. You will be billed later.
- Your application must be received by the last day of the month in which you turn age 65 for you to receive your special birthday opportunity.
- **Your coverage will become effective on the first day of the month following receipt and approval of your completed application and first month's payment, but no sooner than the first day of your 65th birth month.** If your application is received more than six months after you turned age 65 or first enrolled in Medicare Part B at age 65 or older, you may have to answer medical questions. You will receive a Certificate of Insurance confirming your effective date. **(If you would like your coverage to begin at a later date, please indicate below.)**



Requested Effective Date (first of the future month)

- -
(Month, Day, Year)

CONTINUE ON NEXT PAGE 

AARP Medicare Supplement Insurance Plans

Application page 2 of 4

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Medicare supplement coverage—for your protection you are required to answer all the following questions and sign where indicated

- 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 coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- 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 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).

CONTINUE ON NEXT PAGE 

AARP Medicare Supplement Insurance Plans
Application page 4 of 4

10 Continued

- My signature below indicates that I have read and understand the contents of this application.
- I declare that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the application becomes a part of the insurance contract and that if the answers are incomplete, incorrect, or untrue, United HealthCare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- 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 when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand that the coverage under the plan I am applying for will not take effect until issued by **United HealthCare Insurance Company, Horsham, PA 19044**

Note:

If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Signature:

Date:



If return envelope is lost or misplaced, please mail to:
<United HealthCare Insurance Company, c/o AARP Health
P.O. Box 105331
Atlanta, GA 30348-5331>

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Rate Information

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Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Accepted for Informational Purposes 03/19/2009

Comments:
Attachment:
 READABILITY CERTIFICATION FORM 40.pdf

Bypassed -Name: Application **Review Status:** 03/16/2009
Bypass Reason: n/A
Comments:

Bypassed -Name: Health - Actuarial Justification **Review Status:** 03/16/2009
Bypass Reason: n/A
Comments:

Bypassed -Name: Outline of Coverage **Review Status:** 03/16/2009
Bypass Reason: n/A
Comments:

**UNITED HEALTHCARE INSURANCE COMPANY
READABILITY CERTIFICATION**

**THIS IS TO CERTIFY THAT THE FOLLOWING FORM(S) HAVE ACHIEVED A
FLESCH READING EASE TEST SCORE OF:**

FORM NUMBER

FLESCH SCORE

A42805USMMAR01 01A

40



SIGNATURE

PAUL D. KALLMEYER, VICE PRESIDENT COMPLIANCE & LEGAL
NAME AND TITLE

March 16, 2009
DATE