

SERFF Tracking Number: UHLC-126106584 State: Arkansas  
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 42081  
Company Tracking Number: B70005NMDUAR01 01A  
TOI: MS05G Group Medicare Supplement - Standard Sub-TOI: MS05G.001 Plan A  
Plans  
Product Name: Medicare Supplement  
Project Name/Number: AGENT DUAL SIGNATURE/B70005NMDUAR01 01A

## Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: Medicare Supplement SERFF Tr Num: UHLC-126106584 State: ArkansasLH

TOI: MS05G Group Medicare Supplement - Standard Plans SERFF Status: Closed State Tr Num: 42081

Sub-TOI: MS05G.001 Plan A Co Tr Num: B70005NMDUAR01 State Status: Filed-Closed  
01A

Filing Type: Form Co Status: Reviewer(s): Stephanie Fowler  
Author: Michelle Ambach Disposition Date: 04/10/2009  
Date Submitted: 04/08/2009 Disposition Status: Filed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: AGENT DUAL SIGNATURE  
Project Number: B70005NMDUAR01 01A  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 04/10/2009

Status of Filing in Domicile: Pending  
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: 04/10/2009  
Corresponding Filing Tracking Number:

Deemer Date:

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 application is similar in content to B50405NMDUAR01 01A previously approved by your Department on 9/28/07, SERFF#UHLC-125292533. Please note the insertion of an additional Broker Signature line has been added to the enclosed application.

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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 your Department file number: 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. Members who enroll in the AARP Medicare Select Plan will be issued certificate with Certificate Form Nos. MSA 1969, which was approved by your Department on September 1, 2005.

## 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  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation: STATE REQUIRED FILING FEE  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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UnitedHealthcare Insurance Company \$20.00 04/08/2009 27047665



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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	04/10/2009	04/10/2009

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## **Disposition**

Disposition Date: 04/10/2009

Implementation Date:

Status: Filed

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 FORM	Filed	Yes

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## Form Schedule

Lead Form Number: B70005NMDUAR01 01A

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed	B70005NMDUAR01 01A	Application/ ENROLLMENT	Enrollment FORM	Initial		50	B70005NMDUAR01 01A.pdf





# 5 (CONTINUED)

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 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).

You	Your Spouse	Please answer all questions to the best of your knowledge.																				
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	1) Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run healthcare program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.) [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 "yes," continue. If "no," go to question number 2.																				
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	1a) Will Medicaid pay your premiums for this Medicare supplement policy?																				
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	1b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?																				
		2a) 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.																				
		<b>You</b>																				
		START <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 15px; height: 15px;"></td><td style="border: 1px solid black; width: 15px; height: 15px;"></td></tr><tr><td style="text-align: center;">M</td><td style="text-align: center;">M</td><td style="text-align: center;">D</td><td style="text-align: center;">D</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td></td><td></td></tr></table>											M	M	D	D	Y	Y	Y	Y		
M	M	D	D	Y	Y	Y	Y															
		END <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 15px; height: 15px;"></td><td style="border: 1px solid black; width: 15px; height: 15px;"></td></tr><tr><td style="text-align: center;">M</td><td style="text-align: center;">M</td><td style="text-align: center;">D</td><td style="text-align: center;">D</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td></td><td></td></tr></table>											M	M	D	D	Y	Y	Y	Y		
M	M	D	D	Y	Y	Y	Y															
		<b>Your Spouse</b>																				
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M	M	D	D	Y	Y	Y	Y															
		END <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 15px; height: 15px;"></td><td style="border: 1px solid black; width: 15px; height: 15px;"></td></tr><tr><td style="text-align: center;">M</td><td style="text-align: center;">M</td><td style="text-align: center;">D</td><td style="text-align: center;">D</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td><td></td><td></td></tr></table>											M	M	D	D	Y	Y	Y	Y		
M	M	D	D	Y	Y	Y	Y															
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	2b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?																				
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	2c) Was this your first time in this type of Medicare plan?																				
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	2d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?																				
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	3a) Do you have another Medicare supplement policy in force?																				
		3b) If so, with what company and what plan do you have?																				
		<b>You</b>																				
		_____																				
		<b>Your Spouse</b>																				
		_____																				
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	3c) If "yes," do you intend to replace your current Medicare supplement policy with this policy?																				

**CONTINUE ON NEXT PAGE**

# 5 (CONTINUED)

You	Your Spouse	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	4) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)
		4a) If "yes," with what company and what kind of policy?
		<b>You</b>
		_____
		_____
		<b>Your Spouse</b>
		_____
		_____
		4b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)
		<b>You</b>
		START _____ END _____
		M M D D Y Y Y Y                      M M D D Y Y Y Y
		<b>Your Spouse</b>
		START _____ END _____
		M M D D Y Y Y Y                      M M D D Y Y Y Y
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	4c) Are you replacing the other health insurance indicated in question 4a?

**X** \_\_\_\_\_  
YOUR SIGNATURE (REQUIRED)

**X** \_\_\_\_\_  
YOUR SPOUSE'S SIGNATURE (REQUIRED)

# 6 IMPORTANT AUTHORIZATION AND VERIFICATION INFORMATION. PLEASE READ CAREFULLY, AND SIGN AND DATE WHERE INDICATED

- 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 agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand that coverage, if provided, will not take effect until issued by United HealthCare Insurance Company, and actual rates are not determined until coverage is issued.
- I understand that the agent or broker may not change or waive any terms or requirements related to this application and it's contents, underwriting, premium, or coverage.

**Authorization for the Release of Medical Information:**

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give United HealthCare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed only as permitted under applicable federal or state law. I understand that I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. This authorization is valid for 24 months from the date of my signature. I understand that I or my authorized representative may obtain a copy of this form.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other

**CONTINUE ON NEXT PAGE**



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## **Rate Information**

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## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Accepted for Informational Purposes 04/10/2009

**Comments:**

**Attachment:**

READABILITY CERTIFICATION FORM.pdf

**Bypassed -Name:** Application **Review Status:** 04/08/2009  
**Bypass Reason:** SEE FORM SCHEDULE  
**Comments:**

**Bypassed -Name:** Health - Actuarial Justification **Review Status:** 04/08/2009  
**Bypass Reason:** N/A  
**Comments:**

**Bypassed -Name:** Outline of Coverage **Review Status:** 04/08/2009  
**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  
B70005NMDUAR01 01A

FLESCH SCORE  
50



SIGNATURE

Paul Kallmeyer, Vice President, Compliance  
NAME AND TITLE

April 8, 2009  
DATE