

SERFF Tracking Number: UNUM-126129986 State: Arkansas
 Filing Company: Unum Life Insurance Company of America State Tracking Number: 42280
 Company Tracking Number: AE-1087-AR
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: Evidence of Insurability/AE-1087-AR

Filing at a Glance

Company: Unum Life Insurance Company of America

Product Name: Group Critical Illness SERFF Tr Num: UNUM-126129986 State: ArkansasLH

TOI: H07G Group Health - Specified Disease - SERFF Status: Closed State Tr Num: 42280

Limited Benefit

Sub-TOI: H07G.001 Critical Illness

Co Tr Num: AE-1087-AR

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Julie Mader, Dena Miraldi, Vanessa Vice
Disposition Date: 05/06/2009

Date Submitted: 05/05/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Evidence of Insurability

Status of Filing in Domicile: Pending

Project Number: AE-1087-AR

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 05/06/2009

Explanation for Other Group Market Type:

State Status Changed: 05/06/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

New Group Critical Illness/Cancer Insurance Application to be used with Group Critical Illness forms.

Company and Contact

SERFF Tracking Number: UNUM-126129986 State: Arkansas
 Filing Company: Unum Life Insurance Company of America State Tracking Number: 42280
 Company Tracking Number: AE-1087-AR
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: Evidence of Insurability/AE-1087-AR

Filing Contact Information

Vanessa Vice, Contract Consultant vvice@unum.com
 One Fountain Square (423) 294-7048 [Phone]
 Chattanooga, TN 37402

Filing Company Information

Unum Life Insurance Company of America CoCode: 62235 State of Domicile: Maine
 2211 Congress Street Group Code: 416 Company Type: L&H
 Portland, ME 04122 Group Name: State ID Number:
 (207) 575-2211 ext. [Phone] FEIN Number: 01-0278678

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unum Life Insurance Company of America	\$20.00	05/05/2009	27633259

SERFF Tracking Number: UNUM-126129986 State: Arkansas
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Product Name: Group Critical Illness
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/06/2009	05/06/2009

SERFF Tracking Number: UNUM-126129986 State: Arkansas
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Form Schedule

Lead Form Number: AE-1087-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AE-1087-AR	Application/Enrollment Form	Evidence of Insurability	Initial			AE-1087-AR.pdf

**APPLICATION FOR
GROUP CRITICAL ILLNESS INSURANCE
[GROUP CANCER INSURANCE]**

Evidence of Insurability

Unum Life Insurance Company of America (“Unum”)
2211 Congress Street • Portland, Maine 04122

Application Type: Newly Eligible Late Applicant Replace Existing Unum Coverage
 Change to Existing Coverage Rehire

SECTION 1: Employee (Applicant) Information – Always Complete

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender <input type="checkbox"/> F <input type="checkbox"/> M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
[Email Address]		Employee ID/Payroll #
Employer Name	Customer Number	Date of Hire (mm/dd/yyyy)
St/PO Box		Occupation
City		
State	Zip Code	Work Phone #
Are you Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Scheduled Number of Work Hours/week

SECTION 2: Spouse Information – Complete Only if applying for Spouse Coverage

Name (First, Middle, Last)		Social Security Number
Gender <input type="checkbox"/> F <input type="checkbox"/> M	Does the Spouse live in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If “No,” is your Spouse a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth (mm/dd/yyyy)

SECTION 3: Coverage Information – Complete for Employee (Applicant) and for Spouse (if applicable)

	Employee (Applicant)	Spouse
1. Have you or your spouse (if applying) used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Will coverage applied for replace or modify any existing Unum insurance coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes,” provide details below:		
Insured’s Name	Policy Number	

Employee Name: _____
 (Applicant)

Employee SSN: _____
 (Applicant)

SECTION 3: Coverage Information (continued)

3. Coverage Type	Coverage Amount	Cost Per Pay Period
a. Group Critical Illness Insurance <input type="checkbox"/> Critical Illness or <input type="checkbox"/> Critical Illness with Cancer	Employee \$ _____ Spouse \$ _____	Employee \$ _____ Spouse \$ _____
b. Group Cancer Insurance <input type="checkbox"/> Employee (only) <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee, Spouse & Children		\$ _____]
c. <input type="checkbox"/> Wellness Benefit		\$ _____
Total Cost Per Pay Period		\$ _____

SECTION 4: Tier I Medical Profile – Complete as required for all underwritten coverage

	Employee (Applicant)	Spouse
1. Current height and weight	___ ft. ___ in. ___ lbs.	___ ft. ___ in. ___ lbs.
2. Have you (applicant) or your spouse (if applying) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 10 years, have you or your spouse (if applying) received medical advice, sought treatment, including medication, or been hospitalized for any of the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> - Atrial fibrillation, angina, heart attack, coronary artery disease, heart surgery, congestive heart failure or cardiomyopathy - Chronic Obstructive Pulmonary Disease (COPD) or emphysema - Cirrhosis of the liver or Hepatitis B or C - Diabetes (except gestational or diet controlled) - Glaucoma, retinitis pigmentosa or macular degeneration - High blood pressure treated with 3 or more medications - Kidney disease (excluding kidney stones) or failure - Major organ failure (liver, heart, lung or pancreas) - Stroke/Transient Ischemic Attack (TIA) 		
4. Respond only if applying for cancer coverage: In the past 10 years, have you or your spouse (if applying) been diagnosed, received medical advice, sought treatment, including medication, or been hospitalized for cancer or malignancy of any kind (including carcinoma in situ and melanoma), excluding basal and squamous cell carcinoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Name: _____
(Applicant)

Employee SSN: _____
(Applicant)

SECTION 5: Tier II Medical Profile – Complete if additional underwriting is required

Employee (Applicant)

1. To the best of your knowledge and belief, have any two of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:
- a. Heart attack or disease, stroke, kidney disease or diabetes..... Yes No
 - b. Respond only if applying for cancer coverage:
 - Cancer (excluding basal cell carcinoma and squamous cell carcinoma)..... Yes No
2. Have you ever received medical advice, sought treatment, including medication, or been hospitalized for any of the following:
- a. – Chronic Obstructive Pulmonary Disease (COPD), emphysema or chronic lung disease
 - Cirrhosis of the liver or Hepatitis B or C
 - Diabetes (except gestational)
 - Heart attack, coronary artery disease, angina, or surgery on the heart or heart valve(s)
 - Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)
 - Major organ failure (liver, heart, lung or pancreas)
 - Peripheral vascular disease
 - Stroke/Transient Ischemic Attack (TIA) Yes No
 - b. Respond only if applying for cancer coverage:
 - Cancer (excluding basal cell carcinoma and squamous cell carcinoma)..... Yes No
-

Employee Name: _____
(Applicant)

Employee SSN: _____
(Applicant)

SECTION 6: Employee (Applicant) Statements

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter Unum) and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. If I pay part or all of the cost of my coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin.

I understand that no person to be covered for specified disease is also covered by any Title XIX program (Medicaid, Medical or any similar name).

I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

All statements and answers provided on this application are true and complete, and are given to obtain insurance.

CAUTION: Unum will rely on the information provided in order to evaluate this application. If the answers provided are incorrect or untrue, Unum may deny benefits or rescind insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

Employee (Applicant) Signature

Date (mm/dd/yyyy)

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Unum Life Insurance Company of America.

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Limited Benefit
Product Name: Group Critical Illness
Project Name/Number: Evidence of Insurability/AE-1087-AR

Supporting Document Schedules

Satisfied -Name: Flesch Certification	Review Status: Approved-Closed	05/06/2009
Comments:		
Attachments:		
AR Readability Cert (0114k).pdf		
AR Regulation 19 Certificate.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	05/06/2009
Comments:		
Attachment:		
AE-1087-AR.pdf		
Satisfied -Name: Statement of Variability	Review Status: Approved-Closed	05/06/2009
Comments:		
Attachment:		
Statement of Variability.pdf		
Satisfied -Name: NAIC Form	Review Status: Approved-Closed	05/06/2009
Comments:		
Attachment:		
(UNUM)AR NAIC - Life, A&H, Annuity, Credit Trans Doc (eff. 1-1-09).pdf		

**CERTIFICATION REQUIRED BY
ARKANSAS INSURANCE DEPARTMENT REGULATION 19**

I certify that this submission meets the provisions of Regulation 19 as well as all other applicable requirements of the Arkansas Insurance Department.


Signature

Joanna Shepich
Director and Assistant Secretary

Date: 05/05/2009

UNUM LIFE INSURANCE COMPANY OF AMERICA
PORTLAND, MAINE

**APPLICATION FOR
GROUP CRITICAL ILLNESS INSURANCE
[GROUP CANCER INSURANCE]**

Evidence of Insurability

Unum Life Insurance Company of America (“Unum”)
2211 Congress Street • Portland, Maine 04122

Application Type: Newly Eligible Late Applicant Replace Existing Unum Coverage
 Change to Existing Coverage Rehire

SECTION 1: Employee (Applicant) Information – Always Complete

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender <input type="checkbox"/> F <input type="checkbox"/> M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
[Email Address]		Employee ID/Payroll #
Employer Name	Customer Number	Date of Hire (mm/dd/yyyy)
St/PO Box		Occupation
City		
State	Zip Code	Work Phone #
Are you Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Scheduled Number of Work Hours/week

SECTION 2: Spouse Information – Complete Only if applying for Spouse Coverage

Name (First, Middle, Last)		Social Security Number
Gender <input type="checkbox"/> F <input type="checkbox"/> M	Does the Spouse live in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If “No,” is your Spouse a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth (mm/dd/yyyy)

SECTION 3: Coverage Information – Complete for Employee (Applicant) and for Spouse (if applicable)

	Employee (Applicant)	Spouse
1. Have you or your spouse (if applying) used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Will coverage applied for replace or modify any existing Unum insurance coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes,” provide details below:		
Insured’s Name	Policy Number	

Employee Name: _____
 (Applicant)

Employee SSN: _____
 (Applicant)

SECTION 3: Coverage Information (continued)

3. Coverage Type	Coverage Amount	Cost Per Pay Period
a. Group Critical Illness Insurance <input type="checkbox"/> Critical Illness or <input type="checkbox"/> Critical Illness with Cancer	Employee \$ _____ Spouse \$ _____	Employee \$ _____ Spouse \$ _____
[b. Group Cancer Insurance <input type="checkbox"/> Employee (only) <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee, Spouse & Children		\$ _____]
c. <input type="checkbox"/> Wellness Benefit		\$ _____
Total Cost Per Pay Period		\$ _____

SECTION 4: Tier I Medical Profile – Complete as required for all underwritten coverage

	Employee (Applicant)	Spouse
1. Current height and weight	____ ft. ____ in. ____ lbs.	____ ft. ____ in. ____ lbs.
2. Have you (applicant) or your spouse (if applying) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 10 years, have you or your spouse (if applying) received medical advice, sought treatment, including medication, or been hospitalized for any of the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> - Atrial fibrillation, angina, heart attack, coronary artery disease, heart surgery, congestive heart failure or cardiomyopathy - Chronic Obstructive Pulmonary Disease (COPD) or emphysema - Cirrhosis of the liver or Hepatitis B or C - Diabetes (except gestational or diet controlled) - Glaucoma, retinitis pigmentosa or macular degeneration - High blood pressure treated with 3 or more medications - Kidney disease (excluding kidney stones) or failure - Major organ failure (liver, heart, lung or pancreas) - Stroke/Transient Ischemic Attack (TIA) 		
4. Respond only if applying for cancer coverage: In the past 10 years, have you or your spouse (if applying) been diagnosed, received medical advice, sought treatment, including medication, or been hospitalized for cancer or malignancy of any kind (including carcinoma in situ and melanoma), excluding basal and squamous cell carcinoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Name: _____
(Applicant)

Employee SSN: _____
(Applicant)

SECTION 5: Tier II Medical Profile – Complete if additional underwriting is required

Employee (Applicant)

1. To the best of your knowledge and belief, have any two of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:
- a. Heart attack or disease, stroke, kidney disease or diabetes..... Yes No
 - b. Respond only if applying for cancer coverage:
 - Cancer (excluding basal cell carcinoma and squamous cell carcinoma)..... Yes No
2. Have you ever received medical advice, sought treatment, including medication, or been hospitalized for any of the following:
- a. – Chronic Obstructive Pulmonary Disease (COPD), emphysema or chronic lung disease
 - Cirrhosis of the liver or Hepatitis B or C
 - Diabetes (except gestational)
 - Heart attack, coronary artery disease, angina, or surgery on the heart or heart valve(s)
 - Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)
 - Major organ failure (liver, heart, lung or pancreas)
 - Peripheral vascular disease
 - Stroke/Transient Ischemic Attack (TIA) Yes No
- b. Respond only if applying for cancer coverage:
- Cancer (excluding basal cell carcinoma and squamous cell carcinoma)..... Yes No
-

Employee Name: _____
(Applicant)

Employee SSN: _____
(Applicant)

SECTION 6: Employee (Applicant) Statements

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter Unum) and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. If I pay part or all of the cost of my coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin.

I understand that no person to be covered for specified disease is also covered by any Title XIX program (Medicaid, Medical or any similar name).

I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

All statements and answers provided on this application are true and complete, and are given to obtain insurance.

CAUTION: Unum will rely on the information provided in order to evaluate this application. If the answers provided are incorrect or untrue, Unum may deny benefits or rescind insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

Employee (Applicant) Signature

Date (mm/dd/yyyy)

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Unum Life Insurance Company of America.

Unum Life Insurance Company of America
Statement of Variability

The following statements apply to the Application for Group Critical Illness Insurance and Group Cancer Insurance Evidence of Insurability:

1. An Employer may choose not to offer all benefit plans available with the Group Critical Illness or Group Cancer product, in which case we may change the Coverage Types under Section 3 and provide a customized form reflecting only the benefit plans applicable to the Employer. For example, if the Employer chooses to offer only the Critical Illness benefit, we may omit any reference to Cancer.
2. The Tier I and Tier II Medical Profile questions in Sections 4 and 5 may be omitted based on Coverage Types elected by the Employer.
3. Section 5, Tier II Medical Profile may be omitted based on employee coverage amount.
4. For the convenience of the Employer and applicants we may pre-fill certain fields on the form, such as Employer name and address information and Customer Number information.
5. If an Employer refers to its employees as something other than "Employee" (for example: Associates or Members), we may replace references to "Employee" with a term appropriate to that Employer.
6. If an Employer does not offer Spouse or Dependent coverage under a plan, we may delete all references to Spouse or Dependent(s)/Children, including any sections of the form that apply to Spouse or Dependent coverage.
7. We may delete any boxes or text if they do not apply to a particular plan.
8. The employee email address box may be removed.
9. We may vary the content of any form completion or mailing instructions in the event it is appropriate for a particular plan.
10. If an Employer wishes to place their name and company logo on the form, we may place this information on the form (in addition to, but not to replace the appropriate insuring entity or the Unum name and logo).
11. Enrollment methods include producer-assisted situations (in person or via call centers) and self-enrolled situations (using paper or electronic application processes, such as web-based.) Electronic application processes may also be used in producer-assisted situations.
12. Given the various methods for electronic enrollment from which an Employer may choose, such as Interactive Voice Response (IVR) or web-based technology provided via either the Employer's site or a third-party administrator, we wish to allow flexibility in the manner in which we present the questions and other form text. The substance and content of the health questions will not vary. Rather, the manner in which questions are presented to the employees may differ according to the technology utilized. For example, one Employer may prefer IVR technology; thus the questions will be read to the enrollee one at a time. The questions will then be replayed along with the employee's answers, to provide an opportunity for the employee to attest to his/her answers. For web-based enrollments, the number of questions contained on a single screen may vary, and the manner in which the enrollee answers the questions may differ. For electronically transmitted or displayed forms, we will use characteristics designed to meet the same regulatory objective as does the hardcopy form.
13. The Employee (Applicant) Statements text or placement of text may vary in response to or to comply with Federal and/or State Privacy laws.
14. We reserve the right to make non-substantive formatting changes to accommodate systems.

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122	ME		416	416-62235	01-0278678	03

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	1 Fountain Square Chattanooga, TN 37402	1-800-451-8475, ext. 47048	423-294-8346	vvice@unum.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	UNUM-126129986
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9.	Type of Insurance (TOI)	H07G Group Health – Specified Disease – Limited Benefit
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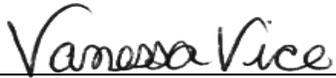
10.	Sub-Type of Insurance (Sub-TOI)	H07G.001 – Critical Illness
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11.	Submitted Documents	<p><input type="checkbox"/> FORMS</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Policy</td> <td><input type="checkbox"/> Outline of Coverage</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input checked="" type="checkbox"/> Application/Enrollment</td> <td><input type="checkbox"/> Rider/Endorsement</td> <td><input type="checkbox"/> Advertising</td> </tr> <tr> <td><input type="checkbox"/> Schedule of Benefits</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>Rates</p> <p><input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate</p> <p><input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____</p> <p>SUPPORTING DOCUMENTATION</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Articles of Incorporation</td> <td><input type="checkbox"/> Third Party Authorization</td> </tr> <tr> <td><input type="checkbox"/> Association Bylaws</td> <td><input type="checkbox"/> Trust Agreements</td> </tr> <tr> <td><input checked="" type="checkbox"/> Statement of Variability</td> <td><input checked="" type="checkbox"/> Certifications</td> </tr> <tr> <td><input type="checkbox"/> Actuarial Memorandum</td> <td></td> </tr> <tr> <td><input checked="" type="checkbox"/> Other _____ NAIC form</td> <td></td> </tr> </table>	<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input checked="" type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising	<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other		<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization	<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements	<input checked="" type="checkbox"/> Statement of Variability	<input checked="" type="checkbox"/> Certifications	<input type="checkbox"/> Actuarial Memorandum		<input checked="" type="checkbox"/> Other _____ NAIC form	
<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate																			
<input checked="" type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising																			
<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other																				
<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization																				
<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements																				
<input checked="" type="checkbox"/> Statement of Variability	<input checked="" type="checkbox"/> Certifications																				
<input type="checkbox"/> Actuarial Memorandum																					
<input checked="" type="checkbox"/> Other _____ NAIC form																					

Effective January 1, 2009

LHTD-1, Page 1 of 2

12.	Filing Submission Date	5/5/2009	
13	Filing Fee (If required)	Amount	<u>\$20.00</u>
		Check Date	<u>EFT</u>
		Retaliatory	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		Check Number	<u>EFT</u>
14.	Date of Domiciliary Approval		
15.	Filing Description:		
<p>New Group Critical Illness/Cancer Insurance Application to be used with Group Critical Illness forms.</p>			

16.	Certification (If required)
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>	
Print Name	<u>Vanessa Vice</u>
Title	<u>Contract Consultant</u>
Signature	<u></u>
Date:	<u>5/5/2009</u>

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Application For Group Critical Illness Insurance (Group Cancer Insurance)	AE-1087-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1