

SERFF Tracking Number: UHLC-126156558 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 42391
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Child Support Enrollment Form
Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: Child Support Enrollment Form SERFF Tr Num: UHLC-126156558 State: ArkansasLH
TOI: H21 Health - Other SERFF Status: Closed State Tr Num: 42391
Sub-TOI: H21.000 Health - Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Author: Ebony Terry Disposition Date: 06/16/2009
Date Submitted: 05/18/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Authorized
Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Franchise
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 06/16/2009 Explanation for Other Group Market Type:
State Status Changed: 06/16/2009
Deemer Date: Corresponding Filing Tracking Number:
Filing Description:

This form replaces a previously approved form MCS.EE.08.AR 1/09 that was the approved 3/25/2009" The following statement was removed from the previous version of the form:

I acknowledge that, if signing below as the non-custodial parent, all information relating to the benefit plan, including but not limited to identification cards and explanation of benefit documents, shall be provided to the custodial parent or other legal guardian."

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Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst Ebony_N_Terry@uhc.com
 4 Taft Court (301) 838-5611 [Phone]
 Rockville, MD 20850 (301) 838-5676[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: \$50.00
 Retaliatory? No
 Fee Explanation: 1 form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$50.00	05/18/2009	27953290

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/16/2009	06/16/2009

Objection Letters and Response Letters

Objection Letters

Response Letters

Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	05/20/2009	05/20/2009			

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Child Support Form Enrollment Form		Ebony Terry	06/12/2009	06/12/2009

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Disposition

Disposition Date: 06/16/2009

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	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	Cover Letter	Approved-Closed	Yes
Form (revised)	Child Support Enrollment Form	Approved-Closed	Yes
Form	Child Support Enrollment Form	Replaced	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 05/20/2009
Submitted Date 05/20/2009
Respond By Date

Dear Ebony Terry,

This will acknowledge receipt of the captioned filing.

Objection 1

- Child Support Enrollment Form (Form)

Comment:

The enrollment application must contain a Fraud Warning statement as required by ACA 23-66-503 and Bulletin 7-97.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Amendment Letter

Amendment Date:
 Submitted Date: 06/12/2009

Comments:

The form has been revised to include the requested Fraud statement.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
MCS.EE.08. AR 05/09	Application/ Enrollment Form	EChild Support Enrollment Form	Initial					M45468 AR medical child supp (4)final 61209.pdf

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Form Schedule

Lead Form Number: MCS.EE.08.AR 05/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MCS.EE.08.AR 05/09	Application/Child Support Enrollment Form	Child Support Enrollment Form	Initial			M45468 AR medical child supp (4)final 61209.pdf

IMPORTANT INFORMATION

In order to make choices about health care coverage and treatment, we believe that it is important to understand how the plan operates. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, the Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of the identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan. That means:
 - We make decisions about whether the health benefit plan selected will reimburse for care that may be received.
 - We do not decide what care is needed or will be received. You and the provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to the plan.
3. We may use individually identifiable information to identify procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with a physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to the provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for my child/children.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding the health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

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Rate Information

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Supporting Document Schedules

Bypassed -Name:	Flesch Certification	Review Status:	Approved-Closed	06/16/2009
Bypass Reason:	N/A			
Comments:				
Bypassed -Name:	Application	Review Status:	Approved-Closed	06/16/2009
Bypass Reason:	N/A			
Comments:				
Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	06/16/2009
Bypass Reason:	N/A			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	06/16/2009
Bypass Reason:	N/A			
Comments:				
Satisfied -Name:	Cover Letter	Review Status:	Approved-Closed	06/16/2009
Comments:	Cover Letter			
Attachment:	AR CS Enrollment CL.pdf			



M.D. IPASM OPTIMUM CHOICE[®] MAMSI[®]
LIFE AND HEALTH INSURANCE COMPANY

4 Taft Court Rockville MD 20850
www.mamsiUnitedHealthcare.com

May 18, 2009,
Via U.S. Mail
Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

NAIC: 79413 United Healthcare Insurance Company

Form # MCS.EE.08.AR 05/09

Dear Ms. Minor,

On behalf of United Healthcare Insurance Company, please accept this correspondence as a submission of the above referenced Enrollment Form. This form is a revised version of a previously approved. Form number MCS.EE.08.AR 1/09 was approved 3/25/2009.

This submission has been submitted electronically via SERFF and United Healthcare Insurance Company recognizes that we may not implement this form until and unless approval has been granted. Should the Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 301.838.5611, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Respectfully,

Ebony N. Terry
Compliance Analyst

Enclosure

ENT

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Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Child Support Enrollment Form	05/18/2009	M45468 AR medical child supp final.pdf

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1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan. That means:
 - We make decisions about whether the health benefit plan selected will reimburse for care that may be received.
 - We do not decide what care is needed or will be received. You and the provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to the plan.
3. We may use individually identifiable information to identify procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with a physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to the provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
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I (we) also authorize the insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding the health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.