

SERFF Tracking Number: USLH-126179990 State: Arkansas
Filing Company: United Security Life and Health Insurance Company State Tracking Number: 42635
Company Tracking Number: AR-BEN-SEL-09
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: Application for Insurance (AR-BEN-SEL-09)
Project Name/Number: Application for Insurance (AR-BEN-SEL-09)

Filing at a Glance

Company: United Security Life and Health Insurance Company

Product Name: Application for Insurance (AR-BEN-SEL-09) SERFF Tr Num: USLH-126179990 State: ArkansasLH

TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 42635
Sub-TOI: H16G.001C Any Size Group - Other	Co Tr Num: AR-BEN-SEL-09	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Lisa Kosvick, Jaime Gettemans	Disposition Date: 06/16/2009
	Date Submitted: 06/09/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Application for Insurance (AR-BEN-SEL-09)

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small

Overall Rate Impact:

Group Market Type: Discretionary

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:

Please find under the "Form Tab" United Security Life and Health Insurance Company's ("USL&H") Application for Insurance that is being filed for review and approval. Recently, USL&H submitted a Certificate Amendment that makes TMJ an offer and we were informed that we need to amend our Application to contain language as outlined under ACA 23-79-750 (c)(2). The first page in the Application is titled "Arkansas Benefit Selection Sheet" (AR-BEN-SEL-09). This

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specific page has never been filed and needs approval; however the remaining seven pages of the Application (APP0407) have been filed and approved and were not amended at this time. This Application will be used with Group Certificates ABC-2008ADCAR, ABC-2008PRPAR, ABC-2008APXAR, ABC-90, ADVANTAGE-04, and PROPLUS-98.

Company and Contact

Filing Contact Information

Jaime Gettemans, jaimegettemans@jandpholdings.com
 6640 S. Cicero Avenue (708) 552-2417 [Phone]
 Bedford Park, IL 60638

Filing Company Information

United Security Life and Health Insurance CoCode: 81108 State of Domicile: Illinois
 Company
 6640 S. Cicero Group Code: Company Type:
 Bedford Park, IL 60638 Group Name: State ID Number:
 (708) 475-6000 ext. [Phone] FEIN Number: 36-3692140

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: AR ADC 054 00 057 (II)(a)(1)
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Security Life and Health Insurance Company	\$50.00	06/09/2009	28465195

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Correspondence Summary

Dispositions

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

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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
Form	Arkansas Selection Benefit Sheet - Application for Insurance	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AR-BEN-SEL-09	Application/ Enrollment Form	Arkansas Selection Benefit Sheet - Application for Insurance	Initial		32	AR-BEN-SEL-09 (Application for Insurance).pdf

ARKANSAS BENEFIT SELECTION SHEET

Please mark the appropriate plan, deductible, coinsurance, and optional benefit(s) desired.
 Submit this with your Application. Availability is subject to Underwriting approval.

Proposed Insured (Print): _____ Date: _____

Unlimited Access Plan

Any Doctor / Any Hospital

Deductible

- \$500 \$1,000
 \$2,500 \$5,000

Optional Benefits

- Basic Drug Card Maternity Benefit
 Enhanced Drug Card Dental Benefit
 Supplemental Accident AD&D

Mandated Offers

- Alcohol & Drug Dependency
 TMJ*
 Mental Disorders
 Hospice

There is no prescription drug coverage on the plan unless an optional drug card is selected.

HealthSelect PPO Plan

Preferred Provider (PPO)

Deductible

- \$1,000 \$1,500
 \$2,500 \$5,000

Optional Benefits

- Basic Drug Card Maternity Benefit
 Enhanced Drug Card Dental Benefit
 Supplemental Accident

Mandated Offers

- Alcohol & Drug Dependency
 TMJ*
 Mental Disorders
 Hospice

There is no prescription drug coverage on the plan unless an optional drug card is selected.

Preferred Value Plan

High Deductible (HDHP)

Deductible

- \$1,500 \$2,500
 \$5,000 \$10,000

Optional Benefits

- Basic Drug Card
 Enhanced Drug Card
 Supplemental Accident

Mandated Offers

- Alcohol & Drug Dependency
 TMJ*
 Mental Disorders
 Hospice

There is no prescription drug coverage on the plan unless an optional drug card is selected.

Healthy Savings Plan

HSA-Qualified

Deductible

- Individual Family
 \$1,500 \$2,500
 \$2,500 \$5,000
 \$3,750 \$7,500
 \$5,000

Optional Benefits

- Maternity Benefit

Coinsurance Options

- 100%
 80/20 to allowable max.
 (Only available with \$1,500 or \$2,500 deductible)

Mandated Offers

- Alcohol & Drug Dependency
 TMJ*
 Mental Disorders
 Hospice

*Rejection of the option for TMJ in **Mandated Offers** means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Additional Options

Term Life Rider

(Not Available on Preferred Value Plan)

- Proposed Insured Insured's Spouse

- Benefit**
 \$10,000 \$10,000
 \$20,000 \$20,000
 \$30,000 \$30,000
 \$40,000 \$40,000
 \$50,000 \$50,000

Cancer Policy

- Individual Plan
 Single Parent Plan
 Family Plan

Benefit Amount

- \$10,000 \$40,000
 \$20,000 \$50,000
 \$30,000

Disability Income Policy

Monthly Benefit: _____
 (from \$400 - \$3,000)

Elimination Period: 7 Days 14 Days 30 Days
 60 Days* 90 Days* *(5 year plan only)

Benefit Period: 6 Months 12 Months 24 Months
 60 Months* *(only available to P Class)

Occupation Class: Professional (P) Accidental (A)
 Manual Labor (B)

*Billing Fees: ___ Annual \$0 ___ Semi-Annual \$10 ___ Quarterly \$10 ___ Monthly Direct \$10
 ___ Credit Card \$10 ___ PAC \$2 ___ Convenience Bill \$10

\$ _____ + \$ **25** + \$ _____ + \$ _____ = Total Remitted
 Modal Premium + Application Fee + *Billing Fee

Please submit the premium, billing fee, and application fee (refundable if insurance is denied, withdrawn or policy is not taken) with your application. Make check payable to United Security Life & Health.

APPLICATION FOR INSURANCE



6640 S. Cicero Avenue
Bedford Park, IL 60638 • 800/875-4422

NEW INSURANCE

Requested Effective Date (1st thru 28th only) _____

ADD ON APPLICATION

Month _____ Day _____

PROPOSED INSURED(S)

(Please include Maiden name) (First, MI, Last)

	Social Security #	Sex	Date of Birth	Age	State of Birth	Marital Status	Height	Weight	Tobacco Use
1. Primary Insured <input type="checkbox"/> Uninsured Applicant									<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Spouse									<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Dependents									Full Time Student
A. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
B. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
C. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
D. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
E. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO

YES NO If No, explain below. The parent where Dependent(s) reside must also sign this application.

4. Residence Address

Street _____ City _____ State _____ Zip _____

Day Time Phone Number _____ / Cell Number _____ Best Time to Call _____ E-mail address _____

5. Billing Address (if different than above)

Street _____ City _____ State _____ Zip _____ Phone Number _____

6. Occupation

Primary Insured – Employer Name _____ Spouse – Employer Name _____

Duties _____ Monthly Earned Income _____ Duties _____ Monthly Earned Income _____

7. Beneficiary (if applying for Life Insurance) If none listed, Beneficiary will be the Estate of the Insured

Primary Insured: Primary _____ Relation to Insured _____ Contingent _____ Relation to Insured _____

Spouse: Primary _____ Relation to Insured _____ Contingent _____ Relation to Insured _____

8. Do you or any Proposed Insured have any health insurance coverage currently in force or pending? YES NO
Name of Company _____ Type of Coverage _____

9. Is this plan of insurance intended to replace any insurance in force? YES NO

10. Has any Proposed Insured ever participated in any of the following occupations/avocations/activities: Aviation, ATV Riding, Bungee Jumping, Crop Dusting, Hang Gliding, Horse Riding, Martial Arts (over age 15), Motorcycle/Motorbike Riding, Motorized Vehicle Racing, Mountain/Rock Climbing, Parachuting, Parasailing, Professional/Semi-professional/Collegiate Athletics, Rodeo Activities, SCUBA Diving, Skydiving? If YES, provide complete details in # 24. YES NO

11. Have any of the Proposed Insureds ever had a driver's license suspended, revoked, been cited for driving while intoxicated, had two or more violations in the past two years or been licensed to operate a motorcycle? YES NO
If YES, Proposed Insured: _____ Driver's License #: _____ State Issued: _____

Details: _____

12. Has every Proposed Insured been a legal resident of the United States for the past year? If NO, give details: YES NO

MEDICAL HISTORY (All health questions must be answered)

- 13.** Is any family member (whether applying for coverage or not) currently pregnant, an expectant parent, or in the process of adopting a child?
IF YES, NO FAMILY MEMBER IS ELIGIBLE FOR COVERAGE, even if the pregnant individual is not applying for coverage. YES NO
- 14.** Has any Proposed Insured ever been told by a medical professional that they have, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or tested positive for HIV or HTLV III? YES NO
- 15.** Has any Proposed Insured had any symptoms, testing, treatment, diagnosis, been prescribed medication for or had a consultation with a medical professional for any of the following physical systems, organs, illnesses, injuries, diseases, or disorders? – **Check all that apply.**
- 15A. Respiratory System** YES NO
If YES, Check all that apply
 Allergies Asthma Bronchitis Emphysema/COPD Pneumonia Sinusitis
 Chronic Cough Tuberculosis Shortness of Breath Sleep Apnea Other Lung Disorder
- 15B. Circulatory System** YES NO
If YES, Check all that apply
 Heart Disease Coronary Artery Disease High Blood Pressure Elevated Cholesterol/Triglycerides
 Varicose Veins Irregular Heartbeat Chest Pain Heart Murmur
 Stroke/TIA Phlebitis Blood Clot Blood Disorder Poor Circulation
- 15C. Digestive System** YES NO
If YES, Check all that apply
 Ulcers Gastritis Colitis Stomach Gallbladder/Gall Stones
 Hernia Hemorrhoids Spleen Bleeding Esophagus/Reflux/GERD
 Pancreas Liver/Bile Ducts Hepatitis (A ____, B ____, C ____) Intestinal Disorder
- 15D. Endocrine System** YES NO
If YES, Check all that apply
 Pancreas Diabetes Abnormal Blood Glucose Pituitary Other Gland Disorder
 Thyroid Goiter Addison's Disease Sugar in the Urine
- 15E. Reproductive System (Male/Female)** YES NO
If YES, Check all that apply
 Ovaries/Ovarian Cyst Caesarean Section Miscarriage Menstrual Disorder
 Infertility Cervix Abnormal PAP Herpes
 Endometriosis Uterus/Uterine Fibroids Genital Warts Prostate/Elevated PSA Sexually Transmitted Diseases
- 15F. Urinary System** YES NO
If YES, Check all that apply
 Kidney Stone/Disorder Bladder Stones Bladder Prostate Urinary Tract Infection
- 15G. Musculo-Skeletal System** YES NO
If YES, Check all that apply
 Back/Spine/Vertebrae Fibromyalgia Arthritis Rheumatism Gout
 Foot/Knee Disorder TMJ/Jaw Disorder Lupus Herniated/Slipped Disc
 Arm/Shoulder Disorder Joint Disorder/Replacement Bursitis Collagen Vascular Disorder
 Connective Tissue Disorder Muscle/Ligament/Tendon/Cartilage Disorder Spinal Manipulation/Adjustment
- 15H. Nervous System** YES NO
If YES, Check all that apply
 Epilepsy Convulsions Seizures Paralysis Parkinson's Disease
 Head Injury Brain Disorder Dementia Headaches/Migraines Alzheimer's Disease Neuropathy
- 15I. Mental/Nervous System** YES NO
If YES, Check all that apply
 Anxiety/Depression Attention Deficit/ADD/ADHD Neurosis/Psychosis Sleep Disorder
 Bi-Polar Disorder Chemical Imbalance Psychiatric Treatment or Counseling Eating Disorder
- 16.** Has any Proposed Insured had any symptom, consulted with, received medical care or advice from, been diagnosed or treated, had surgery for or received any prescription medication from any member of the medical profession for any condition or illness not listed above? YES NO
- 17.** Has any Proposed Insured received treatment for cancer, melanoma, leukemia, tumor/growth, skin cancer, or cyst? YES NO
- 18.** Has any Proposed Insured, in the past five years, taken any prescription medication or received any medical treatment? ... YES NO
- 19.** Has any Proposed Insured been advised by a medical professional to have surgery, treatment, testing or hospitalization and not done so?..... YES NO
- 20.** Has any Proposed Insured had any diagnosis related to, received treatment for, been advised to seek treatment, been told to decrease or discontinue alcohol consumption, used illegal drugs, or been hospitalized due to alcohol or drug use/abuse? YES NO
- 21.** Has any Proposed Insured used, or is currently using, any tobacco products?..... YES NO
If YES, but not currently using, date last used: _____
- 22.** Has any Proposed Insured experienced a weight change of more than 10% of his/her current weight in the past year? YES NO
- 23.** Does any Proposed Insured currently have any internal fixations (i.e. screws, plates) or implants of any kind? YES NO

HIPAA COMPLIANT AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

I hereby apply to United Security Life and Health Insurance Company (USL&H) for insurance under the policy issued to the Apex Benefit Care Insurance Trust. I represent the statements I have made herein are complete and true. I understand the following: (a) if any material information on this application is incorrect, this coverage may be voided; and, (b) if this application is declined and a certificate is not issued, USL&H's only obligation will be to return any premium paid; and, (c) that USL&H will pay benefits for a loss due to a pre-existing condition provided the pre-existing condition was fully disclosed in the application and this coverage has not been excluded or limited by name or specific description; and (d) there is no insurance in force until a certificate indicating the effective date is received from USL&H and the initial premium, including the applicable fee, is paid in full. By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medical or medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of me or any members of my family named in this application, of our health, to give USL&H, its reinsurers, affiliates, or business associates, any such information which shall include, but not be limited to, Alcohol or Drug abuse treatment, Mental Health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing. I understand the information obtained by use of this authorization will be used by the insurance company to determine eligibility for insurance. Any information obtained will not be released by the company to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for two and one half years from the date shown below. (For residents of Arizona, this authorization is valid for 180 days for any HIV-related information.) I acknowledge receipt of the important notice regarding a consumer report and disclosure of information to the Medical Information Bureau. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to USL&H, P.O. Box 388342, Chicago, Illinois 60638. Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or the extent that USL&H has a legal right to contest a claim under an insurance policy or to contest the policy itself. A photographic copy of this authorization and acknowledgement shall be as valid as the original. Upon request I, or my authorized representative, is entitled to receive a copy of this authorization form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for Insurance may be guilty of a crime and may be subject to fines and confinement in prison. **Disclaimer** — If premiums are paid from your employer's account, it is understood that: 1. USL&H assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. The Company is not acting as a sponsor as defined in ERISA. Any compliance under this Act that is applicable to the sponsor, will be fulfilled by the employer, as his own legal counsel may determine. 2. The policy is not guaranteed issue and will be fully underwritten by the Company which may result in the exclusion from coverage of certain family members (if applicable) and health conditions. USL&H assumes no responsibility for collection of premiums and/or the failure of your employer to remit them on a timely basis.

Dated at _____
 _____ City _____ State _____ Zip _____ Date _____

Applicant's Signature _____ **Spouse's Signature (if to be covered)** _____

Dependent's Signature (If 18 or older) _____ **Dependent's Signature (If 18 or older)** _____

Guardian/Representative's Signature/Relationship to Applicant _____ **Dependent's Signature (If 18 or older)** _____

Agent Information: _____
 _____ **Printed Name** _____ **Address** _____ **Phone #** _____

I have truly and accurately recorded the information personally supplied by the applicant. Further, I have made no representations to the applicant other than those contained in the sales brochure.

Agent # _____ **Signature** _____ **E-Mail** _____ **General Agent** _____

Method of Payment: Annual Semi-Annual Quarterly Direct Monthly Direct PAC Credit Card List Bill
 Credit Card Number: _____ Visa MC Discover Exp. Date: _____

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY

Bank Name _____ **Bank Address** _____

As a convenience to me, I hereby request and authorize you to pay and charge my account (check or electronic debit) drawn on my account by and payable to United Security Life and Health Insurance Company, provided there are sufficient funds in said account to pay the same on presentation. I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

Printed Name of Depositor _____ **Signature of Depositor** _____ **Date** _____

(PLEASE TURN OVER TO FINISH APPLICATION)

If you answered "YES" to question #9, you must complete this section.

Notice To Applicant Regarding Replacement of Health Insurance

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a Certificate to be issued by United Security Life and Health Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new Certificate.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new Certificate. This could result in denial or delay of a claim for benefits under this new Certificate, whereas a similar claim might have been payable under your present coverage.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. **FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR CERTIFICATE HAS NEVER BEEN IN FORCE.** After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date

Applicant's Signature

AGENT CHECKLIST

By taking the time to check off the questions below, you are helping to ensure that your application has been filled out completely; allowing us to process the application quickly and accurately.

- | | |
|--|---|
| <input type="checkbox"/> Have you answered EVERY health question? (Make sure to check "Yes" or "No" for all sections of Question #15. If the answer is "Yes," please check all conditions that apply). | <input type="checkbox"/> Have you included payment or credit card information with the application? |
| <input type="checkbox"/> Is the physician information complete with name, address AND phone number? | <input type="checkbox"/> If the applicant is intending to replace current coverage have they signed the above Notice to Applicant Regarding Replacement of Health Insurance? |
| <input type="checkbox"/> Have you attached detailed descriptions for any health questions which have been answered "YES"? | <input type="checkbox"/> Have you completed the Conditional Receipt Form? |
| <input type="checkbox"/> Has the applicant signed AND dated the application? | <input type="checkbox"/> Have you separated and delivered the tear-off page (which includes the MIB, Inc. Pre-Notice, Investigative Consumer Report Notice, Abbreviated Notice of Information Practices, Conditional Receipt and Notice To Applicant Regarding Replacement of Health Insurance) to applicant? |
| <input type="checkbox"/> Have you filled out the Agent Information section, complete with your signature, agent number and current e-mail address? | |

Thank you for submitting your business to USL&H.

Did you know you can now submit applications electronically at www.unitedsecuritylandh.com?

Short Term Major Medical

The Perfect Solution if You Are:

- A Recent College Graduate
- Temporarily Unemployed
- A Temporary or Seasonal Worker
- Retiree Waiting for Medicare Coverage
- Waiting For Coverage from Your Employer
- Recently Discharged from the Military
- Applying for Major Medical Coverage with USL&H

Apply Online at www.unitedsecuritylandh.com and We'll Waive the \$25 Application Fee!

Plan Highlights

- Coverage Available as Early as Next Day
- \$2 Million Lifetime Maximum
- Visit Any Doctor/Any Hospital
- Prescription Drug Coverage
- Limited Benefits While Outside the U.S.

Other Health Care Products from United Security Life and Health

If you are approved for a Major Medical plan with USL&H, you may also be pre-approved for our ancillary products:

E-Z Life (Simplified-Issue)

Piece of mind for your final expenses

- Face Amounts from \$2,500 - \$25,000
- Whole Life Policy
- Simplified Underwriting – Only 7 health questions!
- Optional Accelerated Death Benefit

Disability Income

It works when you can't

- Monthly Benefits from \$400 - \$3,000
- 24-Hour Coverage – On or off the job!
- No Restrictions on How to Use Benefit Money

Cancer Benefit

Provides a benefit as soon as you need it... for whatever you need

- Guaranteed Renewable for Life
- Lump Sum Benefit up to \$50,000 Available
- Benefit Paid Upon Diagnosis - No restrictions on how you use the money!



www.unitedsecuritylandh.com

6640 SOUTH CICERO AVENUE, BEDFORD PARK, ILLINOIS 60638 • 800/875-4422

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Rate Information

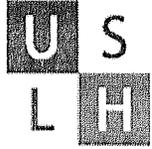
Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 06/16/2009
Comments:
Please see the attached Flesch Certification.
Attachment:
6.9.09 - Flesch Certification (AR-SEL-BEN-09).pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 06/16/2009
Comments:
This filing is the Application that was amended to comply with ACA 23-79-750 (c)(2). Once approved, this Application will be used with Group Certificates ABC-90, ADVANTAGE-04, PROPLUS-98, ABC-2008APXAR, ABC-2008PRPAR, and ABC-2008ADCAR.



UNITED SECURITY

LIFE AND HEALTH INSURANCE COMPANY

6640 S. Cicero Avenue, Bedford Park, Illinois 60638
(708) 475-6100 (800) 875-4422 Fax: (708) 475-6120

FLESCH CERTIFICATION

This is to certify that the attached Arkansas Benefit Selection Sheet (AR-BEN-SEL-09) and Application for Insurance (APP0407) that is being filed for review and approval and is to be used with Group Certificates, ABC-2008ADCAR, ABC-2008PRPAR, ABC-2008APXAR, ABC-90, ADVANTAGE-04 and PROPLUS-98, received a Flesch Reading Ease Score of 31.8. This Application does not comply with the requirements of A.C.A. 23-80-206, but is in compliance with the requirements of A.C.A. 23-80-207 since it is warranted by the nature of a particular policy form.

A handwritten signature in cursive script, appearing to read 'Peter Harmon', written over a horizontal line.

Peter Harmon
Senior Vice President

Date