

SERFF Tracking Number: RSLI-126257380 State: Arkansas  
Filing Company: Reliance Standard Life Insurance Company State Tracking Number: 43138  
Company Tracking Number: LRS-6564-8 ED. 8/09  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term  
Product Name: Group long term disability income  
Project Name/Number: Premiums/

## Filing at a Glance

Company: Reliance Standard Life Insurance Company

Product Name: Group long term disability income SERFF Tr Num: RSLI-126257380 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved-Closed State Tr Num: 43138

Sub-TOI: H11G.003 Long Term Co Tr Num: LRS-6564-8 ED. 8/09 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Author: Richard Vogenitz Disposition Date: 08/14/2009

Date Submitted: 08/06/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Premiums

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/14/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 08/14/2009

Created By: Richard Vogenitz

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Richard Vogenitz

Filing Description:

Reliance Standard Life Insurance Company

Group Long Term Disability Income Insurance

Submitting:

Premiums policy page

Policy Page: LRS-6564-8 Ed. 8/09

We are submitting the above captioned form for review. This is intended to replace policy form LRS-6564-8 Ed. 4/06

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which was previously approved by your department on 9/5/06. The only revision to the form was the bracketing of the 25% reference in item (3) of the Premium Rate section. Any percentage between 1 and 25 can be used.

There is no impact on the Group Long Term Disability Income rates as a result of this revision.

## Company and Contact

### Filing Contact Information

Richard Vogenitz, Senior Compliance Specialist richard.vogenitz@rsli.com  
 2001 Market Street 800-351-7500 [Phone] 4228 [Ext]  
 Suite 1500 267-256-3546 [FAX]  
 Philadelphia, PA 19130-7090

### Filing Company Information

Reliance Standard Life Insurance Company CoCode: 68381 State of Domicile: Illinois  
 2001 Market Street Group Code: Company Type:  
 Suite 1500 Group Name: State ID Number:  
 Philadelphia, PA 19103-7090 FEIN Number: 36-0883760  
 (800) 351-7500 ext. [Phone]

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: \$50 per form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reliance Standard Life Insurance Company	\$50.00	08/06/2009	29665290

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/14/2009	08/14/2009

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## **Disposition**

Disposition Date: 08/14/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Form</b>	Premiums	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number: LRS-6564-8 Ed. 8/09**

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/14/2009	LRS-6564-8 Ed. 8/09	Policy/Cont Premiums ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.000	premiums page.pdf

## PREMIUMS

**PREMIUM PAYMENT:** All Premiums are to be paid by you to us, or to an authorized agent, on or before the due date. The Premium Due Dates are stated on this Policy's face page.

**PREMIUM RATE:** [The Premium due will be the rate per \$100.00 of the entire amount of Covered Monthly Earnings then in force.] We will furnish to you the Premium Rate on this Policy's Effective Date and when it is changed. We have the right to change the Premium Rate:

- [(1) when the extent of coverage is changed by amendment;
- (2) on any Premium Due Date after the [second] Policy Anniversary; or
- [(3) on any Premium Due Date on or after the first Policy Anniversary if your entire group's [Covered Monthly Earnings] changes by [25%] or more from such group's [Covered Monthly Earnings] on the [last Policy Anniversary.]

We will not change the Premium Rate on (2) or (3) above more than once in any [twelve (12) month] period. We will tell you in writing at least [thirty-one (31) days] before the date of a change due to (2) or (3) above.

**GRACE PERIOD:** You may pay the Premium up to [thirty-one (31) days] after the date it is due. This Policy stays in force during this time. If the Premium is not paid during the grace period, this Policy will terminate. You will still owe us the Premium up to the date this Policy terminates.

**WAIVER OF PREMIUM:** No Premium is due us for an Insured while he/she is receiving Monthly Benefits from us. Once Monthly Benefits cease due to the end of his/her Total Disability, Premium Payments must begin again if insurance is to continue.

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachments:</b> AR_Readability_certification.pdf AR_Rule and reg 19_certification.pdf AR_Rule and reg 49_certification.pdf	Approved-Closed	08/14/2009

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> <b>Attachments:</b> AR_App_LRS-8387.pdf AR_Application.pdf	Approved-Closed	08/14/2009

CERTIFICATION OF COMPLIANCE

I certify that we comply with ACA 23-80-206 regarding readability.

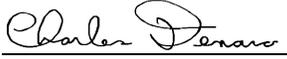


Charles Denaro  
Charles Denaro  
Vice President, Secretary

Date: August 3, 2009

CERTIFICATION OF COMPLIANCE

I certify that we comply with Rule and Regulation 19.



Charles Denaro  
Vice President, Secretary

Date: August 3, 2009

CERTIFICATION OF COMPLIANCE

I certify that we comply with Rule and Regulation 49.



Charles Denaro  
Charles Denaro  
Vice President, Secretary

Date: August 3, 2009

**Use this form for cases that offer basic coverage only**

Instructions: Complete both pages. Type or print with ballpoint pen. The employee and the policyholder must each receive a copy of the completed Group Enrollment Card.

<b>Reliance Standard Life Insurance Company</b>		<b>Group Enrollment Card</b>	
<b>Employer Section</b>	(1) Policyholder		(2) Policy No.
	(3) Location	(4) Full Time Employment Date	(5) Class
	(6) Hours Per Week	(7) Occupation	(8) Salary \$ <input type="checkbox"/> Hrly. <input type="checkbox"/> Mthly. <input type="checkbox"/> Wkly. <input type="checkbox"/> Yrly.
<b>Employee Section</b>	(9) Employee's Last Name		First Middle Initial
	(10) Employee's Birth Date month    day    year	(11) Social Security No.	(12) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	(13) Beneficiary(ies) Full Name(s)	Relationship	% of Proceeds
<b>See Reverse Side For Declination of Insurance</b>	(14) I request to purchase <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Weekly Income <input type="checkbox"/> Long Term Disability		
	(15) I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage(s) requested above. This signature is also to verify: (1) the accuracy of the information contained on this card; and (2) the beneficiary(ies) I have designated.		
		Employee Signature	Date
		LRS-8387-1188	Basic



**Instructions: Use this form only for cases that offer the Insured the ability to purchase supplemental coverage. Complete both pages. Type or print with ballpoint pen. The employee and the policyholder must each receive a copy of the completed Group Enrollment Card.**

<b>Reliance Standard Life Insurance Company</b>		<b>Group Enrollment Card</b>		
<b>Employer Section</b>	(1) Policyholder		(2) Policy No.	
	(3) Location	(4) Full Time Employment Date	(5) Class	
	(6) Hours Per Week	(7) Occupation	(8) Salary \$ <input type="checkbox"/> Hrly. <input type="checkbox"/> Mthly. <input type="checkbox"/> Wkly. <input type="checkbox"/> Yrly.	
<b>Employee Section</b>	(9) Employee's Full Name			
	(10) S.S. No.	(11) <input type="checkbox"/> Male <input type="checkbox"/> Female	(12) Employee's Birth Date mm dd yy	(13) Spouse's Birth Date mm dd yy
	(14) Beneficiary(ies) Full Name(s)		Relationship	% of Proceeds
<b>See Reverse Side For Declination of Insurance</b>	(15) I request to purchase the following Group Insurance Coverages: <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Supp. Life <input type="checkbox"/> Dep. Life <input type="checkbox"/> Weekly Income <input type="checkbox"/> Long Term Disability			
	(16) I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage(s) requested above. This signature is also to verify: (1) the accuracy of the information contained on this card; and (2) the beneficiary(ies) I have designated.			
Employee Signature		Date		

