

SERFF Tracking Number: ULCC-126272311 State: Arkansas  
 Filing Company: ULLICO Life Insurance Company State Tracking Number: 43273  
 Company Tracking Number: ULG-ADD-0709 ULLICO LIFE INSURANCE  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: ULG-ADD-0709  
 Project Name/Number: ULG-ADD-0709/ULG-ADD-0709

## Filing at a Glance

Company: ULLICO Life Insurance Company

Product Name: ULG-ADD-0709

TOI: H04 Health - Blanket Accident/Sickness

Sub-TOI: H04.000 Health - Blanket  
 Accident/Sickness

Filing Type: Form

SERFF Tr Num: ULCC-126272311 State: Arkansas

SERFF Status: Closed-Approved-  
 Closed State Tr Num: 43273

Co Tr Num: ULG-ADD-0709  
 ULLICO LIFE INSURANCE

State Status: Approved-Closed

Authors: Karen Whitham, Carmen  
 Washington

Reviewer(s): Rosalind Minor

Disposition Date: 08/28/2009

Date Submitted: 08/19/2009

Disposition Status: Approved-  
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: ULG-ADD-0709

Project Number: ULG-ADD-0709

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/28/2009

Deemer Date:

Submitted By: Carmen Washington

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Discretionary

Explanation for Other Group Market Type:

State Status Changed: 08/28/2009

Created By: Carmen Washington

Corresponding Filing Tracking Number: ULG-  
 ADD-0709

Filing Description:

Attached for your review and approval are group blanket accidental death, or accidental death and dismemberment, policy and certificate forms ULG-ADD-0709 et al. These are new forms and do not replace any existing forms.

This product will be marketed to labor union groups, and will provide an accidental death and dismemberment, or accidental death, benefit, with or without a workplace accidental death benefit. The coverage provided to insureds is non-contributory, and will terminate after one year.

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The policy may be issued by The Union Labor Life Insurance Company or by ULLICO Life Insurance Company, as licensed in each jurisdiction. The forms have been submitted separately for approval for each company.

All forms are in final print format.

Please do not hesitate to contact me with any questions.

## Company and Contact

### Filing Contact Information

Carmen Washington, Compliance Analyst cwashington@ullico.com  
 8403 Colesville Rd 202-682-8779 [Phone]  
 Silver Spring, MD 20910

### Filing Company Information

ULLICO Life Insurance Company CoCode: 86371 State of Domicile: Texas  
 8403 Colesville Road Group Code: 781 Company Type: Life and Health  
 Silver Spring, MD 20910 Group Name: Union Labor Group State ID Number:  
 (202) 682-0900 ext. [Phone] FEIN Number: 31-0522223

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? Yes  
 Fee Explanation: Based on Texas our domicile state \$100.00 per product filing fee, we determined our one product filing fee to be \$100.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ULLICO Life Insurance Company	\$100.00	08/19/2009	29953866

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Project Name/Number: ULG-ADD-0709/ULG-ADD-0709

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/28/2009	08/28/2009

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Product Name: ULG-ADD-0709  
Project Name/Number: ULG-ADD-0709/ULG-ADD-0709

## Disposition

Disposition Date: 08/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *ULCC-126272311* State: *Arkansas*  
 Filing Company: *ULLICO Life Insurance Company* State Tracking Number: *43273*  
 Company Tracking Number: *ULG-ADD-0709 ULLICO LIFE INSURANCE*  
 TOI: *H04 Health - Blanket Accident/Sickness* Sub-TOI: *H04.000 Health - Blanket Accident/Sickness*  
 Product Name: *ULG-ADD-0709*  
 Project Name/Number: *ULG-ADD-0709/ULG-ADD-0709*

<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>	Blanket Accidental Death and Dismemberment Insurance Policy	Approved-Closed	Yes
<b>Form</b>	Blanket Accidental Death and Dismemberment Insurance Certification	Approved-Closed	Yes
<b>Form</b>	Application for Group Insurance	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: ULG-ADD-0709

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/28/2009	ULG-ADD-0709	Policy/Cont ract/Fratern al	Blanket Accidental Death and Dismemberment Insurance Policy Certificate	Initial		51.200	ULG-ADD-0709.pdf
Approved-Closed 08/28/2009	ULC-ADD-0709	Certificate	Blanket Accidental Death and Dismemberment Insurance Certification	Initial		50.300	ULC-ADD-0709.pdf
Approved-Closed 08/28/2009	ULGA-PH-0709	Application/ Enrollment Form	Application for Group Insurance	Initial		51.900	ULGA-PH-0709.pdf

**[ ULLICO Life Insurance Company**  
(“We, Us, Our, the Company”)  
Administrative Office: PO Box 1360, Blue Springs, MO 64013  
Home Office: 20770 Highway 281 North Suite 108-418, San Antonio, TX 78258]

**GROUP POLICY NO.:** [12345]                      **POLICY DELIVERED IN:** [Texas]  
**EFFECTIVE DATE:** [July 1, 2009]                      **POLICY YEAR:** [July 1, 2009 to June 30, 2010]  
**POLICYHOLDER:** [ABC Labor Union]

The consideration for the Policy is the application and the timely payment of the premium when due. The Policy is issued to the Policyholder named above. It provides benefits to eligible persons becoming insured. Any payments are subject to all the terms and conditions of the Policy.

In the Policy [ULLICO Life Insurance Company] [The Union Labor Life Insurance Company] will be called "we", "our", or "us". The person or persons covered under the Policy will be called "Insureds".

The Policy takes effect on the Effective Date shown above [and terminates at the end of the Policy Year] [and renews in one year periods unless it is terminated as provided in the Policy Termination Provision.] All periods of insurance begin at 12:01 A.M. Standard Time at the Insured's address.

The terms contained on this and the following pages make up the Policy.

The Policy may be inspected at the office of the Policyholder. It is executed on the Effective Date shown above at our Executive Office.

[Officer Signature]  
[Officer Title]

[Officer Signature]  
[Officer Title]

\_\_\_\_\_  
Countersignature of Licensed Resident Agent if Required]

**GROUP BLANKET ACCIDENTAL DEATH [AND DISMEMBERMENT] POLICY  
NON-PARTICIPATING**

**WHEN COVERAGE STARTS AND STOPS**

**Individuals Eligible For Insurance:** [All members of the Policyholder.]

**Individual Effective Date:** This insurance takes effect on the date shown on the Insured’s certificate.

**Individual Termination Date:** The Insured’s coverage stops one year from the Certificate Effective Date or when he stops being a member of the Group Policyholder, whichever happens first.

**ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFIT**

Upon receipt of due proof of loss, the Accidental Death [and Dismemberment] Benefit will be paid if: (1) an Insured, while insured under this benefit, suffers an accidental Injury;; and(2) as the direct result of the accident, and independent of all other causes, the Insured suffers a Covered Loss within 365 days after the accident.

A “Covered Loss” means permanent loss of: [(1)] life; (2) a hand, by complete severance at or above the wrist joint; (3) a foot, by complete severance at or above the ankle joint; or (4) an eye, involving irrecoverable and complete loss of sight in the eye. The amount of benefit to be paid for a Covered Loss is [the Principal Sum] [determined as follows:

**Schedule of Losses**

<b>For Loss of:</b>	<b>The Benefit Is:</b>
Life .....	The Principal Sum
Two Hands; Two Feet; Sight of Two Eyes; One Hand and One Foot; One Hand and Sight of One Eye; or One Foot and Sight of One Eye .....	The Principal Sum
One Hand or One Foot or Sight of One Eye.....	One-Half The Principal Sum

If the Insured suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable. ]

**[WORKPLACE ACCIDENTAL DEATH BENEFIT**

In addition to any other benefit payable under the Policy, We will pay a Workplace Accidental Death Benefit if the Insured suffers a Covered Loss as a result of a Workplace Injury

“Workplace Injury” means [(1)] an accidental injury that occurs while the Insured is at his workplace and performing his regularly scheduled [union] work [or serving in an official capacity for his local, state, or national labor organization]; or (2) an accidental injury that occurs while the Insured is traveling between his residence and his workplace for his regularly scheduled [union] work [or service in an official capacity for your local, state, or national labor organization.]]

The Workplace Injury must be the direct cause of a Covered Loss and must be independent of all other causes. ]

**EXCLUSIONS**

The Policy does not cover loss caused by or resulting from: (a) intentionally self-inflicted injury, suicide, or any attempt at suicide; (b) the voluntary use of drugs, medications or sedatives, unless prescribed by a physician; (c) driving or operating a motor vehicle while under the influence of alcohol or drugs unless taken as prescribed by a physician; (d) travel in any aircraft, except as a passenger on a commercial airplane or a pilot or crewmember of a commercial airplane; (e) any active participation in a riot, armed conflict, or insurrection; (f) an injury that occurs while the Insured is committing or attempting to commit an assault or felony; (g) an injury that occurs while the Insured is engaged in any illegal occupation; (h) sickness, bodily or mental infirmity, or treatment of sickness, bodily or mental infirmity; (i) participation in a race or speed contest; or (j) operating a motorcycle, mini-bike, or motor bike while not wearing a helmet.

## **BENEFICIARY**

**Beneficiary Designation:** Unless otherwise specified by the Insured, death benefits payable at his death are paid to his estate.

**Change of Beneficiary:** Unless the Insured indicates that his beneficiary cannot be changed, he can change the beneficiary at any time. The beneficiary's consent is not needed. Such change must be requested in writing on a form furnished by or satisfactory to the Company. Such change will take effect upon Our receipt of the signed form. The change is subject to: (1) the rights of any assignee; and (2) any payment made of action taken by us before our acknowledgement. If the beneficiary dies before the Insured, the benefit is paid to any remaining beneficiaries. If no designated beneficiary lives longer than him the benefit is paid to his estate.

**Payment to Beneficiary:** Upon receipt of satisfactory Written Proof of Loss, the Company will pay the death benefit to the Insured if alive, or to the Insured's named beneficiary. If the Insured has named more than one beneficiary, each surviving beneficiary will share equally, unless otherwise indicated by the Insured when the beneficiaries were named. If there is no named beneficiary, or if no named beneficiary is surviving at the death of the Insured, payment will be made to the executors or administrators of the Insured's estate.

If the beneficiary is a minor or someone not able to give a valid release for payment, the Company will pay the benefit to his or her legal guardian. If there is no legal guardian, the Company may pay the individual or institution who has, in its opinion, custody and principal support of such beneficiary. The Company will be fully discharged of its liability for any amount of benefit so paid in good faith.

## **WHEN THE INSURED HAS A CLAIM**

**Notice of Claim:** Written notice of claim must be given to us within 30 days after a covered loss occurs, or as soon as possible. The written notice should be accompanied by a copy of the Insured's Certificate and enough information for us to identify the Insured. Upon receipt of the notification of a claim, we will provide claim forms for filing Written Proof of Loss. If the claimant does not receive the claim forms within 15 days after sending notice of the claim, the claimant can file a claim by sending the Company Written Proof of Loss containing all required information.

**Written Proof of Loss:** Written proof of loss must be provided within 90 days after the date of loss or as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless it was legally impossible to do so. The proof of the loss must include all information necessary for us to determine the nature of the loss; and the date of the loss. We may require, as part of the proof, authorization to obtain medical and non-medical information. We will notify the claimant of any additional information required to process a claim.

**Payment of Claim:** We will pay benefits when the claimant files satisfactory Written Proof of Loss.

## **GENERAL PROVISIONS**

**Clerical Error:** Neither clerical error in record keeping, nor delays in making entries shall invalidate the Policy if it was otherwise validly in force. If we find any such error or delay, we will make a fair adjustment of premiums.

**Conformity with State Statutes:** Any provision of the Policy that is in conflict with the laws of the state in which the Policy is delivered, or issued for delivery, is amended to conform to the minimum requirements of those laws.

**Entire Contract, Changes:** The Policy and the application make up the entire contract of insurance. No change in the Policy will take effect until approved by one of our officers in writing, and as attached to the Policy by endorsement. Only the Chairman, Chief Executive Officer, President, a Vice President, the Secretary, or an Assistant Secretary are officers of the Company for this purpose.

**Examination and Autopsy:** When a claim is submitted, the Company has the right, at Our expense, to have physical examinations, or autopsy in case of death, performed on the Insured, where this is not forbidden by law..

**Grace Period:** A grace period of 31 days will be granted to pay each premium when due after the first premium, as long as the Policy is in force. The insurance under the Policy will continue in force during the grace period, or until the date of termination of the Policy if earlier. The Policyholder will be liable for a pro rata premium for the time the Policy was in force during the grace period.

**Individual Certificates of Insurance:** We will issue the individual Certificates of Insurance to each insured Person. The Certificate will state the benefits for which the individual is insured, to whom the benefits are payable, and any other conditions of the Policy that affect insured individuals. If there is any difference between the provisions of the Policy and a Certificate of Insurance, the provisions of the Policy will govern.

**Insurance Data:** The Policyholder shall give us any information which we require with regard to insurance under the Policy. All of the Policyholder's records on this insurance shall be open to us at all reasonable times.

**Legal Actions:** The Insured cannot bring any action at law or inequity for any benefits under the Policy until 60 days after the Insured filed written proof of loss. The Insured cannot bring an action after 3 years from the time that written proof of loss is due.

**Policyholder or Designated Representative Not an Agent:** The Policyholder, or its designated representative, will not be considered to be the agent of the Company for any purpose under the Policy.

**Policy Changes:** The benefits, terms or conditions of the Policy may be changed by a written agreement between the Policyholder and the Company. No such changes will be effective until approved by an officer of the Company. In all matters regarding the Policy, the Policyholder acts for the Insureds under the Policy.

**Policy Termination:** The Policy will terminate [ ] at the end of the Policy Year. [ ] [ ] at the end of the grace period if the premium due has not been paid. [ ] It may be terminated by Us or by the Policyholder with 60 days advance written notice.

**Premium:** All premiums must be paid when due at the Administrative Office of the Company, or at any office authorized by the Company to accept them. The total amount of premium due will be based on the premium rates in effect and the number of lives insured and/or the volume of insurance in force, including any adjustments.

We may change premium rates, by class, for the coverages provided under the Policy on any due date with 31 days advance written notice. We will not change premium rates more than once in any Policy year.

**Statements; Incontestability of Insurance:** All statements made by the Policyholder or an Insured are considered, except for fraud, to be representations and not warranties. No such statements may be used to contest the validity of the Policy [ ] within 2 years from issuance [ ], or an Insured's insurability unless it is in writing and signed by the Policyholder or the Insured; and a copy of the statement is given to the Policyholder, the Insured or his or her Beneficiary.

**ULLICO Life Insurance Company**  
 (“We, Us, Our, the Company”)  
 Administrative Office: PO Box 1360, Blue Springs, MO 64013  
 Home Office: 20770 Highway 281 North Suite 108-418, San Antonio, TX 78258

**BLANKET ACCIDENTAL DEATH [AND DISMEMBERMENT] INSURANCE CERTIFICATE**

CERTIFICATE SCHEDULE	
Certificate Holder: [John Doe]	
Certificate Number: [123456789]	Group Policy Number: [12345]
Certificate Effective Date: [July 1, 2009]	Certificate Termination Date: [June 30, 2010]
Group Policyholder: [ABC Labor Union]	
Accidental Death [and Dismemberment] Benefit (The Principal Sum): [\$5,000]	
[Workplace Accidental Death Benefit: \$5,000]	

The Certificateholder is referred to as “you,” “your,” or “yours” and is the Insured. [ULLICO Life Insurance Company] [The Union Labor Life Insurance Company] is referred to as “we,” “our,” or “us.” The Certificate provides Accidental Death [and Dismemberment] Insurance. It is subject to all the terms and conditions set forth in the Group Policy. Your coverage starts at 12:00 Noon, Standard Time, at your home on the Effective Date shown on the Certificate Schedule. Coverage stops one year from the Certificate Effective Date or when you stop being a member of the Group Policyholder, whichever happens first. The annual premium for this insurance is paid for on your behalf by the Policyholder.

**ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFIT**

Upon receipt of due proof of loss, the Accidental Death [and Dismemberment] Benefit will be paid if: (1) while insured under this benefit, you suffer an accidental Injury; and(2) as the direct result of the accident, and independent of all other causes, you suffer a Covered Loss within 365 days after the accident.

A “Covered Loss” means permanent loss of: [(1)] life; (2) a hand, by complete severance at or above the wrist joint; (3) a foot, by complete severance at or above the ankle joint; or (4) an eye, involving irrecoverable and complete loss of sight in the eye. The amount of benefit to be paid for a Covered Loss is [the Principal Sum] [determined as follows:

For Loss of:	Schedule of Losses	The Benefit Is:
Life .....		The Principal Sum
Two Hands; Two Feet; Sight of Two Eyes; One Hand and One Foot; One Hand and Sight of One Eye; or One Foot and Sight of One Eye .....		The Principal Sum
One Hand or One Foot or Sight of One Eye .....		One-Half The Principal Sum

If the Insured suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable. ]

**[WORKPLACE ACCIDENTAL DEATH BENEFIT**

In addition to any other benefit payable under the Certificate, We will pay a Workplace Accidental Death Benefit if you suffer a Covered Loss as a result of a Workplace Injury.

“Workplace Injury” means [(1)] an accidental injury that occurs while you are at your workplace and performing your regularly scheduled [union] work [or serving in an official capacity for your local, state, or national labor organization] [; or (2) an accidental injury that occurs while you are traveling between your residence and your workplace for your regularly scheduled [union] work [or service in an official capacity for your local, state, or national labor organization. ]]

The Workplace Injury must be the direct cause of a Covered Loss and must be independent of all other causes. ]

**EXCLUSIONS**

This Certificate does not cover loss caused by or resulting from: (a) intentionally self-inflicted injury, suicide, or any attempt at suicide; (b) the voluntary use of drugs, medications or sedatives, unless prescribed by a physician; (c) driving or operating a motor vehicle while under the influence of alcohol or drugs unless taken as prescribed by a physician; (d) travel in any aircraft, except as a passenger on a commercial airplane or as a pilot or crewmember of a commercial airplane; (e) any active participation in a riot, armed conflict or insurrection; (f) an injury that occurs while you are committing or attempting to commit an assault or felony; (g) an injury that occurs while you are engaged in any illegal occupation; (h) sickness, bodily or mental infirmity, or treatment of sickness, bodily or mental infirmity; (i) participation in a race or speed contest; or (j) operating a motorcycle, mini-bike, or motor bike while not wearing a helmet

**NON-CONTRIBUTORY and NON-RENEWABLE**

## BENEFICIARY

**Beneficiary Designation:** Unless otherwise specified by you, death benefits payable at your death are paid to your estate.

**Change of Beneficiary:** Unless you indicate that your beneficiary cannot be changed, you can change the beneficiary at any time. The beneficiary's consent is not needed. Such change must be requested in writing on a form furnished by or satisfactory to the Company. Such change will take effect upon Our receipt of the signed form. The change is subject to: (1) the rights of any assignee; and (2) any payment made or action taken by us before our acknowledgement. If the beneficiary dies before you, the benefit is paid to any remaining beneficiaries. If no designated beneficiary lives longer than you the benefit is paid to your estate.

**Payment to Beneficiary:** Upon receipt of satisfactory Written Proof of Loss, the Company will pay the death benefit to you if alive, or to your named beneficiary. If you have named more than one beneficiary, each surviving beneficiary will share equally, unless otherwise indicated by you when the beneficiaries were named. If there is no named beneficiary, or if no named beneficiary is surviving at your death, payment will be made to the executors or administrators of your estate.

If the beneficiary is a minor or someone not able to give a valid release for payment, the Company will pay the benefit to his or her legal guardian. If there is no legal guardian, the Company may pay the individual or institution that has, in its opinion, custody and principal support of such beneficiary. The Company will be fully discharged of its liability for any amount of benefit so paid in good faith.

## CLAIMS

**Notice of Claim:** Written notice of a claim must be given to us within 30 days after a covered loss occurs, or as soon as reasonably possible. The written notice should be accompanied by a copy of this Certificate and enough information for us to identify the Insured. Upon receipt of the notification of a claim, the Company will provide claim forms for filing Written Proof of Loss. If the claimant does not receive the claim forms within 15 days after sending notice of the claim, the claimant can file a claim by sending the Company Written Proof of Loss containing all required information.

**Written Proof of Loss:** Written Proof of Loss must be given within 90 days after the loss or as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless it was legally impossible to do so. The proof of the loss must include all information necessary for the Company to determine the nature of the loss; and the date of the loss. The Company may require, as part of the proof, authorization to obtain medical and non-medical information. The Company will notify the Person of any additional information required to process a claim.

**Payment of Claims:** Payment is made when we receive satisfactory Written Proof of Loss.

## GENERAL PROVISIONS

**Clerical Error:** Neither clerical error in record keeping, nor delays in making entries shall invalidate insurance otherwise validly in force under this Certificate.

**Conformity with State Statutes:** Any provision of the certificate that is in conflict with the laws of the state in which the Policy is delivered, or issued for delivery, is amended to conform to the minimum requirements of those laws.

**Entire Contract, Changes:** The Policy and the application make up the entire contract of insurance. No change in the Policy will take effect until approved by one of our officers in writing, and as attached to the Policy by endorsement. Only the Chairman, Chief Executive Officer, President, a Vice President, the Secretary, or an Assistant Secretary are officers of the Company for this purpose.

**Examination and Autopsy:** When a claim is submitted, the Company has the right, at Our expense, to have physical examinations, or autopsy in case of death, performed on the Insured, where this is not forbidden by law.

**Legal Actions:** A lawsuit may not be brought against us (e.g. if we do not pay a claim): (1) during the 60 days after we receive written Proof of Loss; or (2) after 3 years from the time the Proof of Loss is required.

**Statements; Incontestability of Insurance:** All statements made by the Policyholder or an Insured are considered, except for fraud, to be representations and not warranties. No such statements may be used to contest the validity of this certificate unless it is in writing and signed by the Policyholder or the Insured; and a copy of the statement is given to the Policyholder, the Insured or his or her beneficiary.

**U**LLICO Life Insurance Company  
("We, Us, Our, the Company")  
Administrative Office: PO Box 1360, Blue Springs, MO 64013  
Home Office: 20770 Highway 281 North Suite 108-418, San Antonio, TX 78258  
Telephone: (816) 229-7191  
www.ullico.com

**APPLICATION FOR GROUP INSURANCE**

Application is Hereby Made to:

**U**LLICO LIFE INSURANCE COMPANY **U** **T**HE UNION LABOR LIFE INSURANCE COMPANY **U**

By: **U**ABC Labor Union **U**

Whose address is: **U**123 ABC Street, 4th Floor, Anytown, TX 77777-7777 **U**

For Policy Number: **U**GP-12345 **U**

This Policy is hereby approved and all of its terms and provisions are accepted.

Dated: **U**July 1, 2009 **U** at **U**San Antonio, Texas **U**

Executed for the Policyholder:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name

This application is executed in duplicate, one copy to be attached to the Policy and the other to be returned to the Company.

SERFF Tracking Number: ULCC-126272311 State: Arkansas  
 Filing Company: ULLICO Life Insurance Company State Tracking Number: 43273  
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 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: ULG-ADD-0709  
 Project Name/Number: ULG-ADD-0709/ULG-ADD-0709

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> Please see the attached Certification of Compliance and ADD-0709 Certification of Readability. <b>Attachments:</b> Certification of Compliance (ULLICO LIFE).pdf ADD-0709 Certification of Readability.pdf	Approved-Closed	08/28/2009

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A. The application is under the form tab. <b>Comments:</b>	Approved-Closed	08/28/2009

**ARKANSAS  
CERTIFICATION OF COMPLIANCE**

I hereby certify I have carefully reviewed each form being submitted in this filing and that, to the best of my knowledge and belief, find that each of the requirements specified in Rules and Regulations 19 & 49 and Consumer Information ACA 23-79-138 have been met.

By: Carmen Washington Date: 8/19/09

Print Name: Carmen M. Washington, Compliance Analyst

Insurer: ULLICO LIFE INSURANCE COMPANY

## CERTIFICATION OF READABILITY

I certify that the forms submitted with this filing achieved the following Flesch Test Reading Scores:

<b>Form</b>	<b>Description</b>	<b>Score</b>
ULG-ADD-0709	Group Policy	51.2
ULC-ADD-0709	Group Certificate	50.3
ULGA-PH-0709	Application for Group Insurance	51.9

  
**PRESIDENT**

---

Gary L. Burke  
ULLICO Life Insurance Company  
The Union Labor Life Insurance Company

July 21, 2009  
Date