

SERFF Tracking Number: CUNA-126240976 State: Arkansas
Filing Company: CUNA Mutual Insurance Society State Tracking Number: 43102
Company Tracking Number: 2009-LTCAP-ML
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: LTCi Multi-Life Application
Project Name/Number: 2009 Multi-Life Application for Long-Term Care/

Filing at a Glance

Company: CUNA Mutual Insurance Society

Product Name: LTCi Multi-Life Application

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form

SERFF Tr Num: CUNA-126240976 State: Arkansas

SERFF Status: Closed-Approved State Tr Num: 43102

Co Tr Num: 2009-LTCAP-ML State Status: Closed

Reviewer(s): Harris Shearer

Disposition Date: 09/21/2009

Authors: Kari Hamrick, Kathy

Strauser, Carma Bouska, Kimberly

Steggall

Date Submitted: 07/30/2009

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: 2009 Multi-Life Application for Long-Term Care

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/21/2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 07/24/2009

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/21/2009

Created By: Carma Bouska

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Carma Bouska

Filing Description:

Please find attached application form 2009-LTCAP-ML for your examination and approval. It is a new form, in final print, with the exception of ink, font style, paper stock and logo. This submission does not contain any unusual, innovative or unique features from normal industry standards.

This application will be used to apply for individual Long Term Care Insurance Policy 2006-LTC-COMP(AR), approved by the Department on October 23, 2008. This application will be used in employer situations where the employer wishes to make long term care insurance available to 3 or more employees and the employer is paying a portion of the premium.

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Upon approval, this form will be available to be printed through a secured site on the internet where agents and home office personnel will have the option to complete fields within the application on-line. As fields are completed, sections may be expanded to accommodate information applicable to each section. The form will then be printed on paper and a wet signature obtained. When technology permits, the process may include electronic signature capabilities. This form was written to be readable and easily understood by insureds. It was combined with the policy form to achieve a flesch score of 50.

Thank you for your review of this submission.

Company and Contact

Filing Contact Information

Carma Bouska, carma.bouska@cunamutual.com
 2000 Heritage Way 319-483-3511 [Phone]
 Waverly, IA 50677

Filing Company Information

CUNA Mutual Insurance Society CoCode: 62626 State of Domicile: Iowa
 2000 Heritage Way Group Code: 306 Company Type:
 Waverly, IA 50677 Group Name: State ID Number:
 (319) 352-4090 ext. [Phone] FEIN Number: 39-0230590

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
CUNA Mutual Insurance Society	\$20.00	07/30/2009	29533035

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harris Shearer	09/21/2009	09/21/2009
Approved	Harris Shearer	08/12/2009	08/12/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Update to Filing Description 8-31-09.	Carma Bouska	09/01/2009	09/01/2009

SERFF Tracking Number: CUNA-126240976 *State:* Arkansas
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Disposition

Disposition Date: 09/21/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Update to Filing Description 8-31-09.		Yes
Form	Multi-Life Application For Long-Term Care		Yes

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Disposition

Disposition Date: 08/12/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Amendment Letter

Submitted Date: 09/01/2009

Comments:

Dear Madam:

I have added a document to the Supporting Documentation tab titled, "Update to Filing Description 8-31-09". It is to correct a statement made within the filing description of this submission.

Please note that the referenced application will be used in employer situations where the employer wishes to make long term care insurance available to 3 or more employees; however, the employer will not be responsible for paying any portion of the premiums.

Thanks for allowing us to correct this information within this filing.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Update to Filing Description 8-31-09.

Comment:

Update to Filing Description 8-31-09.pdf

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Form Schedule

Lead Form Number: 2009-LTCAP-ML

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	2009-LTCAP-ML	Application/Multi-Life Application Enrollment For Long-Term Care Form	Initial		50.000	2009-LTCAP-ML.pdf

CUNA Mutual Insurance Society

2000 Heritage Way
Waverly, Iowa 50677
Phone: 1.800.798.6600

Credit Union Number: _____
Lead # (if LTCI Specialist): _____

MULTI-LIFE APPLICATION FOR LONG-TERM CARE INSURANCE

Only Employees (age 65 and younger) and Members of the Board of Directors (age 75 and younger) may use this form.

Sponsoring Employer: _____ **Account #:** _____

IF YOU ARE AN EMPLOYEE, PLEASE ANSWER THE FOLLOWING QUESTIONS BEFORE COMPLETING THIS APPLICATION.	
1. Are you currently actively at work with the sponsoring employer? <i>(If you are on leave of absence or receiving Social Security Disability Income you are not "actively at work".)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. During the last 6 months:	
a. Have you worked for the sponsoring employer at least 30 hours per week?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Have you missed 10 or fewer days due to illness, injury or infirmity?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YOU ANSWERED "NO" TO ANY OF THE QUESTIONS LISTED ABOVE, YOU ARE NOT ELIGIBLE TO USE THIS APPLICATION.	
IF YOU ARE A BOARD MEMBER, PLEASE ANSWER THE FOLLOWING QUESTIONS BEFORE COMPLETING THIS APPLICATION.	
1. Are you an active member of the sponsoring employer's board of directors?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Do you regularly attend the sponsoring employer's board meetings?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. How many hours per week do you currently work for any employer?	<input type="checkbox"/> 0-29 <input type="checkbox"/> At least 30
<p>IF YOU ANSWERED "NO" TO QUESTION #1 OR #2 LISTED ABOVE, YOU ARE NOT ELIGIBLE TO USE THIS APPLICATION. If you are age 69 or younger, your answer to question #3 listed above will affect the Facility Benefit Services Maximum Monthly Benefit Amount you may select.</p>	
SECTION A: APPLICANT INFORMATION (Please print.)	
Name: _____	
Street Address: _____	
City: _____	State: _____ Zip: _____
Social Security #: _____	Birth Date (Mo/Day/Year): ____/____/____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Phone: Home (____) _____ Work (____) _____	Best Time to call: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
SECTION B: BENEFIT SELECTION	
Change to Existing Coverage?	<input type="checkbox"/> YES
Estimated Benefit Period (Check One.) <i>If you are a Board Member only the 1 year and 2 year benefit periods are available.</i>	<input type="checkbox"/> 1 yr. <input type="checkbox"/> 2 yrs. <input type="checkbox"/> 3 yrs. <input type="checkbox"/> 4 yrs. <input type="checkbox"/> 5 yrs.
Facility Benefit Services Maximum Monthly Benefit Amount	\$ _____
1. <i>Maximum Amount for an Employee:</i>	(Available in \$100 increments.)
a. \$15,000 if you are a Senior Level Executive, as defined by the sponsoring employer; or	Min. Amount: \$1,500
b. \$9,000 if you are an employee other than a Senior Level Executive.	Max. Amount: Varies. See information at left.
2. <i>Maximum Amount for a Board Member:</i>	
a. \$6,000 if you are age 69 or younger and working at least 30 hours per week;	
b. \$3,000 if you are age 69 or younger and working less than 30 hours per week; or	
c. \$1,500 if you are age 70-75.	
Maximum Benefit Amount Facility Benefits Maximum Monthly Benefit Amount x Estimated Benefit Period x 12	\$ _____
Home and Community Benefit Services Maximum Monthly Benefit (Select the % of the Facility Benefit Services Maximum Monthly Benefit from above.)	<input type="checkbox"/> 0% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
Elimination Period (Number of Days.) <i>If you are a Board Member only the 90, 100 and 180 day elimination periods are available.</i>	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 100 <input type="checkbox"/> 180
Requested Policy Effective Date , if other than the first of the month following the date of application.	_____/_____/_____ Month / Day / Year

SECTION C: OPTIONAL BENEFIT SELECTION			
Inflation Protection Option Rider (You <u>MUST</u> check one.) * I acknowledge I have received and reviewed the outline of coverage and graphs that compare the benefits and premiums of this policy with and without inflation protection. I have reviewed the selection of Inflation Protection Option Riders and reject inflation protection.	<input type="checkbox"/> 3% Compound <input type="checkbox"/> 5% Simple <input type="checkbox"/> 5% Compound <input type="checkbox"/> No inflation protection*		
Shared Extended Expense Rider (N/A with 1 year Estimated Benefit Period)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Home and Community Care 10-Day Elimination Period Rider	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Living at Home Rider	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Spouse or Partner Waiver of Premium at Death Rider	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Refund of Premium at Death Prior to Age 75 Rider	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Refund of Premium at Death Rider	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Restoration of Maximum Benefit Rider	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Nonforfeiture Benefit Rider	<input type="checkbox"/> YES <input type="checkbox"/> NO		
SECTION D: INSURABILITY PROFILE (Please answer these questions BEFORE you continue with this application.)			
1. Are you now receiving disability, Social Security disability benefits, Workers' Compensation or Medicaid?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
2. Are you confined to a hospital or nursing home or receiving the services of a home health care agency or attending adult day care, or have any of these been recommended to you?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
3. Has it been recommended that you have surgery?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
4. Do you need assistance from or supervision by another individual for dressing, eating, continence, bathing, toileting, walking or transferring to or from a bed or chair?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
5. Have you been treated for or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
6. Do you currently use crutches, oxygen, respirator, dialysis, walker, wheelchair, quad or tripod cane, motorized scooter or chair lift?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
7. Do you currently have or have you ever been advised by a member of the medical profession that you have any of the following: <table border="0" style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 50%; vertical-align: top;"> a.) Amputation due to disease; b.) ALS (Lou Gehrig's Disease); c.) Confusion or forgetfulness; d.) Memory loss; e.) Muscular Dystrophy; f.) Organic brain syndrome; g.) Paralysis, Paraplegia or Quadriplegia; h.) Senility; i.) Alzheimer's Disease; j.) Cirrhosis of the liver; k.) Dementia; </td> <td style="width: 50%; vertical-align: top;"> l.) Multiple Sclerosis; m.) Organ transplant n.) Osteoporosis with fractures; o.) Parkinson's disease; p.) Systemic Lupus Erythematosus; q.) Diabetes that is controlled with more than 50 units of insulin per day; r.) Diabetes controlled with insulin (in any amount) for more than 15 years; s.) Stroke; or t.) TIAs (2 or more)? </td> </tr> </table>	a.) Amputation due to disease; b.) ALS (Lou Gehrig's Disease); c.) Confusion or forgetfulness; d.) Memory loss; e.) Muscular Dystrophy; f.) Organic brain syndrome; g.) Paralysis, Paraplegia or Quadriplegia; h.) Senility; i.) Alzheimer's Disease; j.) Cirrhosis of the liver; k.) Dementia;	l.) Multiple Sclerosis; m.) Organ transplant n.) Osteoporosis with fractures; o.) Parkinson's disease; p.) Systemic Lupus Erythematosus; q.) Diabetes that is controlled with more than 50 units of insulin per day; r.) Diabetes controlled with insulin (in any amount) for more than 15 years; s.) Stroke; or t.) TIAs (2 or more)?	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes for any condition at left, check "YES" and circle condition(s).
a.) Amputation due to disease; b.) ALS (Lou Gehrig's Disease); c.) Confusion or forgetfulness; d.) Memory loss; e.) Muscular Dystrophy; f.) Organic brain syndrome; g.) Paralysis, Paraplegia or Quadriplegia; h.) Senility; i.) Alzheimer's Disease; j.) Cirrhosis of the liver; k.) Dementia;	l.) Multiple Sclerosis; m.) Organ transplant n.) Osteoporosis with fractures; o.) Parkinson's disease; p.) Systemic Lupus Erythematosus; q.) Diabetes that is controlled with more than 50 units of insulin per day; r.) Diabetes controlled with insulin (in any amount) for more than 15 years; s.) Stroke; or t.) TIAs (2 or more)?		
<p>If you answered "YES" to any Section D questions, PLEASE DO NOT CONTINUE. We regret that you are not eligible for this coverage. If you answered "NO" to all Section D questions, please CONTINUE.</p>			

SECTION E: SPOUSE/PARTNER DISCOUNT

<p>Is a Spouse or Partner* applying for or do they already have a CUNA Mutual Insurance Society Long-Term Care Insurance policy?</p> <p>Spouse/Partner Name: _____</p> <p>Social Security # _____ or Policy # _____</p> <p><i>*Spouse or Partner means: 1.) the person to whom you are legally married; or 2.) any civil union partner, domestic partner, reciprocal beneficiary or other term defined by law for your state of residence to mean a person with equal rights to that of a spouse; or 3.) the person with whom you have had a committed relationship for at least five years. (You have both lived in the same dwelling unit and have shared the living expenses.) A parent-child relationship does not qualify.</i></p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "YES", provide details at left.</p>
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SECTION F: PREMIUM AND PAYMENT MODE INFORMATION

Estimated Total Monthly Premium? \$ _____ **List Bill Group No:** _____

Initial Premium Submitted with Application? \$ _____
(A minimum of 2 months premium is required. Do not submit premium with application for a Change to Existing Coverage.)

SECTION G: OTHER COVERAGE AND REPLACEMENT INFORMATION

<p>1. Do you have another Long-Term Care Insurance policy or certificate pending or in-force? (Including health care service contract or health maintenance organization contract.)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>2. Did you have another Long-Term Care Insurance policy or certificate in-force during the last twelve (12) months?</p> <p><u>Details:</u> Company name and address for prior policy: Company: _____ Address: _____ City: _____ State: _____ Zip Code: _____ If the policy lapsed when did it lapse? ____ / ____ / ____ Policy Number: _____</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "YES", provide details at left.</p>
<p>3. Are you covered by Medicaid?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>4. Do you intend to replace any of your medical or health insurance coverage with this Long-Term Care Insurance Policy?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>5. Have you ever been denied coverage for Long-Term Care Insurance?</p> <p><u>Details:</u> If you answered "YES", what was the Company name, date and reason why (if known)? _____ _____</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "YES", provide details at left.</p>

SECTION H: PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I understand that once every two (2) years I will be given an opportunity to change my written designation.

I elect **NOT** to designate a person to receive such notice.
 I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Full Name: _____ Phone No: (_____) _____

Home Address: _____

City: _____ State: _____ Zip: _____

SECTION I: CONDITIONS OF APPLICATION

The applicant has received the following:

- Notice to Applicant
- HIPPA Privacy Notice (1861-H(LTC))
- Privacy Notice (1861-2)
- Outline of Coverage
- Long Term Care Insurance Personal Worksheet
- Things You Should Know Before You Buy LTC Insurance
- Shopper's Guide to Long Term Care Insurance
- Potential Rate Increase Disclosure Form
- Notice to Applicant Regarding Replacement
- Important Notice to Persons on Medicare (for applicants eligible for Medicare)
- Guide to Health Insurance for People with Medicare (for applicants eligible for Medicare)

SECTION J: STATEMENT OF UNDERSTANDING AND AUTHORIZATION

STATEMENT OF UNDERSTANDING: I understand and agree that coverage will not begin (except as described under the Conditional Insurance Agreement) until CUNA Mutual Insurance Society (the Company) has approved my application, assigned a Policy Effective Date, and received the initial premium. If requesting a change to existing coverage, I agree that any change will not be effective until the date set by the Company following approval of this request and payment of the additional premium. I have given the above answers to obtain this insurance or to make a change to my existing insurance. These answers are true and complete to the best of my knowledge and belief. I know that insurance could be void or benefits denied if the answers on this application are incorrect or untrue. I also understand that I may be contacted in person or by telephone by a representative of the Company as part of the underwriting process. A copy of this application will become part of any policy that is issued to me.

AUTHORIZATION STATEMENT: I authorize any health care providers, pharmacy benefit manager or other pharmaceutical firm, the Department of Motor Vehicles, insurance companies, MIB, Inc., or other person or organizations which have information as to the diagnosis, treatment or prognosis of my physical or mental condition, prescription drug records, and any other information needed to evaluate my application for insurance, to give all information (except psychiatric treatment notes) to CUNA Mutual Insurance Society ("Company"), it's affiliates and its reinsurers to determine eligibility for insurance or benefits. Information obtained will be released only to reinsurers, MIB, Inc., persons performing business duties as delegated or contracted for by the Company related to my application and subsequent insurance related functions, as permitted or required by law, or as I further authorize. I understand that some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I agree this authorization is valid for 24 months, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims or process applications and may be a basis for denying this application or a claim for benefits.

FRAUD WARNING : 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 subject to fines and confinement in prison, depending on state law.

APPLICANT SIGNATURE

Name: _____ Date (Month/Day/Year): _____

State Where Signed: _____

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR LONG-TERM CARE INSURANCE POLICY.

Return this Application to:

OVERNIGHT:
CUNA Mutual Insurance Society
c/o Long Term Care Services
411 N Baylen St
Pensacola FL 32501-3901

MAILING GROUND:
CUNA Mutual Insurance Society
c/o Long Term Care Services
PO Box 13547
Pensacola FL 32591-3547

NOTICE TO APPLICANT: THIS NOTICE IS TO BE READ BY THE APPLICANT FOR INSURANCE

Although your application is our initial source of information, we may also collect medical information pertaining to your health history through copies of your medical records and we may conduct telephone or in-person interviews. Information regarding your insurability will be treated as confidential. CUNA Mutual Insurance Society, its affiliates or its reinsurers may also collect information from MIB, Inc. (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members, and we make a brief report to MIB. If you apply for coverage or file a claim with another MIB member company, MIB, upon request, will supply the company with information in its file.

If you ask, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. Information for consumers about MIB may be obtained on it's website at www.mib.com.

CUNA Mutual Insurance Society, its affiliates or its reinsurer(s) may also release information in its file to other insurance companies to whom you may apply for insurance or to whom a claim for benefits may be submitted. Upon your written request, we will provide you with information contained in your file. You also have the right to receive a detailed notice regarding our insurance information practices which will include a summary of your rights to access and how to correct all information that we may receive.

For more information about any of the above, please write to the Chief Underwriter of CUNA Mutual Insurance Society, 2000 Heritage Way, Waverly IA 50677.

PREMIUM RECEIPT

This acknowledges receipt of the initial premium to be applied in connection with your application to us for long term care insurance. This receipt will be null and void if your check is not payable to CUNA Mutual Insurance Society or is not paid upon presentation. Any premium received after the application date and before a policy is issued will be returned to you. We will return your premium if we do not approve your application.

Printed Name of Applicant: _____
\$ _____ received from Applicant on (Month/Day/Year): _____

**Make check payable to CUNA Mutual Insurance Society.
Do not pay cash, make check payable to the insurance producer, or leave the payee blank.**

CONDITIONAL INSURANCE AGREEMENT

Conditions of Coverage: Coverage under this Conditional Insurance Agreement is provided only if all of the following requirements have been satisfied:

- 1.) You are insurable not only under our Long Term Care Service standards and practices, but also meet our Company's Standard risk criteria;
- 2.) You have not made any material misrepresentations or misstatements on the application for coverage; and
- 3.) The amount of premium submitted with your application satisfies the Company's initial premium requirement.

If one or more of the conditions above is not met, the Company will incur no liability under this Conditional Insurance Agreement. This Conditional Insurance Agreement does not apply to Changes to Existing Coverage.

Start Date for Conditional Insurance Agreement: If you meet the Conditions of Coverage described above, coverage under this Conditional Insurance Agreement will start:

- 1.) As of the date you signed your application if either of the following is true:
 - a.) You do not request a Policy Effective Date; or
 - b.) Your Requested Policy Effective Date is 35 calendar days or less from the date you signed your application.
- 2.) As of your Requested Policy Effective Date, if your Requested Policy Effective Date is more than 35 calendar days from the date you signed your application.

End Date for Conditional Insurance Agreement: Coverage under this Conditional Insurance Agreement ends on the **earliest** of the following dates:

- 1.) The date your premium is refunded and notice is mailed that the application is not accepted;
- 2.) The date the Company offers you a policy other than as applied for;
- 3.) The date the policy is issued as applied for; or
- 4.) 90 days from the date of your application.

No Insurance producer or Broker has the authority to alter or waive any of the provisions of this Conditional Insurance Agreement.

(Give Entire Page to Applicant)

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 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: FFF109.pdf AR Cert of Comp with Rule 19 & 49.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: This is an application filing. Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not applicable for this application filing. Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: Not applicable for an application filing. Comments:		

	Item Status:	Status Date:
Satisfied - Item: Update to Filing Description 8-31-09. Comments: Attachment:		

SERFF Tracking Number: CUNA-126240976 *State:* Arkansas
Filing Company: CUNA Mutual Insurance Society *State Tracking Number:* 43102
Company Tracking Number: 2009-LTCAP-ML
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: LTCi Multi-Life Application
Project Name/Number: 2009 Multi-Life Application for Long-Term Care/
Update to Filing Description 8-31-09.pdf

CERTIFICATION

This is to certify that the attached Policy Forms comply with the requirements of the Life and Disability Insurance Policy Language Simplification Act. The Flesch reading ease scores for these form(s) are shown below.

Form Number(s) and Title(s):	Flesch Score:
2009-LTCAP-ML Multi-Life Application for Long-Term Care Insurance	50



Signature of Officer of the Company

July 30, 2009
Date

**Certificate of Compliance with
Arkansas Rule and Regulation 19 & 49**

Insurer: CUNA Mutual Insurance Society

Form Number(s): 2009-LTCAP-ML

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulations 19 and 49.



Signature of Company Officer

Michael A. Hulme, FSA, MAAA

Name

Director, Life & Health Products

Title

July 30, 2009

Date

2009-LTCAP-ML

Update to Filing Description 8-31-09

We would like to correct a statement made within the filing description of this submission.

Please note that the referenced application will be used in employer situations where the employer wishes to make long term care insurance available to 3 or more employees, however, the employer will not be responsible for paying any portion of the premium.