

SERFF Tracking Number: MASS-126277649 State: Arkansas
Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number: 43345
Company Tracking Number: FR1133 809
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
Unrelated to marketing with employer or
association groups
Product Name: FR1133 809
Project Name/Number: FR1133 809/FR1133 809

Filing at a Glance

Company: Massachusetts Mutual Life Insurance Company

Product Name: FR1133 809

SERFF Tr Num: MASS-126277649 State: Arkansas

TOI: H111 Individual Health - Disability Income

SERFF Status: Closed-Approved-
Closed State Tr Num: 43345

Sub-TOI: H111.008 Combined Short Term and
Long Term - Unrelated to marketing with
employer or association groups

Co Tr Num: FR1133 809

State Status: Approved-Closed

Filing Type: Form

Authors: Lynne Mahan, Robin
Perez, Jennifer Dube

Reviewer(s): Rosalind Minor

Disposition Date: 09/17/2009

Date Submitted: 08/26/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: FR1133 809

Project Number: FR1133 809

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/17/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/17/2009

Created By: Lynne Mahan

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Lynne Mahan

Filing Description:

RE: Massachusetts Mutual Life Insurance Company

NAIC#: 435-65935

FEIN #: 04-1590850

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FR1133 809 Temporary Disability Insurance Agreement

The above-referenced form is being submitted for your department's review and approval. The agreement is new and will not replace any previously approved form. The form is described below. The form is in final print format. Final print copies of the form along with any required certifications and filing fee are enclosed.

When approved and implemented, this agreement will allow an applicant to apply for and receive temporary disability insurance while we are evaluating their application for disability income insurance. As per the terms of the form, it also provides insurability protection for changes in health after the application and all routine exams are completed as long as the client answers no to a couple of basic medical questions and pays the minimum premium for the policy applied for. It will be included as part of our disability income application packages, but only needs to be completed when an applicant wishes to have temporary coverage.

Company and Contact

Filing Contact Information

Lynne A. Mahan, Compliance Assistant LMahan@MassMutual.com
1295 State Street 860-562-3462 [Phone]
M-381 860-562-6109 [FAX]
Springfield, MA 01111-0001

Filing Company Information

Massachusetts Mutual Life Insurance Company CoCode: 65935 State of Domicile: Massachusetts
1295 State Street Group Code: 435 Company Type:
MIP: M381 Group Name: State ID Number:
Springfield, MA 01111 FEIN Number: 04-1590850
(800) 767-1000 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$75.00
Retaliatory? Yes
Fee Explanation: 75.00 per form

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Massachusetts Mutual Life Insurance Company	\$75.00	08/26/2009	30127045

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	09/17/2009	09/17/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
FR1133 809	Note To Reviewer	Lynne Mahan	09/17/2009	09/17/2009
Temporary Disability Insurance	Note To Filer	Rosalind Minor	09/17/2009	09/17/2009

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Disposition

Disposition Date: 09/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Temporary Disability Insurance Agreement	Approved-Closed	Yes

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Note To Reviewer

Created By:

Lynne Mahan on 09/17/2009 10:11 AM

Last Edited By:

Rosalind Minor

Submitted On:

09/17/2009 01:22 PM

Subject:

FR1133 809

Comments:

This applies to everyone who meets the eligibility requirements and wishes to apply for temporary disability income insurance.

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Product Name: FR1133 809
Project Name/Number: FR1133 809/FR1133 809

Note To Filer

Created By:

Rosalind Minor on 09/17/2009 09:52 AM

Last Edited By:

Rosalind Minor

Submitted On:

09/17/2009 01:22 PM

Subject:

Temporary Disability Insurance

Comments:

Before final review of this submission, please clarify whether this product will apply to everyone who wishes to apply and receive this temporary insurance.

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Form Schedule

Lead Form Number: FR1133 809

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/17/2009	FR1133 809	Application/Temporary Enrollment	Disability Insurance Agreement	Initial		51.100	TDIA 8.20.09.pdf
		Form					

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY ("the Company")
 1295 State Street, Springfield, Massachusetts 01111-0001

Please read this Temporary Disability Insurance Agreement ("Agreement") carefully. It is important to you.

This Agreement provides a maximum of 75 days of coverage while insurability is being determined. The maximum amount of monthly benefits and the maximum period for which benefits may be paid for disability under this Agreement is LIMITED. This Agreement is only to be used for new policies. It cannot be used in conjunction with a "Bill at Issue" request and cannot be used for additions to existing, in force policies.

Summary - This Agreement provides LIMITED coverage while we review the Proposed Insured's application to decide if we will issue the policy(ies) applied for. This Agreement does not commit the Company to issue any policy(ies).

Eligibility Requirements for Temporary Insurance Coverage – No coverage will be available under this Agreement if there are incorrect, untrue, incomplete or omitted statements or other material misrepresentations of fact in any part of the application, which includes the Part 1, the Part 2, any amendments, any questionnaires and supplements to either part and this Agreement. The Company will grant temporary coverage to the Proposed Insured if all the following conditions are met:

1. The advance payment (equal to a minimum of at least one month's premium) has been provided to our Agent, and the instrument (method) submitted as payment is honored and there are sufficient funds to pay the required premium;
2. The Part 1 of the application has been completed and signed on the same date as this Agreement; and
3. All of the following questions are answered and each is answered "No".

Has the Proposed Insured:

	Yes	No
a. In the past 5 years, received treatment for, been advised to seek treatment for, or been diagnosed by a health professional, physician or other practitioner as having an emotional or mental disorder, stroke, cancer, tumor, chest pain or heart attack, or any disease, disorder or problem of the kidneys, arteries, neck, or back?	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 5 years, received treatment, attended a program or been counseled for alcohol or drug abuse, or been advised by a health professional to receive such treatment?	<input type="checkbox"/>	<input type="checkbox"/>
c. Within the past 12 months, applied for, been declined for, or had issued any other individual disability insurance?	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 90 days:		
• Been admitted to a hospital or medical facility, or been recommended admission to a hospital or medical facility by a health professional?	<input type="checkbox"/>	<input type="checkbox"/>
• Had surgery or been advised to have surgery by a health professional?	<input type="checkbox"/>	<input type="checkbox"/>
• Had any diagnostic test, excluding tests for the Human Immunodeficiency Virus (HIV), for which the results are unknown, or been advised by a health professional to have any diagnostic test, excluding tests for HIV, which has not yet been completed?	<input type="checkbox"/>	<input type="checkbox"/>

No soliciting agent is authorized to accept any payment with the application if any of the above questions are answered "Yes" or left blank.

Temporary Insurance Coverage

Accidental Bodily Injury – Coverage starts at 12:01 AM on the date following the simultaneous:

1. Completion of the application and this Agreement; and
2. Payment of at least the minimum advance premium.

Coverage is provided only for a disability due to an accidental bodily injury that occurs on or after this date.

Sickness – Coverage starts at 12:01 AM on the date following the simultaneous:

1. Completion of the application (which includes completion of a medical examination if required by the Company's underwriting guidelines) and this Agreement; and
2. Payment of at least the minimum advance premium.

Coverage is provided only for a disability due to a sickness that first manifests itself on or after this date.

Stop Date for Coverage Under this Agreement

Temporary insurance coverage will end on the earliest of the following:

1. The date the Company issues a policy;
2. The date the Company refunds the advance payment;
3. The fifth day after mailing to the address provided on the application to the Proposed Insured a notice that the request for coverage has been declined, to include refund if applicable; or
4. 75 days from the date of this Agreement.

If no Massachusetts Mutual Life Insurance Company disability policy takes effect, the advance payment will be refunded when Temporary Insurance Coverage ends.

Limited Benefits Under this Agreement

EXCEPT AS LIMITED IN THE NEXT PARAGRAPH, TEMPORARY INSURANCE COVERAGE UNDER THIS AGREEMENT WILL BE SUBJECT TO THE SAME TERMS AND CONDITIONS AS WOULD APPLY UNDER THE POLICY(IES) APPLIED FOR. No matter how much insurance you applied for or how much of an advance payment you made, the following limitations apply to the coverage under this Agreement issued by Massachusetts Mutual Life Insurance Company for disability insurance:

1. The monthly benefit will be the lesser of \$5,000, or the amount of monthly benefit for disability for which you applied and the Proposed Insured qualifies for based on the Company's published underwriting limits;
2. Benefits will begin to accrue on the later of the day after the waiting period applied for is met or the 91st day of disability; and
3. The maximum benefit period will be the shorter of the maximum benefit period applied for or 24 months.

Health Insurability Protection. Subject to the restrictions contained in this paragraph, any health changes that occur after the latest of (1) the date the Application Part 1 and Part 2 if required have been completed and signed, or (2) the date this Agreement has been completed and signed and the minimum payment required with it has been received, or (3) the date that any required medical examination(s) and test(s) are completed, will not be considered in determining whether to issue the Policy for which the Proposed Insured has applied. The Company reserves the right to limit coverage under the Policy, based upon its assessment of any such changes in health, to (1) the lesser of (a) a \$5,000 monthly benefit, or (b) the amount of monthly benefit for which you applied and the Proposed Insured qualifies for based on the Company's published underwriting limits, and (2) the shorter of (a) the maximum benefit period applied for, or (b) 24 months.

Payment and Return of Payment. Make all checks or other payments payable to MassMutual. Do not make any checks or other payments payable to the Agent or leave the payee blank. The minimum advance premium required to pay for temporary insurance coverage under this Agreement is the amount equal to a one-month premium under the Policy applied for, regardless of the mode or frequency of payment selected for the proposed Policy.

Contestability. The Company may contest the validity of the insurance pursuant to this Agreement, and deny any of the benefit due, for any material misrepresentation of fact made on this Agreement or the application, which includes the Part 1, the Part 2 and any amendments, any questionnaires and supplements to either part.

Agreements and Signatures

An amount of \$ _____ was received as advance payment for limited temporary disability income insurance coverage on the life of the Proposed Insured.

▶ Signed at _____ on _____

X _____
Signature of Proposed Insured

Printed Name of Proposed Insured

X _____
Signature of Agent

Printed Name of Agent Agency #

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	Yes	No
a. In the past 5 years, received treatment for, been advised to seek treatment for, or been diagnosed by a health professional, physician or other practitioner as having an emotional or mental disorder, stroke, cancer, tumor, chest pain or heart attack, or any disease, disorder or problem of the kidneys, arteries, neck, or back?	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 5 years, received treatment, attended a program or been counseled for alcohol or drug abuse, or been advised by a health professional to receive such treatment?	<input type="checkbox"/>	<input type="checkbox"/>
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• Been admitted to a hospital or medical facility, or been recommended admission to a hospital or medical facility by a health professional?	<input type="checkbox"/>	<input type="checkbox"/>
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▶ **Signed at** _____ on _____

X _____
Signature of Proposed Insured

Printed Name of Proposed Insured

X _____
Signature of Agent

Printed Name of Agent Agency #

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Our Readability Certification is attached. Attachment: Readability Certification.PDF	Approved-Closed	09/17/2009

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Not applicable to this application form filing. Comments:	Approved-Closed	09/17/2009

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not applicable to this application form filing. Comments:	Approved-Closed	09/17/2009

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: Not applicable to this application form filing. Comments:	Approved-Closed	09/17/2009

READABILITY CERTIFICATION

I hereby certify the accuracy of the flesch reading ease test score for the following policy forms. These forms are at least 10 (ten) point type, 2 (two) point leaded.

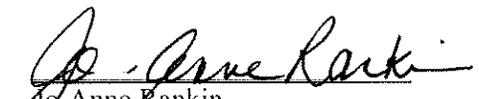
FORM NUMBER AND TITLE

FLECHSCORE

FR1133 809 Temporary Disability Insurance Agreement

51.1

Signature:


Jo-Anne Rankin
Vice President

Date:

8/25/09