Filing at a Glance

Company: Central United Life Insurance Company

Product Name: New Cancer Application
TOI: H07I Individual Health - Specified Disease - - Limited Benefit
Sub-TOI: H07I.002 Dread Disease
Filing Type: Form

SERFF Tr Num: CEUL-126416278
SERFF Status: Closed-Approved-Closed
Co Tr Num: CCI 1209

Author: Robert Coleman
Date Submitted: 01/07/2010

State: Arkansas
State Tr Num: 44493

State Status: Approved-Closed
Reviewer(s): Rosalind Minor
Disposition Date: 01/07/2010
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: revised application
Project Number:
Requested Filing Mode:

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 01/07/2010

Deemer Date:
Submitted By: Robert Coleman
Filing Description:
See cover letter in Supporting Documentation

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Arkansas is our state of domicile.
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 01/07/2010
Created By: Robert Coleman
Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Robert Coleman, Compliance Manager
10700 NW Freeway

RColeman@manhattanlife.com
713-821-6482 [Phone]

Houston, TX 77092 713-821-6551 [FAX]

Filing Company Information

Central United Life Insurance Company	CoCode: 61883	State of Domicile: Arkansas
Wortham Tower	Group Code:	Company Type:
2727 Allen Parkway	Group Name:	State ID Number:
Suite 500	FEIN Number: 42-0884060	
Houston, TX 77019-2100		
(713) 529-0045 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50.00 per submission
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Central United Life Insurance Company	$50.00	01/07/2010	33320831

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/07/2010	01/07/2010

Disposition

Disposition Date: 01/07/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CEUL-126416278*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*44493*
Company Tracking Number:	*CCI 1209*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*New Cancer Application*		
Project Name/Number:	*revised application/*		

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
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Cancer, Critical Care, Intensive Care Application	Approved-Closed	Yes

Form Schedule

Lead Form Number: CCI 1209

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/07/2010	CCI 1209	Application/ Enrollment Form	Cancer, Critical Care, Intensive Care Application	Initial			CCI_1209.pdf

❑ New Application ❑ Change/Policy No. _____ ❑ Conversion/Policy No. _____
❑ Group No._____

CENTRAL UNITED LIFE INSURANCE COMPANY

10700 Northwest Freeway, Houston TX 77092

Cancer, Critical Care, Intensive Care Application

Name of Applicant _____ Date of Birth _____ Sex _____
(Last) (First) (MI)

Address of Applicant _____ Phone # (____) _____
Area Code

City: _____ State: _____ Zip: _____ Soc. Sec. # _____

Height _____ Weight _____

Name of Covered Spouse or Dependent	Ht	Wt	DOB	Name of Covered Spouse or Dependent	Ht	Wt	DOB

Payment Method: ❑ Payroll ❑ Nonpayroll

Mode of Payment: ❑ Monthly Bankdraft ❑ Annually ❑ Quarterly ❑ 9-Pay ❑ 24-Pay ❑ 26-Pay ❑ 52-Pay

Requested Effective Date: _____

Is the premiums under this policy pre-taxed through a Cafeteria Plan? ❑ Yes ❑ No

Premium Collected $ _____ Date: _____ Agents Name: _____

Plan A	Plan B	Plan C	Plan D
[$100] Daily Room	[$150] Daily Room	[$300] Daily Room	[$150] Daily Room
[$1,000] First Occurrence	[$2,500] First Occurrence	[$5,000] First Occurrence	[$10,000] First Occurrence
[$2,500] Surgical	[$3000] Surgical	[$4,500] Surgical	[$4000] Surgical
[$2,500] monthly Chemo/Radiation	[$3,000] monthly Chemo/Radiation	[$4,000] monthly Chemo/Radiation	[$5,000] monthly Chemo/Radiation
[$50] Cancer Screening	[$50 or100] Cancer Screening [❑ $50 OR ❑ $100]	[$100] Cancer Screening	[$100] Cancer Screening
❑ Individual _____	❑ Individual _____	❑ Individual _____	❑ Individual _____
❑ 1 Parent _____	❑ 1 Parent _____	❑ 1 Parent _____	❑ 1 Parent _____
❑ Family _____	❑ Family _____	❑ Family _____	❑ Family _____

❑ **Critical Care Benefit Rider**
❑ Individual _____ ❑ 1 Parent _____ ❑ Family _____

❑ **Intensive Care Unit Rider** ❑ [$300] a day Rider ❑ [$600] a day Rider
❑ Individual _____ ❑ 1 Parent _____ ❑ Family _____

❑ Cancer First Occurrence Policy ❑ [$ 5,000] ❑ [$7,500] ❑ [$10,000] ❑ [$15,000]
❑ Cancer Screening Rider ❑ [$300] a day Rider ❑ [$600] a day Rider
❑ Individual _____ ❑ 1 Parent _____ ❑ Family _____

Total Deductions _____

1. I am Employed by _____
2. Cancer: To the best of my knowledge and belief, no person to be covered under the terms of this policy has now or during the past ten years has had cancer in any form including carcinoma in situ, except ❑ _____ who is (are) to be excluded from coverage under this policy. ❑ NONE CHECK ONE BOX.
3. Cancer: I have not, nor has any proposed insured, tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), except ❑ _____ who is (are) to be excluded from coverage under this policy. ❑ NONE CHECK ONE BOX.
4. Cancer: I hereby represent that to the best of my knowledge, information and belief, no person to be insured under this policy is now or has ever been diagnosed or treated for Addison's disease, amyotrophic lateral sclerosis, diphtheria, encephalitis, epilepsy, legionnaires' disease, lupus erythematosus, meningitis, multiple sclerosis, muscular dystrophy, myasthenia gravis, Niemann-Pick disease, osteomyelitis, poliomyelitis, Reye's syndrome, rheumatic fever, Rocky Mountain spotted fever, sickle-cell anemia, Tay-Sachs disease, tetanus, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, Whipple's disease, and whooping cough, except ❑ _____ _____ (Circle condition and state name) who is (are) to be excluded from the dread disease condition circled. ❑ NONE CHECK ONE BOX.
5. Intensive Care Rider: I hear by represent that to the best of my knowledge, information and belief, within the last 6 months no person to be insured, has (1) undergone a biopsy, (2) had an elevated PSA (Prostate Specific Antigen) or (3) received medical advice or consultation or hade medical tests advised or performed, including those during the course of routine checkups where the results were other than normal or still pending for cancer, except ❑ _____ who is (are) to be excluded from coverage under this policy. ❑ NONE CHECK ONE BOX.

6. Intensive Care Rider: Are you, your spouse or anyone to be insured pregnant? ❑ Yes ❑ No If yes, coverage cannot be issued under this Intensive Care Policy/Rider to any applicant.
7. Critical Care/ Intensive Care Rider: Has any person to be insured ever received medical care for or been diagnosed with heart disease, heart surgery, any abnormalities of the heart, chest pain, heart attack, stroke, pacemaker implanted, blood vessel surgery, or been diagnosed or treated with high blood pressure unless controlled by diet and/or medication for at least one year? ❑ Yes ❑ No
If Yes, list the name(s) of persons _____
_____ Those persons will not be issued coverage under this Policy/Rider.
8. Do you have another policy cancer and/or intensive care plan you intend on keeping? ❑ Yes ❑ No If Yes, please state the name of the company for the plan and the type of policy _____
9. Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No If Yes, give name of the company and policy number: _____
10. Beneficiary Designation: _____
11. Critical Care/Intensive Care Rider: Has any parent age 50 or less of any person to be insured died of heart attack or stroke? ❑ Yes ❑ No If yes, list the name(s) of persons: _____
_____ Those persons will not be issued coverage under this Policy/Rider.

NOTICE: Central United Life Insurance Company will not insure you if you have another cancer policy in force. Central United Life Insurance Company is basing the issuance of a cancer policy on the response to these questions. If the applicant has another cancer policy in force, Central United Life Insurance Company may issue the policy with the understanding the other cancer policy will be terminated and replaced by the cancer policy issued by Central United Life Insurance Company. If the other policy is not terminated, Central United Life Insurance Company will rescind the cancer policy.

12. All Policies: Mail policy to: ❑ agent ❑ insured _____
13. All Policies: The "effective date" of the policy/riders will be the date recorded on the Policy Schedule by the Home Office. It is not the date the application is signed. When all underwriting requirements have been satisfied, coverage will begin as stated in your policy including any riders and/or endorsements. I acknowledge that I received the Outline of Overage applicable to this policy.
14. All Policies: I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; and (d) no change to the policy will valid until approved by an Officer of the Company which must be noted on or attached to the policy. I represent that no person to be covered under the terms of the policy being applied for is also covered by any Medicaid or similar program. I have read, or had read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief.

Warning: Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

Signed at City: _____ State: _____ Date: _____

Applicant's Signature _____ Agent's Signature: _____

Requested Policy Effective Date: _____ Agent Number: _____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Central United Life Insurance Company of Houston, Texas. 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 policy.

(1.) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy; or the new policy may also provide for a waiting period for certain specified conditions. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2.) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. 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 policy 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 any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____
(Date)

_____
(Applicants Signature)

NOTICE: All premium checks must be made payable to Central United Life Insurance Company. Do not make the check payable to the agent or leave the payee blank.

Bank Draft Authorization - Authorization to Honor Checks Drawn By Central United Life Insurance Company

To: _____

Your Bank's Address: _____

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and made payable to the order of Central United Life Insurance Company of Houston, Texas, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree you shall be fully protected in honoring such check. I further agree that if any such check 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.

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	01/07/2010
Bypass Reason:	Application only. Will be made part of policy to which it is attached.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/07/2010
Bypass Reason:	Application in form schedule. Seeking approval of application only.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/07/2010
Bypass Reason:	Application only.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/07/2010
Bypass Reason:	Application only.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	01/07/2010
Comments:			
Attachment:			

AR Cover Letter CUL.pdf

CENTRAL UNITED LIFE

Robert J. Coleman, ACS, AIAA, AIRC, FLMI
Compliance Manager

January 7, 2010

Arkansas Insurance Department

RE: Central United Life Insurance Company
NAIC #: 61883 FEIN: 42-0884060
Health Filing Form #: CCI 1209 Cancer, Critical Care, Intensive Care Application

The following form is submitted for your review and approval.

CCI 1209 Cancer, Critical Care, Intensive Care Application

This form is new and does not replace any previously approved form.

This application will be used with the listed, previously approved forms written by Central United Life Insurance Company.

CP 4000AR 4/04	Limited Cancer and Dread Disease Policy (approved 5/12/04)
OC-CP 4000 AR 4/04	Outline of Coverage
ICUR 4000	Intensive Care Unit Rider (approved 5/12/04)
CCBR 4000	Critical Care Benefit Rider (approved 5/12/04)
SBR4000	Waiver of Premium/Strike Benefit Rider (approved 8/24/09)
FOB97	First Occurrence Benefit Rider (approved 3/19/98)
FOB98AR	Cancer First Occurrence Benefit Policy (approved 2/22/00)
CSB98	Cancer Screening Benefit Rider (approved 5/1/98)

If you have any questions regarding this form or need additional information in order to complete your review, please call or contact me at the numbers/addresses below.

Sincerely,

Robert J. Coleman

Central United Life Insurance Company
10700 Northwest Freeway
Houston, Texas 77092
Email: rcoleman@manhattanlife.com

Phone: 713-821-6482
Toll Free: 800-669-9030 ext. 6482
Fax: 713-821-6551

MANHATTAN INSURANCE GROUP