

SERFF Tracking Number: UHLC-126460211 State: Arkansas
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 44614
Company Tracking Number:
TOI: HOrg02I Individual Health Organizations - Sub-TOI: HOrg02I.005C Individual - Other
Health Maintenance (HMO)
Product Name: Conversion Product Application
Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.
Product Name: Conversion Product Application SERFF Tr Num: UHLC-126460211 State: Arkansas
TOI: HOrg02I Individual Health Organizations - SERFF Status: Closed-Approved- State Tr Num: 44614
Health Maintenance (HMO) Closed
Sub-TOI: HOrg02I.005C Individual - Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Tracy Slaughter Disposition Date: 01/25/2010
Date Submitted: 01/19/2010 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 01/25/2010 Explanation for Other Group Market Type:
State Status Changed: 01/25/2010
Deemer Date: Created By: Tracy Slaughter
Submitted By: Tracy Slaughter Corresponding Filing Tracking Number:
Filing Description:
January 19, 2010

Ms. Rosalind Minor
Certified Rate & Form Analyst
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

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Re: UnitedHealthcare of Arkansas, Inc.
NAIC No. 95446
Conversion Application Filing, Form No. INDCONVAPP.H.08.AR (1/10)
Flesch Score: 45.1

Dear Ms. Minor

On behalf of UnitedHealthcare of Arkansas, Inc., I am submitting the enclosed Individual Conversion Application form listed above for your Department's review and approval.

We are requesting to use this form in conjunction with our recently approved Conversion Product, form filing POLCNV.H.08.AR et al approved on January 8, 2009 under SERFF Tracking Number UHLC-125959050.

This form is our standard form and has been prepared for use in your state with Individual Conversion Products. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Tracy Slaughter
UnitedHealthcare Insurance Company
MN012-S117
5901 Lincoln Drive
Edina, MN
Ph: 952-992-5438/ Fax: 952-992-5105
Toll free: 800-250-6180 Ext. 25438/ Email: tslaughter@uhc.com

Company and Contact

Filing Contact Information

Tracy Slaughter, Contract Specialist
5901 Lincoln Dr
tslaughter@uhc.com
952-992-5438 [Phone]

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 Product Name: Conversion Product Application

Project Name/Number: /
 Edina, MN 55436 952-992-5105 [FAX]

Filing Company Information

UnitedHealthcare of Arkansas, Inc. CoCode: 95446 State of Domicile: Arkansas
 Plaza West Building Group Code: Company Type: HMO
 415 North McKinley Street, Suite 300 Group Name: State ID Number:
 Little Rock, AK 72205 FEIN Number: 63-1036819
 (952) 992-7428 ext. [Phone]

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$50.00	01/19/2010	33610805

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/25/2010	01/25/2010

SERFF Tracking Number: UHLC-126460211 *State:* Arkansas
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Disposition

Disposition Date: 01/25/2010

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	Cover Letter	Approved-Closed	Yes
Form	Application for Individual Conversion Policy	Approved-Closed	Yes

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Form Schedule

Lead Form Number: INDCONVAPP.H.08.AR (1/10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/25/2010	INDCONVA PP.H.08.A R (1/10)	Application/ Enrollment Form	Application for Individual Conversion Policy	Initial		45.100	INDCONVAP P.H.08.AR.pdf

APPLICATION FOR INDIVIDUAL CONVERSION POLICY

PLEASE PRINT ALL ANSWERS

Mail Completed Application and Initial Premium Payment To:

[UnitedHealthcare, Division: Benefit Services, P.O. Box 22409, Louisville, KY 40252]

Section 1: Applicant Information

Name of Former Group Policyholder (Employer)	Group Policy Number	Group Policyholder City & State
Name of Subscriber (Employee) (if different than Applicant)	Current Group Certificate #	Subscriber's Social Security #
Name of Applicant	Relationship to Subscriber	Applicant's Social Security #
Applicant's Address (Street, City, State, Zip)		Daytime Telephone Number

Section 2: Qualifying Event (Check One)

Reason for Termination of Group Coverage

- Termination of Employment
 Other (describe) _____

Are you or any member of your family currently:

- Eligible for or covered by Medicare. Yes No
- Covered by another group plan, policy, contract, or agreement providing benefits for hospital or medical care. Yes No
- Covered for similar benefits by another individual policy or under any arrangement of coverage for individuals in a group, whether insured or uninsured; or covered for similar benefits by reason of any state or federal law. Yes No
- Covered for any extended benefits under your prior terminated group policy. Yes No

If "Yes", give details of other coverage in the table below (use the back of this form if more space is needed).

Table of Other Coverages

For (Name of Individual)	Type of Coverage HMO, PPO, Indemnity, Other (please specify)	Individual Annual Deductible	Name of Insurer or Carrier and Telephone Number or Address
		\$	
		\$	
		\$	
		\$	

Coverage Provided by UnitedHealthcare of Arkansas, Inc.

Section 3: Plan Election and Premium Rate(s)

Select the Individual Conversion Plan for which you are applying:

- Choice HMO Conversion Plan Other

Complete the information below for all eligible members of Applicant's family for whom Conversion coverage is requested. Please include all the family members who were covered under the previous Group Coverage but only those family members.

Names of current Covered Family Members (Print full name)	Date of Birth Mo. Day Yr.	Social Security Number	Sex		Relationship To Applicant	Currently covered under Group Coverage?	MONTHLY PREMIUM COMPUTATION
			M	F			List monthly premium amount for each person to be covered, including each child.
APPLICANT					xxx	Yes	\$
						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

Total Premium: This amount is the premium for the initial month of coverage and must accompany this Application.

Check or money order (payable to UnitedHealthcare) if accepted, will be accepted subject to collection.

\$

Note: For Covered Family Members, in addition to those listed above, attach additional required information to this application

Section 4: Authorization

I authorize UnitedHealthcare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted diseases and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurers or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of these disclosures and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility and enrollment. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

Please maintain a copy of this authorization for your records.

I hereby request UnitedHealthcare and Affiliates, on the basis of the foregoing statement and answers, to provide me with an Individual Conversion Policy as indicated in this application. It is agreed that: (1) No Agent or any other person except an Officer of UnitedHealthcare and Affiliates has the power to make, modify, or discharge any insurance policy or to bind UnitedHealthcare and Affiliates by making promise respecting benefits under any insurance policy; (2) To the extent that the benefits provided by the Individual Conversion Policy are applied for, coverage hereunder, will replace coverage under the group coverage(s) referred to in this application. The Individual Conversion Policy will become effective, if issued, upon cessation of such group coverage(s).

I understand that I am completing an Individual Conversion Policy application and that each response must be complete and accurate. I request the indicated Individual Conversion coverage for myself and, if the plan provides, for my dependents. I understand that UnitedHealthcare and Affiliates is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. The information provided on this application is accurate and complete. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Signature of Applicant

Date

To Be Complete by UnitedHealthcare of Arkansas, Inc.

Coverage Effective Date _____

Individual Conversion Policy Number _____

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/25/2010
Comments:			
Attachment:			
	ARFlesch.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/25/2010
Comments:			
	This a new application filing.		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/25/2010
Bypass Reason:	N/A - Conversion Application form filing only		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	01/25/2010
Comments:			
Attachment:			
	Conversion Application CvrLtr 011910.pdf		

UnitedHealthcare of Arkansas, Inc.
Hartford, Connecticut
NAIC # 95446
CERTIFICATION OF COMPLIANCE

This is to certify that the accompanying forms comply with your state's readability requirements:

A. Option Selected

The forms are scored separately for the Flesch reading ease test. Flesch Score is indicated below.

<u>Form</u>	<u>Flesch Score</u>
INDCONVAPP.H.08.AR (1/10)	45.1

B. Test Option Selected

Test was applied to each entire policy form.

C. Standards for Certification

A checked block indicates the standard has been achieved.

- 1. The form text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option chosen in Section A above.
- 2. It is printed in not less than ten point type, one point leaded.
- 3. The layout and spacing of the policy forms separate the paragraphs from each other and from the border of the paper.
- 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
- 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the forms.



Juanita B. Luis, Assistant Secretary

Date: January 19, 2010



January 19, 2010

Ms. Rosalind Minor
Certified Rate & Form Analyst
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: UnitedHealthcare of Arkansas, Inc.
NAIC No. 95446
Conversion Application Filing, Form No. INDCONVAPP.H.08.AR (1/10)
Flesch Score: 45.1

Dear Ms. Minor

On behalf of UnitedHealthcare of Arkansas, Inc., I am submitting the enclosed Individual Conversion Application form listed above for your Department's review and approval.

We are requesting to use this form in conjunction with our recently approved Conversion Product, form filing POLCNV.H.08.AR et al approved on January 8, 2009 under SERFF Tracking Number UHLC-125959050.

This form is our standard form and has been prepared for use in your state with Individual Conversion Products. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

A handwritten signature in cursive script that reads 'Tracy Slaughter'.

Tracy Slaughter

UnitedHealthcare Insurance Company
MN012-S117

5901 Lincoln Drive

Edina, MN

Ph: 952-992-5438/ Fax: 952-992-5105

Toll free: 800-250-6180 Ext. 25438/ Email: tslaughter@uhc.com