

SERFF Tracking Number: USLH-126708424 State: Arkansas
Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
Company
Company Tracking Number: DI-10POL-AR
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Disability Income 2010 Policy
Project Name/Number: Disability Income 2010 Policy/

Filing at a Glance

Company: United Security Life and Health Insurance Company

Product Name: Disability Income 2010 Policy SERFF Tr Num: USLH-126708424 State: Arkansas
TOI: H111 Individual Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 46963
Closed

Sub-TOI: H111.004 Other Co Tr Num: DI-10POL-AR State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Jaime Gettemans Disposition Date: 10/25/2010
Date Submitted: 10/04/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Disability Income 2010 Policy

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: Resubmission

Previous Filing Number: Unknown

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/25/2010

Explanation for Other Group Market Type:

State Status Changed: 10/25/2010

Deemer Date:

Created By: Jaime Gettemans

Submitted By: Jaime Gettemans

Corresponding Filing Tracking Number:

Filing Description:

Please see the attached Cover Letter, which has been submitted under the "Supporting Documents" tab, for a detailed filing description.

Company and Contact

Filing Contact Information

Jaime Gettemans,

jaimegettemans@jandpholdings.com

SERFF Tracking Number: USLH-126708424 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
 Company
 Company Tracking Number: DI-10POL-AR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income 2010 Policy
 Project Name/Number: Disability Income 2010 Policy/

6640 S. Cicero Avenue 708-552-2417 [Phone]
 Bedford Park, IL 60638

Filing Company Information

United Security Life and Health Insurance CoCode: 81108 State of Domicile: Illinois
 Company
 6640 S. Cicero Group Code: Company Type:
 Bedford Park, IL 60638 Group Name: State ID Number:
 (708) 475-6000 ext. [Phone] FEIN Number: 36-3692140

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: \$50 per form times 3 forms equals \$150.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Security Life and Health Insurance Company	\$150.00	10/04/2010	40214040

SERFF Tracking Number: USLH-126708424 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
 Company
 Company Tracking Number: DI-10POL-AR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income 2010 Policy
 Project Name/Number: Disability Income 2010 Policy/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/25/2010	10/25/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/08/2010	10/08/2010	Jaime Gettemans	10/15/2010	10/15/2010

SERFF Tracking Number: USLH-126708424 State: Arkansas
Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
Company
Company Tracking Number: DI-10POL-AR
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Disability Income 2010 Policy
Project Name/Number: Disability Income 2010 Policy/

Disposition

Disposition Date: 10/25/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: USLH-126708424 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
 Company
 Company Tracking Number: DI-10POL-AR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income 2010 Policy
 Project Name/Number: Disability Income 2010 Policy/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document (revised)	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Loss of Time - Accident and Health Benefits	Approved-Closed	Yes
Form	Application for Disability Insurance	Approved-Closed	Yes
Form	Disability Income Insurance Brochure	Approved-Closed	Yes

SERFF Tracking Number: USLH-126708424 State: Arkansas
Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
Company
Company Tracking Number: DI-10POL-AR
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Disability Income 2010 Policy
Project Name/Number: Disability Income 2010 Policy/

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/08/2010

Submitted Date 10/08/2010

Respond By Date

Dear Jaime Gettemans,

This will acknowledge receipt of the captioned filing.

Objection 1

- Loss of Time - Accident and Health Benefits, DI-10POL-AR (Form)

Comment:

An outline of coverage must be submitted as required by Rule and Regulation 18, Section 8B.

Objection 2

- Loss of Time - Accident and Health Benefits, DI-10POL-AR (Form)

Comment:

All individual health products must be accompanied by the rates and an actuarial memorandum which justifies the rates being charged.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: USLH-126708424 State: Arkansas
Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
Company
Company Tracking Number: DI-10POL-AR
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Disability Income 2010 Policy
Project Name/Number: Disability Income 2010 Policy/

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/15/2010
Submitted Date 10/15/2010

Dear Rosalind Minor,

Comments:

I hope this correspondence finds you well.

Response 1

Comments: Pursuant to your above objection, please find submitted under the "Supporting Documents" tab the Outline of Coverage for this filing.

Related Objection 1

Applies To:

- Loss of Time - Accident and Health Benefits, DI-10POL-AR (Form)

Comment:

An outline of coverage must be submitted as required by Rule and Regulation 18, Section 8B.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: Pursuant to your above objection, please find attached the Actuarial Memorandum, including the rates, submitted under the "Supporting Documents" tab. This is the same Actuarial Memorandum as our 2006 Policy, and we are not changing the rates.

Related Objection 1

SERFF Tracking Number: USLH-126708424 State: Arkansas
Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
Company
Company Tracking Number: DI-10POL-AR
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Disability Income 2010 Policy
Project Name/Number: Disability Income 2010 Policy/

Applies To:

- Loss of Time - Accident and Health Benefits, DI-10POL-AR (Form)

Comment:

All individual health products must be accompanied by the rates and an actuarial memorandum which justifies the rates being charged.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Health - Actuarial Justification

Comment: Please find attached the Actuarial Memorandum and Rates for this filing. This is the Actuarial Memorandum from our 2006 filing; however, we are not changing the rates.

Satisfied -Name: Outline of Coverage

Comment: Pursuant to your 10.8.10 Objection Letter, please find attached the Outline of Coverage for this filing.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We hope that this response sufficiently addresses all open issues with this filing.

We look forward to your approval.

Sincerely,

Jaime Gettemans

Sincerely,

Jaime Gettemans

SERFF Tracking Number: USLH-126708424 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
 Company
 Company Tracking Number: DI-10POL-AR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income 2010 Policy
 Project Name/Number: Disability Income 2010 Policy/

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/25/2010	DI-10POL-AR	Policy/Cont Loss of Time - ract/Fratern Accident and Health al Benefits Certificate	Revised	Replaced Form #: DI-06POL and DI-06POL-AR Previous Filing #: Unknown		DI-10POL-AR.pdf
Approved-Closed 10/25/2010	DI-10APP	Application/ Enrollment Form	Revised	Replaced Form #: DI-06APP Previous Filing #: Unknown		DI-10APP.pdf
Approved-Closed 10/25/2010	DIBRO-2010	Advertising Disability Income Insurance Brochure	Revised	Replaced Form #: DI-06BRO Previous Filing #: Unknown		DIBRO-2010.pdf

This Policy provides benefits, as shown in the Schedule, for loss resulting from Sickness or Accidental Injury to the extent herein provided. This Policy is renewable until the month of Your 65th birthday, but subject to Our right to increase premiums by class.



**UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY
6640 SOUTH CICERO AVENUE, BEDFORD PARK, ILLINOIS 60638
708-475-6100 / 800-875-4422 / FAX 708-475-6120**

LOSS OF TIME ACCIDENT AND HEALTH BENEFITS

We will pay You benefits for covered loss due to Sickness and Accidental Injury as described in this Policy. Benefit payment is governed by the terms of this Policy.

This Policy is issued in consideration of Your application and the Initial Premium payment. A copy of Your application is attached to and made a part of this Policy. The Initial Premium is shown within the Schedule in this Policy. It is due on or before the Policy Date. Payment of the Initial Premium by the due date will keep the Policy in force from the Policy Date to the Next Payment Date. Renewal premiums are then due on each renewal date. Renewal dates occur at the start of each "Period of Insurance". This period is shown in the Schedule and it may be one (1), three (3), six (6) or twelve (12) months. Every "Period of Insurance" starts and ends at 12:01 a.m. standard time at Your home.

**GUARANTEED RENEWABLE UNTIL THE MONTH YOU REACH AGE 65, OR RETIREMENT,
WHICHEVER OCCURS FIRST, AT PREMIUM RATES IN EFFECT ON RENEWAL DATES**

You may keep this Policy in effect by renewing it until the month of Your 65th birthday. Once You reach age 65, this Policy automatically terminates. We cannot cancel or refuse to renew this Policy because of a change in Your health or physical condition that occurs while this Policy is in force. We cannot add any restrictions due to a change in Your health or physical condition that occurs while this Policy is in force. To keep this Policy in force, You must pay each renewal premium when due or within the Grace Period. Premiums may be changed on a renewal date as provided. If You do not renew this Policy on a renewal date, this will not affect a claim incurred and reported to the Company prior to the date the Policy terminates, but all benefits terminate the month You reach age 65.

NOTICE OF TEN (10) DAY RIGHT TO EXAMINE POLICY

Please read this Policy carefully. If You are not satisfied with this Policy, return it within ten (10) days after the date You receive it. You may return it to Our Home Office at the address above or to Your agent. We will cancel this Policy as of the Policy Date and refund Your premium payment.

Check Your attached application. If it is not complete or has an error, please let Us know immediately. An incorrect application may cause Your insurance to be voided, or a claim reduced or denied.

Pre-Existing Condition Limitation. We will pay benefits for Pre-Existing Conditions only under certain conditions. These conditions are fully described in the section of this Policy titled "Pre-Existing Condition."

This Policy is signed for Us as of its Policy Date.

Handwritten signature of Sandra J. Horn in cursive script.

President

Handwritten signature of Robert J. Dux in cursive script.

Secretary

SCHEDULE

PLAN: Disability Income – Loss of Time

INSURED: [John Doe]

POLICY NUMBER: [D06]

POLICY DATE: [XX/XX/XXXX]

NEXT PAYMENT DATE: [XX/XX/XXXX]

FIRST RENEWAL DATE: [XX/XX/XXXX]

INITIAL PREMIUM: [\$ 50.00]

TOTAL DISABILITY BENEFITS BEFORE AGE 65 AND BEFORE YOU ARE NO LONGER WORKING:

TOTAL DISABILITY BENEFIT: [\$400 - \$3,000.00] per month

ELIMINATION PERIOD: [7, 14, 30, 60, 90] DAYS

MAXIMUM BENEFIT PERIOD: [6, 12, 24, 60] MONTHS

ACCIDENTAL DEATH BENEFIT: [\$2,500.00]

BENEFIT PROVISIONS

TOTAL DISABILITY BENEFIT. This benefit is payable only for Total Disability which starts before Your 65th birthday **AND** before You are No Longer Working, if earlier. Total Disability must occur while this Policy is in force and be caused by Sickness or Accidental Injury. Subject to the terms herein, We will pay You a monthly Total Disability Benefit during Your Total Disability. We will pay at the rate of the Total Disability Benefit for the part of the period of Total Disability which occurs on and after the Elimination Period; up to the Maximum Benefit Period, or until Your Total Disability ends, or to Your 65th birthday, whichever is earlier.

Only one Total Disability Benefit will be paid for any period of time during which two or more Total Disabilities exist simultaneously.

AUTOMATIC TOTAL DISABILITY BENEFIT

You will automatically be deemed to be totally disabled if, while this Policy is in force, Sickness or Accidental Injury shall result in the total and irrecoverable loss of:

- 1) sight in both eyes; or
- 2) hearing in both ears; or
- 3) speech; or
- 4) use of both hands; or
- 5) use of both feet; or
- 6) use of a hand and a foot.

If one of these six (6) events occurs by Sickness or Accidental Injury while this Policy is in force, Total Disability will be presumed regardless of Your ability to work and regardless of Your being under the regular care of a physician. The benefit will begin on the day of such loss and will last for the Maximum Benefit Period chosen.

BENEFIT INCREASE OPTION

While this Policy is in force You have the right to increase the Total Disability Benefit up to five hundred dollars (\$500) a month once every three (3) years on the Policy anniversary date, up to a lifetime maximum Total Disability Benefit amount of \$3,000 monthly. No evidence of health insurability will be required for this increase, however, Your premium rate will be adjusted to reflect the higher Total Disability Benefit.

We must receive written notice of Your request to increase and receive proof of income: no earlier than sixty (60) days before the Policy anniversary date on which the increase will be made but no later than thirty (30) days before such Policy anniversary date.

BENEFIT LIMITATION

This Total Disability Benefit, together with all other disability payments received from other insurance plans or benefit plans, Workers' Compensation and Social Security disability payments, cannot exceed 66²/₃% of Your average gross monthly earned income for the calendar year preceding the disability. If You retire prior to age 65, You must give Us written notice of Your retirement. If you fail to give Us this notice and incur a claim, any premium payments received in advance will be refunded after Your retirement and Your Policy will terminate.

Example Benefit Limitation Calculation

Annual Gross Income as shown on 1040 or W-2 forms:	\$30,000.00
Divided by twelve (12) to determine monthly income:	\$2,500.00
(Reduced to 66 ² / ₃ %):	\$1,665.00
<u>Maximum Total Disability Benefit:</u>	\$1,665.00
The net Total Disability Benefit payable is based on the lesser of the Total Disability Benefit of Your Policy or 66 ² / ₃ % of Your Monthly Income as calculated above. However, if you are receiving disability payments from other insurance or benefit plans including Workers' Compensation or Social Security, the amount that You are receiving from the other insurance or benefit plan is deducted from the Maximum Total Disability.	
Benefit as calculated above except that now You are receiving a \$950.00 monthly disability benefit from another source.	(\$950.00)
<u>Adjusted Maximum Total Disability Benefit from US:</u>	\$715.00

After deduction of the other Disability benefit payment, the net Total Disability Benefit Payable is the lesser of the Total Disability Benefit of Your Policy or the Adjusted Maximum Total Disability Benefit as calculated above.

COORDINATION OF BENEFITS

Coordination of Benefits (“*COB*”) is a provision that coordinates the benefits paid to You with benefits You are receiving from other sources that cover the same loss of income due to disability. COB clauses are designed to make certain You do not obtain more benefits than those necessary to replace Your lost income.

If You are covered as an employee, member or subscriber under more than one plan, then the plan that has been in effect the longest is primary, back to Your original effective date under the plan.

Coordination with Social Security Disability Benefits

When a participant is unable to work for an extended period of time, he or she may be eligible for Social Security Disability Income (“SSDI”). SSDI allows an employee to receive income.

A participant who is disabled should apply for SSDI as soon as it is clear that the duration of the disability will be longer than six months. When the participant applies for USL&H disability income benefits, USL&H will require that the participant apply for SSDI benefits, and will offer assistance throughout the SSDI application process.

If the participant is eligible for Social Security disability benefits, any such payment will be subtracted from disability benefits he or she receives from the USL&H disability income benefit plan.

It is not uncommon for the SSDI application and approval process to take several months, and for benefits paid to be retroactive back to a certain date of disability. A participant receiving USL&H disability income benefits is required by USL&H to reimburse the Company for any Social Security benefits received for the same period of time he or she was receiving disability benefit payments from our Company.

Other Disability Benefit Plans

The USL&H Disability Income Benefit Plan is designed to provide a certain degree of income protection if a participant is unable to work for long periods of time. However, the plan may reduce the disability benefit paid if, while a participant is disabled, he or she may be eligible for benefits from other income sources. If so, benefits may be reduced by the amount of these other income benefits, including:

- Any amounts which the participant or any dependents receive (or are assumed to receive) under:
 - any Pension Plans;
 - any Railroad Retirement Act benefits;
 - any local state, provincial or federal government disability or retirement plan or law as it relates to the participant;
 - all sick pay, salary continuance payments, personal time off (“PTO”) or severance pay;
 - any work loss provision in mandatory "No-Fault" auto insurance;
 - any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
- Any Social Security disability benefits the participant or any third party receives (or are assumed to receive) on the participant's behalf or for his or her dependents; or, which his or her dependents receive (or are assumed to receive) because of the participant's entitlement to such benefits.
- Any employer-funded retirement plan benefits. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by a participant's employer. It does not include:
 - an individual deferred compensation agreement;
 - a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan;
 - any participant savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
- Any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same disability claim, and which contains the same or a similar provision for

reduction because of other insurance, the plan will pay the proportion of the total benefit payable under the Policy, without other insurance, as it applies to the total benefits under all such policies;

- Any amounts paid because of lost earnings or loss of earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined;
- Any wage or salary for work performed.
- Although this Coordination of Benefits may reduce the amount received from the USL&H Disability Income Benefit Plan, all benefits together will still equal the total amount the participant is eligible for under the plan.

ADDITIONAL PAYMENT FOR HOSPITAL CONFINEMENT

If, because of Sickness or Accidental Injury, You are confined within an accredited Hospital, We will pay, in addition to any other benefits provided under this Policy, a daily additional payment equal to one-thirtieth ($\frac{1}{30}$) of the Total Disability Benefit stated in the Schedule for each day during which You are confined, but not exceeding a period of two (2) months as the result of any one Sickness or Accidental Injury. This additional payment benefit is subject to the Elimination Period.

ACCIDENTAL DEATH BENEFIT

The Accidental Death Benefit as shown on the Schedule, insures You against death resulting from an accident, directly and independently of all other causes. The accident must take place while You are insured by this Policy and subsequent death must take place within ninety (90) days after the accident. The benefit proceeds would be paid to your named Beneficiary and if no Beneficiary is named the benefit proceeds would be paid to Your estate.

ORGAN TRANSPLANT BENEFIT

After this Policy has been in force six (6) months or more, if You become totally disabled as a result of giving one of Your organs for use as a transplant, benefits shall be payable the same as for any other total disability.

RENEWAL PREMIUMS

Renewal premiums are based on Our Premium Rate Table in use on the renewal date. We have the right to change this Premium Rate Table with thirty (30) days notice to You. Renewal premiums due for this Policy then change accordingly. Any change made applies to all policies of this type of form in Your state. However, Your premium will not change because of Your health or claim experience. Rates before Your 65th birthday and while You are working are based on Your age and insurance classification at the original effective date of this Policy.

DEFINITIONS

1. ***“Accidental Injury”*** means bodily harm which is caused by an accident. It includes all injuries received in any one accident occurring while this Policy is in force.
2. ***“Complications of Pregnancy”*** means separate conditions made worse or caused by pregnancy, including any or all of the following:
 - i. 633.0 to 633.9 Ectopic Pregnancy
 - ii. 634.0 to 634.9 Spontaneous Abortion
 - iii. 639.1 Delayed or Excessive Hemorrhage
 - iv. 639.2 Damage to Pelvis Organs and Tissues
 - v. 639.6 Embolism
 - vi. 640.0 Threatened Abortion
 - vii. 641.0 Placenta Previa Without Hemorrhage
 - viii. 641.1 Hemorrhage from Placenta Previa
 - ix. 642.5 Severe Pre-Eclampsia
 - x. 642.6 Eclampsia
 - xi. 643.1 Hyperemesis Gravidarum
 - xii. 654.5 Cervical Incompetence
 - xiii. 664.2 Third Degree Perineal Laceration

- xiv. 664.3 Fourth Degree Perineal Laceration
- xv. 665.1 Rupture of Uterus during Labor
- xvi. 669.7 Cesarean Delivery Non Elective
- xvii. 670.0 Major Puerperal Infection

Complications of Pregnancy does not include: false labor; premature labor; high risk pregnancy or delivery; caesarean section delivery which was elective; occasional spotting; Health Care Practitioner prescribed rest; morning sickness; or similar conditions that occur in a difficult pregnancy.

3. **"Elimination Endorsement"** means the exclusion of coverage for a certain medical condition for a certain time period.
4. **"Elimination Period"** means the number of days (waiting period) of Total Disability from the start of a disability for which no benefits will be paid. The Schedule shows the Elimination Period.
5. **"Gross Monthly Income"** means Your last year's annual gross earned income based on Your filed Federal Income Tax Return Form 1040 and/or W2 Form(s) for personal services from all Your occupations; less any business expenses paid during the same period which are related to gross income for Your personal services and are deductible business expenses for Federal income tax purposes. "Gross Monthly Income" shall not include (a) income received from deferred compensation, severance and pension plans; or (b) loss of time and disability benefits received; or (c) royalties; or (d) any form of investment income such as rents, interest, dividends and capital gains.

If You are a business owner, such as: an owner of a sole proprietorship, a partner in a partnership, a shareholder of a corporation or subchapter S-corporation, or a member of a limited liability company or limited liability partnership and You perform the substantial and material duties or activities of Your Occupation or another occupation within the scope of a legal business entity, earnings include the amounts reported on your personal Federal Income Tax form 1040 and your personal W2/1099 forms:

1. Your share (based on ownership or contractual agreement) of the gross revenue or income earned by such business entities including earned by You and others under Your supervision or direction; LESS
2. Your share (based on ownership or contractual agreement) of the usual and customary unreimbursed business expenses of those entities which are incurred on a regular basis, are essential to the established business operation of the entity, are deductible for Federal Income Tax purposes, and do not exceed expenses before Disability began. Such expenses do not include salaries, benefits, and other forms of compensation which are payable to You, or to any person related by blood or marriage to You unless such person was a full-time employee of such business working at least thirty (30) hours per week for at least sixty (60) days prior to the start of Your period of Disability; PLUS
3. Any contributions to a pension or profit sharing plan made on Your behalf by all such business entities and not waived by contract during Disability.

Earnings do not include any form of unearned income such as dividends, rents interest, capital gains, income received from any form of deferred compensation, retirement, pension plan, income from royalties, or disability benefits.

6. **"Hospital"** means a licensed institution, other than an Extended Care Facility, that provides in-patient medical care and treatment for sick and injured persons. Services provided by a Hospital must also include all of the following:
 - diagnosis and treatment of Injury and Sickness;
 - full-time supervision by at least one Physician;
 - 24-hour nursing service by registered nurses; and
 - surgery or formal arrangements for available surgical facilities.

It does not mean rehabilitation, convalescent, nursing, rest, or Extended Care Facilities, or facilities operated exclusively for treatment of the aged, drug addiction, or alcoholism, whether such facilities are operated as a separate institution or a section of an institution operated as a Hospital.

7. **“Maximum Benefit Period”** starts after satisfaction of the Elimination Period and is the longest time for which benefits will be paid for any one disability. The Maximum Benefit Period for this Policy is shown on the Schedule.
8. **“Occupation”** means the occupation (or occupations, if more than one) in which You are gainfully employed during the twelve (12) months prior to the time You became disabled
9. **“Physician”** means a person who is duly licensed or legally authorized to give medical care and treatment, within the scope of that person's license, and qualified to attest to Your Total Disability.

A physician cannot be You or anyone related to You by blood or marriage, a member of Your household, Your business or professional partner or employer, or any person who has a financial affiliation or business interest with You.
10. **“Retired”** If You are not disabled, retirement means retiring before age 65 and receiving or being eligible to receive income under the terms of a public or private pension, annuity or retirement plan. However, if You become disabled while this Policy is in force, and that disability causes You to retire, benefits will be paid up to the maximum number of months as indicated in the Schedule or until the month You reach age 65, whichever comes first.
11. **“Sickness”** means an illness, disease, or a complication of pregnancy of an insured person occurring while this Policy is in force.
12. **“Total Disability”** or **“Totally Disabled”** means not being able to perform all the substantial and material duties required by Your regular occupation.

When you are Totally Disabled, We will pay the Monthly Indemnity as follows:

- You must become Totally Disabled while the Policy is in force.
- You must satisfy the Elimination Period.
- Monthly Indemnity will stop at the end of the Benefit Period or, if earlier, on the date You are no longer Totally Disabled.

If Total Disability results from the same or related cause(s) as an earlier Total Disability, and the two are separated by less than six (6) months, during which time You regularly performed all the substantial and material duties of Your work, the new Total Disability will be considered to be part of the prior one. If the two are separated by at least six (6) months during which time You regularly performed all the substantial and material duties of Your work or if two Total Disabilities are due to separate and unrelated causes: then they will be considered to be separate Total Disabilities, and each will be subject to its own Elimination Period and Maximum Benefit Period.

- If the sixty (60) month benefit period is chosen, it is agreed and understood that benefits will be paid if Total Disability prevents You from performing the substantial and material duties of Your occupation for the first twelve (12) months.
- If your Total Disability exceeds twelve (12) months, benefits will be paid if You are unable to perform the substantial and material duties of any occupation. Any occupation shall mean any income producing work for which You are reasonably suited by education, training or experience.

13. **“You, Your”** means the person named as the Insured on the Schedule of this Policy.

14. **“We, Our, Us”** means United Security Life and Health Insurance Company.

PRE-EXISTING CONDITION

“Pre-Existing Condition” means a Sickness or Accidental Injury for which You received medical advice, care or treatment within twelve (12) months prior to this Policy’s effective date or for which You had symptoms within that twelve (12) month period which would have led a prudent person to seek diagnosis, care or treatment. If the condition is not disclosed in Your application, such condition will not be eligible for benefit payment until You have been covered for twenty-four (24) continuous months, unless otherwise excluded by an Elimination Endorsement.

Any condition that is fully disclosed and not excluded by an Elimination Endorsement is not considered a Pre-Existing Condition.

EXCLUSIONS

This Policy does **not** cover disability resulting from:

- A Pre-Existing Condition.
- Conditions or activities specifically excluded by an Elimination Endorsement.
- Suicide or attempted suicide, while sane or insane.
- Intentional self-inflicted injury or sickness, while sane or insane.
- War or act of war, declared or undeclared.
- Participation in a riot.
- Loss while in the military, naval or air service of any country.
- Rest cures (unless such rest is prescribed by a Physician for an underlying physical condition and is subject to interpretation of an Independent Medical Review Organization).
- Normal pregnancy or childbirth.
- Air travel, other than as a fare-paying passenger on a scheduled, commercial flight.
- Loss due to mental illness, alcoholism or drug addiction.
- The commission of a crime or while engaged in an illegal act, illegal occupation, or felonious act or aggravated assault.
- Injuries sustained while under the influence of alcohol or non-prescription or prescription drugs not prescribed by Your licensed treating physician.

TERMINATION

This Policy terminates on the earliest of (1) the last day of the Grace Period provided for an unpaid premium; (2) the day of Your 65th birthday; or (3) the first policy month in which You are retired. **You must notify Us if You retire before the policy month in which You are 65 years of age. If You do not notify Us, Our liability will be limited to the amount of premium We have accepted for periods after the first policy month in which You are retired.**

Termination of this Policy shall not prejudice any claim which began before the date of termination, but all benefits terminate the month You reach age 65.

GENERAL PROVISIONS

ASSIGNMENT: We will not be deemed to know of an assignment unless We receive it, or a copy of it, at Our Home Office before We have made a payment on a claim. We are not obligated to verify that an assignment is valid or otherwise sufficient.

CHANGE OF BENEFICIARY FOR ACCIDENTAL DEATH BENEFIT: You can change the beneficiary at any time by giving Us written notice. The beneficiary's consent is not required for this or any other change in the Policy, unless the designation of the beneficiary is irrevocable.

CLAIM FORMS: When We receive the Notice of Claim, We will send You Claim Forms for filing proofs of loss. If We do not send these Claim Forms to You within fifteen (15) days after We receive the Notice of Claim, You will meet the proof of loss requirements by giving Us a signed written statement of the nature and extent of the loss within the time limit stated in the "Proof of Loss" provision.

CLERICAL ERROR: If You make a clerical error, that error will not terminate an otherwise valid and in force policy. However, non-disclosure of any item deemed material by the Company, whether intentional or otherwise, is not a clerical error.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its Policy Date, is in conflict with the applicable laws of the state in which it is delivered is hereby amended to conform to the minimum requirements of such laws.

ENTIRE CONTRACT – CHANGES: This Policy and Your application make up the entire contract between Us and You. No change in this Policy will be effective until it is approved by one of Our officers. This change and approval must be noted on or attached to the Policy. **No agent has authority to change the application, this Policy or waive any of its provisions.**

GRACE PERIOD: If Your premium and applicable fee are due and unpaid, and if neither We nor You have given signed written notice that this Policy is to be terminated, We will continue Your insurance in force for thirty-one (31) days after that premium due date; however, You will owe Us premium and fees accruing during this thirty-one (31) day Grace Period.

LEGAL ACTIONS: No Legal Action may be brought to recover on this Policy within sixty (60) days after written notice of loss has been given as required by this Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

MISSTATEMENT OF AGE: If Your age has been misstated, whether intentional or unintentional, all benefits payable under this Policy shall be adjusted such as the premium paid would have purchased at the correct age, unless Your true age was 65, in which case We would return any premium paid.

MONTHLY INCOME, EVIDENCE OF: We require evidence to determine Your average gross earned monthly income prior to Your Total Disability, as defined in “*Gross Monthly Income*”.

NOTICE OF CLAIM: Written notice of claim for loss must be given to Us within thirty (30) days after the date that that loss occurred or began. If notice cannot be given within thirty (30) days, it must be given as soon as reasonably possible. The notice can be given to Us at Our Home Office or to Your agent. Notice should include Your name, Your policy number and description of the claim.

PAYMENT OF CLAIMS, DEATH: Disability benefits terminate at Your death. However, any Disability benefit that was due before Your death but unpaid at the time of Your death will be paid to Your estate. If benefits are payable to Your estate or to a person who cannot give a valid release, We may pay benefits up to \$1,000 to any member of Your immediate family who We believe is entitled to payment. If We pay benefits in good faith to a relative, We will not have to pay those benefits again.

PAYMENT OF PREMIUM: The premium for the insurance described in this Policy is based on the applicable Premium Rate Table in effect for this Policy on the date premium is due. The first premium for Your coverage is to be remitted to Us on or before the Policy Date shown on the Schedule of this Policy. Each succeeding premium is due according to the payment mode You selected.

We may change the Premium Rate Table from time to time. The new table will apply to You only after Your First Renewal Date (as shown on the Schedule) has passed. Any new table may be made effective on any of the following dates:

- Any premium due date, provided We have notified You of such change at least thirty (30) days before such premium due date; or
- Any date that the provisions of this Policy are changed or the coverage provided by this Policy is changed.

PHYSICAL EXAMINATIONS: While Your claim is pending or anytime thereafter, We have the right and to have You examined as often as We may reasonably require at a doctor of Our choice and at Our expense.

PREMIUM ADJUSTMENT: We will make premium adjustments that involve the return of unearned premium because of error, delay or termination of this Policy. However, We will only return the premium for the six (6) month period just before the date We receive notice that the adjustment should be made. The return will be reflected as a credit on the next premium billing.

PROOF OF LOSS: You must provide Us with written Proof of Loss at Our home office for a loss within 90 days after the end of each monthly period for which You are claiming benefits. All losses must occur while the Policy is in force.

We can require any proof that We consider necessary to evaluate Your claim. Such proof may include, but is not limited to, medical records, employment records, business records, evidence of Your Prior and Current Income, financial records, and any other information necessary for Us to evaluate Your claim.

If you cannot give Us written Proof of Loss within the prescribed time, We will not deny or reduce your claim if You give Us written Proof of Loss as soon as reasonably possible. Under no circumstance will We pay benefits if written Proof of Loss is delayed for more than one year, unless You have lacked legal capacity.

REINSTATEMENT: Any individual who wishes to be reinstated as an Insured Person will be required to complete a new application and may be approved or disapproved as would any new applicant.

STATEMENT BY THE POLICYHOLDER: Any statement made by You will be considered a truthful representation and the Company will rely on such statements.

SUBROGATION: In no event shall subrogation benefits exceed the lesser of: (a) The amount paid pursuant to this Policy by Us, a health maintenance organization, a self-funded group, a multiple-employer welfare arrangement, or a hospital or medical services corporation; or (b) Fifty percent (50%) of the gross aggregate amount recovered from all such third parties by Us or a covered person.

In the event more than one (1) health insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation having contractual subrogation rights are entitled to the subrogation benefits specified in subsections (a) and (b) of this section, such benefits will be apportioned according to the amounts that We, a health maintenance organization, a self-funded group, a multiple-employer welfare arrangement, or a hospital or medical services corporation paid to You or a covered person.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this Policy for any loss, other than loss for which this Policy provides any periodic payment, will be paid when We receive sufficient due proof of such loss. All accrued benefits for loss which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid upon receipt of due written proof.

TIME LIMIT ON CERTAIN DEFENSES: (a) After two (2) years from the Policy Date of this Policy, no misstatements made by the Applicant in the Application for such Policy shall be used to void the Policy or to deny a claim for loss incurred (as defined in the Policy) commencing after the expiration of such two (2) year period; (b) No claim for loss incurred (as defined in the Policy) commencing after two (2) years from the Policy Date of this Policy shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

UNEARNED PREMIUM: Upon Your death, We will refund to Your estate that part of the unearned premium which applies to the period after Your date of death.

UNPAID PREMIUM: When a claim is paid, any unpaid premium due during the Grace Period but unpaid may be deducted from the claim payment.

WORKERS' COMPENSATION, OTHER DISABILITY BENEFITS: The benefits provided under this Policy are in lieu of, and not in addition to, any other disability benefit payment, whether provided by Workers' Compensation Insurance or otherwise.

- New Insurance Coverage
- Add-On

Desired (not guaranteed) Effective Date:	
Month	Day (1st or 15th)

Please TYPE or PRINT

1. PROPOSED INSURED:

Last _____ First _____ Middle Initial _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Birth Date: _____ Age Last Birthday: _____
 Birthplace: _____ Sex: M F
 Marital Status: Single Married
 Height: Ft. _____ In. _____ Weight: _____ lbs.
 Social Security No.: _____
 Home Phone No.: (_____) _____
 Beneficiary (Full Name): _____
 Relationship: _____

2. COMPLETE THE FOLLOWING BUSINESS INFORMATION:

Name of Employer: _____
 Employer's Address: _____
 City, State, Zip: _____
 Business Phone: (_____) _____
 Occupation Title: _____
 Duties (describe in detail): _____

 Basic Earnings: \$ _____ Wk. Mo. Yr.
 (If Self-Employed, list income after business expenses paid as reported on most recent IRS Form 1040)
 Other Occupations in Last Five Years: _____

3. SELECT THE FOLLOWING OPTIONS: (Higher Amounts Available via Underwriting Approval)

Monthly Benefit: \$ _____ (\$400 - \$3,000) Maximum 2/3 of Monthly Salary
 Benefit Period: 6 Mos. 1 Year 2 Years 5 Years (Only Available to P Class)
 Elimination Period: 7 Days 14 Days 30 Days 60 Days 90 Days
 Payment Method: Annual Semi-Ann. Qrtly. Monthly PAC
 Credit Card Visa/MasterCard/Discover: _____
 Expiration Date: _____

4. A. What Disability Income Plans do you have now, and what applications do you now have pending for other plans?

Name: _____
 Amount of Monthly Benefit: \$ _____
 B. Will this Policy replace any current coverage? Yes No

5. Have you:

- A. Missed any work days due to health reasons in the last 6 months? Yes No
- B. Made a claim for, or received benefits from, any source for disability? Yes No

6. Do you contemplate, or have you within the last two years, been engaged in the following activities: Hang Gliding, Parachuting, Racing (any kind), riding a Motorcycle, ATV, or Dirt Bike, Rodeo Activities, Mountain Climbing, Competitive Skiing, Scuba or Sky Diving, or other hazardous sports/hobbies? Yes No

7. Driver's License No.: _____ State: _____

8. Have you ever had your driver's license suspended or revoked, been cited for driving while intoxicated in the past 5 years, or had two or more violations in the past two years? Yes No
 If YES, Explain: _____

9. Have you smoked cigarettes, cigars or a pipe, or chewed tobacco within the last year? Yes No

10. Have you had any diagnosis related to, received treatment for, been advised to seek treatment, or been hospitalized due to alcohol or drug use/abuse? Yes No

11. In the past five years, have you taken any prescription medication or received any medical treatment? Yes No

12. In the last 10 years, have you been diagnosed or treated for:

- A. Heart Trouble or Circulatory System Disorders? Yes No
- B. High Blood Pressure? Yes No
- C. Abnormal Pulse? Yes No
- D. Lung or Respiratory Trouble? Yes No
- E. Stomach or Intestinal Trouble? Yes No
- F. Disorder of the Bladder, Kidney or Urinary System? Yes No
- G. Spine or Back Disorder? Yes No
- H. Disease or Disorder of Muscle, Bones or Joints? Yes No
- I. Arthritis or Rheumatism? Yes No
- J. Neuritis or Sciatica? Yes No
- K. Nervous or Mental Disorder? Yes No
- L. Diabetes or Sugar in Urine? Yes No
- M. Cancer, Tumors or Leukemia? Yes No
- N. Liver or Gall Bladder Trouble? Yes No
- O. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
- P. Disease or Disorder of the Immune System? Yes No
- Q. Sickle Cell Anemia or Blood Disorder? Yes No

13. Have you within the past 5 years:

- A. Experienced a Persistent Cough, Chronic Fatigue, Significant Weight Loss, Night Sweats, Enlarged Glands or Chronic Diarrhea? Yes No
- B. Been advised to have a surgical operation? Yes No
- C. Been a patient or advised to enter a hospital or health care facility? Yes No
- D. Consulted, been attended or examined by a doctor or other practitioner? Yes No

14. Have you had any physical deformities, impairments or ill health not recorded in answer to questions 9, 10, 11, 12 and 13? Yes No
Missouri residents need only relate their history for past 10 years.

Save Time & Money With PAC
 Pre-Authorized Checking (PAC) is the convenient way to pay. No unintentional lapses, no checks to make out, no postage stamps to bother with, no premium notices to return, and lower billing fees.
 If selecting **PAC, ATTACH VOIDED CHECK** and complete Authorization.

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY

Bank Name _____ Bank Address _____
 As a convenience to me, I hereby request and authorize you to pay and charge my account (checks or electronic debits) drawn on my account by and payable to United Security Life and Health Insurance Company, provided there are sufficient funds in said amount to pay the same on presentation. I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit is 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. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

Printed Name of Depositor _____ Signature of Depositor _____ Date _____

DI-10APP

LEAVE WITH APPLICANT

HEALTH CONDITIONAL RECEIPT

Applicant	Proposed Insured
Plan Applied For	
Amount Received	Requested Effective Date
	Date of Receipt

Special Disability Income Plan Features

24-Hour Coverage

Your policy covers you all day, every day, even while you are on the job!

Premium Guarantee

Your rates will not increase during the life of your policy, even after you become injured!

Unrestricted Benefit Usage

The monthly benefit you receive after your claim is approved comes without restrictions. Use it to pay for whatever needs arise during your disability.

Continuous Coverage

Because this is an individual policy, you can keep the policy in force even if you change or lose your job.

Guaranteed Renewable To Age 65

USL&H cannot cancel your policy at anytime prior to age 65, as long as you pay your premiums on time.

Convenient Payment Methods

We accept checks and major credit cards. You can also elect to pay your premiums through an automatic withdrawal from your checking account.

USL&H offers a quality plan for most occupations!



Policy Exclusions & State Variations

Policy Exclusions

The policy does not cover disability resulting from:

- A Pre-Existing Condition. *(Does not apply in Indiana)*
- Conditions or activities specifically excluded by an Elimination Endorsement.
- Suicide or attempted suicide, while sane or insane. *(Insane does not apply to Missouri residents)*
- Intentional self-inflicted injury or sickness, while sane or insane. *(Insane does not apply to Missouri residents)*
- War or act of war, declared or undeclared.
- Participation in a riot.
- Loss while in the military, naval or air service of any country.
- Rest cures (unless such rest is prescribed by a Physician for an underlying physical condition and is subject to interpretation of an Independent Medical Review Organization).
- Normal pregnancy or childbirth.
- Air travel, other than as a fare-paying passenger on a scheduled, commercial flight.
- Loss due to mental illness, alcoholism or drug addiction.
- The commission of a crime (or attempt to commit in NE) while engaged in an illegal act, illegal occupation, or felonious act or aggravated assault.
- Injuries sustained while under the influence of alcohol or non-prescription or prescription drugs not prescribed by Your licensed treating physician.



United Security Life & Health
www.unitedsecuritylandh.com
6640 South Cicero Ave., Bedford Park, IL 60638

Refer to policy #DI-10POL. This brochure provides a brief description of the policy. Read the policy carefully. It alone describes in detail the rights and obligations of both you and the insurance company.

DIBRO-2010 09/10



Disability Income Insurance

It Works When You Can't.



Why Disability Income Insurance?

Give yourself peace-of-mind and prepare for the unexpected with short-term disability insurance. You can use your benefits to **make up for lost salary or wages**, **pay for ongoing household expenses**, or **apply them towards large medical bills**.

In short, our disability insurance policy helps you maintain a portion of your income and continue paying bills if you become disabled.

Consider the following facts:

30% Of workers entering the work force today will become disabled before retiring.¹

62% Of bankruptcies filed in 2007 were due to inability to pay for medical expenses.²

Receive up to 66^{2/3}% of your income* while recovering from a disability



If I Become Disabled, What Do I Receive?

Disability Income policyholders can receive **up to 66^{2/3}%** of their income* while disabled. What you receive is based on your current income and the Monthly Benefit, Elimination Period and Benefit Period you select.

Monthly Benefit Amount (\$400 - \$3,000/month)

A wide range of Monthly Benefits are available; however, you cannot choose an amount that is greater than 66^{2/3}% of your income*.

Elimination Period (7, 14, 30, 60 or 90 days)

If you become disabled³, you will start receiving disability benefits after your Elimination Period has expired. Choose from the Elimination Periods listed above.

Benefit Period (6, 12, 24 or 60 months)

You will continue to receive disability benefits until you are no longer totally disabled or until the Benefit Period has been exhausted. You can choose from the Benefit Periods listed above.

Are There Any Other Special Benefits?

We also provide the following benefits **at no extra charge!**

\$2,500 Accidental Death Benefit

This benefit is payable for death resulting from an accident directly and independently of all other causes. The loss must take place within 90 days after the incident.

Hospital Confinement Benefit

If a sickness or accidental injury puts you in the hospital, the policy will pay up to an **additional \$3,000 per month** for two months.

Organ Transplant Benefit

If you become totally disabled as a result of giving one of your organs for use as a transplant, benefits will be payable as for any other disability. (Policy must be in force at least six months)

Applying For Coverage

Eligibility

The Disability Income plan is available to most working employees who meet the following criteria:

- Age 18—59
- Have not missed more than 5 consecutive days due to sickness or accidental injury within last 180 days
- Occupation is considered to be acceptable by our Underwriting Guidelines
- Applicant resides in Arizona, Arkansas, Illinois, Indiana, Missouri or Nebraska

Get A Quote!

Premium will vary based on your age, occupation and benefit selections. To get a quick quote, you can:

- Visit www.unitedsecuritylandh.com
- Contact your local insurance agent

Call your local insurance agent for a free quote!



* See policy for definition.

¹ Social Security Administration, Fact Sheet January 31, 2007

² The American Journal of Medicine, June 4, 2009

³ Total Disability is defined as being unable, due to sickness or injury, to perform all of the substantial and material duties required of the insured's regular occupation. While you are disabled, you must be under the care of a physician for the cause of the total disability.

SERFF Tracking Number: USLH-126708424 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
 Company
 Company Tracking Number: DI-10POL-AR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income 2010 Policy
 Project Name/Number: Disability Income 2010 Policy/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/25/2010

Comments:

Please find attached the Flesch Certification for the Loss of Time Accident and Health Benefits Policy for this filing.

Attachment:

Flesch Certification (DI-10POL-AR).pdf

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	10/25/2010

Comments:

Please note that the application has been submitted under the "Forms Schedule" tab for review and approval.

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	10/25/2010

Comments:

Pursuant to your 10.8.10 Objection Letter, please find attached the Outline of Coverage for this filing.

Attachment:

DI-10OUTLINE.pdf

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	10/25/2010

Comments:

Please find attached the cover letter which contains a detailed filing description for this filing.

Attachment:

Loss of Time Cover Letter (AR).pdf



UNITED SECURITY

LIFE AND HEALTH INSURANCE COMPANY

6640 S. Cicero Avenue, Bedford Park, Illinois 60638
(708) 475-6100 (800) 875-4422 Fax: (708) 475-6120

FLESCH CERTIFICATION

This is to certify that the attached Loss of Time – Accident and Health Benefits Policy (DI-10POL-AR) received a Flesch Reading Ease Score of 39.4. This form does not comply with the requirements of A.C.A. 23-80-206, but is in compliance with the requirements of A.C.A. 23-80-207 since it is warranted by the nature of a particular policy form.

Robert G. Dial
Vice President & Secretary

10/1/2010

Date

**UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY
[BEDFORD PARK, ILLINOIS]**

**LOSS OF TIME - ACCIDENT AND HEALTH BENEFITS
OUTLINE OF COVERAGE --- POLICY FORM DI-10POL-AR**

- 1) *READ YOUR POLICY CAREFULLY* – This outline provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**
- 2) *DISABILITY INCOME PROTECTION COVERAGE* – Policies of this category are designed to provide to persons insured, coverage for disabilities resulting from a covered Sickness or Accidental Injury, subject to any limitations set forth in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- 3) *DESCRIPTION OF THE POLICY:*
 - (a) This Policy provides a Total Disability Benefit as specified on the Schedule. The Maximum Benefit Period and the Elimination Period are also indicated in this Schedule.
 - (b) If hospital confinement is required, the Policy will pay an additional 100% of the Total Disability Benefit stated in the Schedule for a period that the insured is confined to a hospital up to a maximum of two (2) months. (Subject to Elimination Period)
 - (c) If You die as a result of an Accidental Injury, Your beneficiary will receive a \$2,500.00 benefit.
 - (d) If, while insured, You lose the use of both hands or feet, or one hand and one foot, or hearing in both ears, or sight of both eyes, or Your speech, We will consider You to be totally disabled and We will pay the maximum benefit chosen. The losses named above must be total and permanent.
 - (e) After the Policy has been in force six (6) months or more and You become totally disabled as a result of giving one of Your organs for use as a transplant, benefits will be payable as for any other total disability.
- 4) *BENEFIT LIMITATION* -- This Total Disability Benefit, together with all other disability payments received from other insurance plans or benefit plans, Workers' Compensation and Social Security disability payments, cannot exceed 66²/₃% of Your average gross monthly earned income for the twelve (12) months preceding the disability. If You retire prior to age 65, You must give Us written notice of Your retirement. Any premium payments received in advance will be refunded.

Example Benefit Limitation Calculation

Annual Gross Income as shown on 1040 or W-2 forms:	\$30,000.00
Divided by twelve (12) to determine monthly income:	\$2,500.00
(Reduced to 66 ² / ₃ %):	\$1,665.00
Maximum Total Disability Benefit:	\$1,665.00
The net Total Disability Benefit payable is based on the lesser of the Total Disability Benefit of Your Policy or 66 ² / ₃ % of Your Monthly Income as calculated above. However, if you are receiving disability payments from other insurance or benefit plans including Workers' Compensation or Social Security, the amount that You are receiving from the other insurance or benefit plan is deducted from the Maximum Total Disability.	
Benefit as calculated above except that now You are receiving a \$950.00 monthly disability benefit from another source.	(\$950.00)
Adjusted Maximum Total Disability Benefit from US:	\$715.00

After deduction of the other Disability benefit payment, the net Total Disability Benefit Payable is the lesser of the Total Disability Benefit of Your Policy or the Adjusted Maximum Total Disability Benefit as calculated above.

- 5) *DESCRIPTION OF THE EXCEPTIONS, REDUCTIONS AND LIMITATIONS:*
This Policy does not cover disability resulting from:
 - A Pre-Existing Condition.
 - Conditions or activities specifically excluded by an Elimination Endorsement.
 - Suicide or attempted suicide, while sane or insane.
 - Intentional self-inflicted injury or sickness, while sane or insane.
 - War or act of war, declared or undeclared.
 - Participation in a riot.
 - Loss while in the military, naval or air service of any country.
 - Rest cures (unless such rest is prescribed by a Physician for an underlying physical condition and is subject to interpretation of an Independent Medical Review Organization).
 - Normal pregnancy or childbirth.
 - Air travel, other than as a fare-paying passenger on a scheduled, commercial flight.
 - Loss due to mental illness, alcoholism or drug addiction.
 - The commission of a crime or while engaged in an illegal act, illegal occupation, or felonious act or aggravated assault.
 - Injuries sustained while under the influence of alcohol or non-prescription or prescription drugs not prescribed by Your licensed treating physician.
- 6) *GUARANTEED RENEWABLE UNTIL AGE 65 OR RETIREMENT, WHICHEVER OCCURS FIRST:*
We cannot cancel, refuse to renew, or restrict Your Policy due to a change in Your health, or physical condition that occurs while You are insured under this Policy. We have the right to change the premium schedule for all policies of this form in Your State.



October 1, 2010

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

RE: UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY

FEIN# 36-3692140 / NAIC# 81108

DI-10POL-AR - Loss of Time – Accident and Health
Benefits (Individual Disability Income Policy)
DI-10APP - Application for Disability Insurance
DIBRO-2010 - Disability Income Insurance Brochure

To Whom It May Concern:

Enclosed is the form referenced above for your review and approval. This form is a revised form and replaces the previously filed forms entitled Individual Loss of Time (Disability Income) Policy **DI-06POL** and Policy Amendment **DI-06POL-AR**, which were approved by your Department on December 18, 2006.

This new form, **DI-10POL-AR**, will be effective for all new business going forward from the approval date of the Arkansas Department.

Application for Disability Insurance **DI-10APP** and Disability Income Insurance Brochure **DIBRO-2010** are also being filed for your review and approval. These forms are revised forms and replace the previously filed forms entitled Application for Disability Insurance **DI-06APP** and Disability Income Brochure **DI-06BRO**, which were both approved by the Arkansas Department on December 18, 2006. Both of these newly revised forms will be used with this Individual Loss of Time (Disability Income) Policy.

The referenced forms will provide income protection to those individuals unable to perform the duties and functions of their occupations as a result of Accident Injury or Sickness.

This product will be individually underwritten and marketed by United Security Life and Health Insurance Company's Agent/Broker field force.

Variable material is indicated on these forms by brackets.

Quality Products from Caring Professionals

6640 South Cicero Avenue, Bedford Park, IL 60638
800-875-4422 / 708-475-6100 Fax: 708-475-6120

October 1, 2010
Page Two

Please direct any questions, correspondence or approval to my attention concerning this filing. I look forward to your approval of these forms. You can contact me directly at 708-552-2417 or via email at jaim egettemans@priscorp.net.

Sincerely,

A handwritten signature in black ink that reads "Jaime Gettemans". The signature is written in a cursive style with a large initial "J" and a long, sweeping underline.

Jaime Gettemans
Compliance Department
Fax: (708) 552-2464

SERFF Tracking Number: USLH-126708424 State: Arkansas
 Filing Company: United Security Life and Health Insurance State Tracking Number: 46963
 Company
 Company Tracking Number: DI-10POL-AR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income 2010 Policy
 Project Name/Number: Disability Income 2010 Policy/

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/06/2010		Supporting Outline of Coverage Document	10/15/2010	