

SERFF Tracking Number: RNIC-126894677 State: Arkansas  
Filing Company: Reserve National Insurance Company State Tracking Number: 47245  
Company Tracking Number:  
TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental  
Product Name: APP-DV AR (11/10) Dental and Vision Application  
Project Name/Number: APP-DV AR (11/10) Dental and Vision Application/

## Filing at a Glance

Company: Reserve National Insurance Company

Product Name: APP-DV AR (11/10) Dental and Vision Application SERFF Tr Num: RNIC-126894677 State: Arkansas

Vision Application

TOI: H10I Individual Health - Dental

SERFF Status: Closed-Approved-  
Closed State Tr Num: 47245

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewers: Rosalind Minor  
Disposition Date: 11/17/2010

Authors: Kyle Conrad, Brenda

Ingram, Misty Anglin  
Date Submitted: 11/08/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: APP-DV AR (11/10) Dental and Vision Application

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: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/17/2010

Explanation for Other Group Market Type:

State Status Changed: 11/17/2010

Deemer Date:

Created By: Brenda Ingram

Submitted By: Brenda Ingram

Corresponding Filing Tracking Number:

Filing Description:

Ms. Rosalind D. Minor

Certified Rate and Form Analyst

Life and Health Division

Arkansas Insurance Department

1200 West Third Street

Little Rock, AR 72201-1904

SERFF Tracking Number: RNIC-126894677 State: Arkansas  
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RE: Reserve National Insurance Company - NAIC # 68462; FEIN# 73-0661453  
Form APP-DV AR (11/10) – Dental and Vision Insurance Application

Dear Ms. Minor:

We are submitting the above-referenced form, which we request you consider for approval. This is a new filing not previously submitted.

Form APP-DV AR (11/10) will be used as the application for our recently-approved Supplemental Dental and Vision Expense Policy DV-1.

If this filing meets with your approval, please send us evidence thereof.

Thank you for your consideration in this matter. If there are any questions, you may contact me by telephone at (800) 874-1431, by fax at (405) 840-3426 or by e-mail at [kconrad@unitrin.com](mailto:kconrad@unitrin.com).

Sincerely,

Kyle D. Conrad  
Senior Vice President  
and Associate Corporate Counsel

## Company and Contact

### Filing Contact Information

Kyle Conrad, Vice President & Associate Corporate Counsel  
6100 N. W. Grand Blvd  
Oklahoma City, OK 73118  
kconrad@unitrin.com  
800-874-1431 [Phone] 549 [Ext]

### Filing Company Information

Reserve National Insurance Company  
6100 N.W. Grand Boulevard  
Oklahoma City, OK 73118  
(405) 848-7931 ext. 549[Phone]  
CoCode: 68462  
Group Code: 215  
Group Name: Reserve National  
FEIN Number: 73-0661453  
State of Domicile: Oklahoma  
Company Type: Life and Health  
State ID Number:

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: AR -application form fee  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	\$50.00	11/08/2010	41648800

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/17/2010	11/17/2010

*SERFF Tracking Number:*      *RNIC-126894677*                      *State:*                      *Arkansas*  
*Filing Company:*              *Reserve National Insurance Company*              *State Tracking Number:*      *47245*  
*Company Tracking Number:*  
*TOI:*                      *H101 Individual Health - Dental*              *Sub-TOI:*                      *H101.000 Health - Dental*  
*Product Name:*              *APP-DV AR (11/10) Dental and Vision Application*  
*Project Name/Number:*      *APP-DV AR (11/10) Dental and Vision Application/*

## **Disposition**

Disposition Date: 11/17/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Dental and Vision Insurance Application	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	APP-DV AR (11/10)	Application/Enrollment	Dental and Vision Insurance Application	Initial		59.109	APP-DV AR (11 10).pdf
	11/17/2010	Form					

AGENT CODE \_\_\_\_\_  
 MGR CODE \_\_\_\_\_

**FOR HOME OFFICE USE ONLY**  
 POLICY NUMBER(S): \_\_\_\_\_

EFFECTIVE DATE		
Month	Day	Year

1. Full Name of Each Applicant			Social Security No.	Relation To Proposed Insured	BIRTH DATE			Age	Sex	Reg. Monthly Prem.
First	Middle Initial	Last			Mo.	Day	Yr.			
1				Proposed Insured						
2										
3										
4										
Policy Year Deductible <b>\$100.00</b>			Policy Year Maximum <input type="checkbox"/> \$1,000.00 <input type="checkbox"/> \$1,500.00		<b>TOTAL</b>					

2. Residence of Proposed Insured \_\_\_\_\_  
 Street No. / Rural Route and/or Box Number                      City                      State                      Zip Code

3. Residence Telephone No. area code (\_\_\_\_\_) No: \_\_\_\_\_

Business or alternate area code (\_\_\_\_\_) No: \_\_\_\_\_

(a) E-mail address \_\_\_\_\_

(b) Name, Address and Telephone No. of payor, if different from above \_\_\_\_\_

4. Do you have any Dental or Vision coverage in force at the time of this application?..... Yes  No

5. If the answer to question 4 is "yes," do you intend to replace your current Dental or Vision coverage with the policy applied for?..... Yes  No   
 (Complete replacement notice on reverse side if "yes")

6. Does any applicant currently have a dental crown or bridge, or wear dentures?..... Yes  No   
 If yes, which applicant(s) and details \_\_\_\_\_

7. Has any applicant been advised to have any dental work which has not been completed?..... Yes  No   
 If yes, which applicant(s) and details. \_\_\_\_\_

8. Does any applicant currently wear eyeglasses or contact lenses?..... Yes  No   
 If yes, which applicant(s) and details. \_\_\_\_\_

**To enroll in the E-Z Way pre-authorized payment plan for renewal premiums, check the monthly or quarterly payment box, sign and date the authorization, and return with a voided personal check. Not available for initial premium.**

Through the E-Z Way plan, your bank will pay your future **renewal** premiums from your checking account. The E-Z Way plan will eliminate the necessity of writing a check.

To take advantage of this convenient plan, simply complete the right-side portion of this form. On your next billing date, the premium will be paid by your bank. The payment will be reflected in your bank statement.

<b>THE E-Z WAY PLAN AUTHORIZATION TO RESERVE NATIONAL INSURANCE COMPANY</b>	
As a convenience to me, I hereby request and authorize you to pay and charge to my account checks or credits on my account by and payable to Reserve National Insurance Company, Oklahoma City, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or credit 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 that you shall be fully protected in honoring any such check or credit. I further agree that if any such check or credit 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.	
<input type="checkbox"/> <b>MONTHLY PAYMENT...</b> or <input type="checkbox"/> <b>QUARTERLY PAYMENT</b>	
_____ X _____ Date	_____ Your signature <b>EXACTLY</b> as it appears on Bank Records

FOR HOME OFFICE USE

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National Insurance Company, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or insurance company or MIB, INC. ("MIB"), that has any records or knowledge of me or any of the members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof.

I have paid to Reserve National Insurance Company the sum of \$ \_\_\_\_\_ which is a  Monthly  Quarterly  Semi-Annual  Annual premium, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

If accepted by the Company the applicant requests coverage to be effective: A.  Date of application, applicable only on quarterly or longer modes. B.  Date of issue C.  Other \_\_\_\_\_  
 SEND POLICY TO APPLICANT OR  AGENT TO DELIVER.

I acknowledge receipt of an outline of coverage for which this application is made..... Yes  No

I am eligible for Medicare and acknowledge receipt of a "Guide to Health Insurance for People with Medicare"..... Yes  No

**NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Town and State where signed \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature of Owner (if other than Proposed Insured)

\_\_\_\_\_  
Signature of Proposed Insured/Applicant

I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon.

\_\_\_\_\_  
Signature of Agent

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application or other information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Reserve National Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. 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. 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 present policy. This is not only your right, but it is also in your best interests 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 an 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:

APP-DV AR (11/10) \_\_\_\_\_ Date \_\_\_\_\_ Applicant's Signature \_\_\_\_\_ Page 2 

**Another easy way to pay your premium is with your VISA, Mastercard or DISCOVER card.**

Please charge to my:      

ACCOUNT# AS SHOWN ON CARD

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

EXPIRATION DATE \_\_\_\_\_

**PLEASE SELECT**

Please charge my credit card for the initial premium.

Please charge my credit card for all future renewal premiums. I understand this authorization will remain in effect until revoked by me or until my credit card expires:  Monthly Payment  Quarterly Payment

Amount authorized \$ \_\_\_\_\_

AUTHORIZED SIGNATURE \_\_\_\_\_  
(PLEASE SIGN HERE)

NAME OF CARDHOLDER \_\_\_\_\_  
(PLEASE PRINT NAME AS SHOWN ON CARD)

DATE AUTHORIZED \_\_\_\_\_

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	11/17/2010
<b>Comments:</b>		
<b>Attachment:</b> Readability Certification APP-DV AR _11-10_.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	11/17/2010
<b>Comments:</b> The application has been attached to the Form Schedule for approval.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Health - Actuarial Justification	Approved-Closed	11/17/2010
<b>Bypass Reason:</b> Not applicable.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	11/17/2010
<b>Bypass Reason:</b> Not applicable.		
<b>Comments:</b>		



601 East Britton Road ■ Oklahoma City, OK 73114  
www.ReserveNational.com

## READABILITY CERTIFICATION

**FORM NUMBER: Form APP-DV AR (11/10) – Dental and Vision Insurance Application**

The words, sentences, and syllables of Form APP-DV AR (11/10) were counted to be used in the Flesch Readability Formula in order to determine the readability score of the form. Formal names, medical terms and words defined (implicitly or explicitly) in the policy/rider/endorsement were not counted.

WORDS:	342
SENTENCES:	20
SYLLABLES:	527

This resulted in a Flesch Readability score of **59.109**.

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KYLE D. CONRAD  
Senior Vice President  
and Associate Corporate Counsel