

SERFF Tracking Number: PRUD-126924976 State: Arkansas
Filing Company: The Prudential Insurance Company of America State Tracking Number: 47429
Company Tracking Number: IIGH-GRP114914-LH-AR
TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified
Product Name: GRP 114914
Project Name/Number: GLTC 4 Simplified Issue Application Form/2555

Filing at a Glance

Company: The Prudential Insurance Company of America

Product Name: GRP 114914

SERFF Tr Num: PRUD-126924976 State: Arkansas

TOI: LTC03G Group Long Term Care

SERFF Status: Closed-Approved-
Closed State Tr Num: 47429

Sub-TOI: LTC03G.001 Qualified

Co Tr Num: IIGH-GRP114914-LH-
AR State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Harris Shearer,
Stephanie Fowler

Author: Laura Hughes

Disposition Date: 12/20/2010

Date Submitted: 12/02/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GLTC 4 Simplified Issue Application Form

Status of Filing in Domicile: Pending

Project Number: 2555

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Employer, Association

Overall Rate Impact:

Filing Status Changed: 12/20/2010

State Status Changed: 12/20/2010

Deemer Date:

Created By: Laura Hughes

Submitted By: Laura Hughes

Corresponding Filing Tracking Number:

Filing Description:

See Attached Filing Letter under Supporting Documentation Tab

Company and Contact

Filing Contact Information

Karen L. Smyth, Vice President

Karen.Smyth@Prudential.com

80 Livingston Avenue

973-548-6614 [Phone]

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 Roseland, NJ 07068 973-548-6630 [FAX]

Filing Company Information

The Prudential Insurance Company of America CoCode: 68241 State of Domicile: New Jersey
 751 Broad Street Group Code: 304 Company Type: Life
 Newark, NJ 07102-3777 Group Name: State ID Number:
 (973) 802-6000 ext. [Phone] FEIN Number: 22-1211670

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Prudential Insurance Company of America	\$50.00	12/02/2010	42548778

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	12/20/2010	12/20/2010

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Disposition

Disposition Date: 12/20/2010

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		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Explanation of Use	Accepted for Informational Purposes	Yes
Supporting Document	Filing Letter	Accepted for Informational Purposes	Yes
Form	Simplified Issue Application Form	Approved	Yes

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Form Schedule

Lead Form Number: GRP 114914

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/20/2010	GRP 114914	Application/ Enrollment Form	Simplified Issue Application Form	Revised	Replaced Form #: GRP 114914 Previous Filing #: GRP 113700	40.100	GRP114914 Standard Insurability Profile (Short).pdf

Insurability Profile for Long Term Care Insurance

INSTRUCTIONS: Read and complete all necessary parts of this Medical History & Insurability Form. **Please print using blue or black ink.** Use an "X" to mark boxes where indicated. **Provide your signature in all areas required.** If you answer "NO" to each question, attach the completed Insurability Profile Form to your Enrollment Form and mail it in the enclosed, postage-paid envelope to: Prudential Long Term Care Unit, P.O. Box 8526, Philadelphia, PA 19176. *If you have questions, call 1-800-732-0416.*

[The following does not apply to residents of Florida, New Jersey, or Virginia.]

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may result in criminal and/or civil penalties.

[To residents of Florida.

Caution: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[To residents of New Jersey.

Caution: Any person who includes any false or misleading information on an application for coverage under a group policy is subject to criminal and civil penalties.]

[To residents of Virginia.

Caution: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits as application or files a claim containing a false or deceptive statement may have violated the state law.]

A. APPLICANT INFORMATION

Full name _____ e-mail address: _____
Daytime phone () - Evening phone () - Best time to call: AM PM
Date on accompanying enrollment form _____ Group Contract Holder [(Employer/Association)] _____

B. TELL US ABOUT YOUR INSURABILITY

1. Within the past 7 years have you had, currently have, or have you been diagnosed with, or treated by or consulted a licensed health care practitioner for any of the following conditions:

Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Kidney Failure, cirrhosis of the liver, Huntington's Disease, Post Polio Syndrome, Lou Gehrig's Disease (ALS), or other chronic neurological Disease/Disorder? Yes No

Alzheimer's disease, chronic memory loss, frequent or persistent forgetfulness, senility, dementia or organic brain syndrome, schizophrenia or mental retardation? Yes No

Type I diabetes (juvenile)? Yes No

Type II diabetes (adult onset) with more than 50 units of insulin per day or in combination with any kidney condition, heart condition, amputation, Transient Ischemic Attack (TIA) or any complications of nerves or eyes? Yes No

- Metastatic cancer (cancer that has spread from the original site)? Yes No
- Stroke (CVA), Transient Ischemic Attack (TIA) within the past 5 years or in combination with heart surgery, or more than one TIA? Yes No
- 2. Within the past 12 months**, have you had, do you currently have, or have you been diagnosed with, or treated by or consulted a licensed health care practitioner for congestive heart failure or symptoms of congestive heart failure? Yes No
- 3. Within the past 12 months** have you utilized any of the following: Yes No
Wheelchair, Motorized Scooter, Walker, Crutches, Quad Cane, Oxygen, Respirator or Kidney Dialysis?
- 4. Within the past 12 months**, have you been advised to utilize the services of or needed: Yes No
home health care/home care, adult day care, or care in a nursing home, assisted living/residential care facility, or other long term care facility?
- 5. Do you currently need, receive, or been advised to receive assistance or supervision by another person for taking your medication or in performing any of the following: bathing, eating, toileting, bowel or bladder control (continence), dressing, walking, moving in or out of bed or chair?** Yes No
- 6. This section pertains to Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and, if permitted, HIV-related (Human Immunodeficiency Virus) diagnosis and treatment.**

PLEASE COMPLETE THE SECTION BELOW THAT CORRESPONDS TO YOUR STATE OF RESIDENCE.

Minnesota Residents: Please read prior to answering the questions in the "ALL states" section below.

You do NOT need to disclose any HIV (Human Immunodeficiency Virus or AIDS virus) tests, which were given to you as:

- 1) a criminal offender or crime victim as a result of a crime that was reported to the police;
- 2) a patient who received the services of emergency medical services personnel at a hospital or medical care facility;
- 3) emergency medical personnel who were tested as a result of performing emergency medical services.

"Emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, and other persons who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience a significant exposure to an inmate who is transported to facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

All states except Connecticut, Florida, Maine, Maryland, Vermont or Wisconsin

Within the past 10 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

- Acquired Immune Deficiency Syndrome (AIDS)? Yes No
- AIDS Related Complex (ARC)? Yes No
- Any HIV infection (Human Immunodeficiency Virus)? Yes No

Connecticut, Maine and Wisconsin

You may answer these questions "No" if you have tested positive for HIV (Human Immunodeficiency Virus) and have not developed symptoms of the disease AIDS.

Within the past 10 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

- Acquired Immune Deficiency Syndrome (AIDS)? Yes No
- AIDS Related Complex (ARC)? Yes No

Florida

Within the past 10 years, have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? Yes No

Maryland

Within the past 7 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? Yes No

AIDS Related Complex (ARC)? Yes No

Any HIV infection (Human Immunodeficiency Virus)? Yes No

Vermont

You may answer these questions "No" if you have tested positive for HIV (Human Immunodeficiency Virus) and have not developed symptoms of the disease AIDS.

Within the past 10 years, have you been diagnosed as having or treated by a licensed medical physician for any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? Yes No

AIDS Related Complex (ARC)? Yes No

Attention: If you answered "Yes" to any question from 1-6 in Part B, do not complete the remainder of this form. We regret that we will be unable to offer you Long Term Care coverage as you do not meet our minimum acceptance criteria. If you answered "NO" to all questions 1-6 in Part B, please continue.

[7. Within the past 12 months have you been hospitalized or within the past 24 months have you applied for or received any form of Disability or Workman's Compensation or been declined for Long Term Care insurance?] Yes No

[8. I certify that I am an actively at work employee, working at least [25] hours per week, as of the date this form is completed.] Yes No

[Name of Employer _____ Employer Phone Number (____) _____ - _____]

Employer Address _____

Contact Person _____]]

[Attention: If question 7 is answered "yes," [and/or question 8 is answered "no"] you may be eligible for coverage but you must answer additional questions regarding your Medical History. If you answered "NO" to question 7 [and "YES" to question 8], please continue Or

Attention: If question 7 is answered "yes" [and/or question 8 is answered "no"]you may be eligible for coverage but you must submit a Medical History & Insurability Form which is subject to full underwriting. Please return to the "Download Enrollment Form" section and select and complete the Medical History and Insurability Form. If you answered "NO" to question 7 [and "YES" to question 8], please continue Or

Attention: If question 7 is answered "yes" [and/or question 8 is answered "no"]you may be eligible for coverage but you must submit a Medical History & Insurability Form which is subject to full underwriting. Please complete the Medical History and Insurability Form found in the Enroll Now Booklet. If you answered "NO" to question 7 [and "YES" to question 8], please continue.]

C. READ AND SIGN APPLICANT AGREEMENTS

Caution: If your answers on this form are incorrect or untrue, or fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your insurance coverage.

To the best of my knowledge and belief, the answers on this Insurability Profile for Long Term Care Insurance are complete and true. I understand and agree:

- The information on this Insurability Profile for Long Term Care Insurance is the basis for the coverage for which I am applying to The Prudential Insurance Company of America (Prudential).
- My coverage will NOT take effect unless: Prudential has approved this Insurability Profile for Long Term Care Insurance and statements and answers given in applying for this coverage do not change materially until the date this Insurability Profile for Long Term Care Insurance is approved.
- I certify that I have read this Insurability Profile for Long Term Care Insurance or had it read to me, and I realize that any false statement or misrepresentation in this Insurability Profile for Long Term Care Insurance may result in loss of coverage under the Group Contract.

X Applicant Signature

Date

The Prudential Insurance Company of America, Newark, NJ, Prudential Financial and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates.

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Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: Attachment: AR - Readability Certification - 10-2010.pdf</p>		
<p>Satisfied - Item: Application Comments: Application attached under Forms Tab</p>		
<p>Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not applicable Comments:</p>		
<p>Bypassed - Item: Outline of Coverage Bypass Reason: Not applicable Comments:</p>		
<p>Satisfied - Item: Explanation of Use Comments: Attachment: Explanation of Use.pdf</p>	Accepted for Informational Purposes	12/20/2010

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	Item Status:	Status
Satisfied - Item: Filing Letter	Accepted for Informational Purposes	Date: 12/20/2010

Comments:

Attachment:

AR Filing Letter - 10-21-2010.pdf

**CERTIFICATION
OF
READABILITY**

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA hereby certifies that this filing complies with Arkansas Code ACA 23-80-206, Policy Language Simplification Standards and achieves a Flesch reading ease test score as shown below.



Signature

Karen L. Smyth
Name

Vice President
Title

November 30, 2010
Date

Line of
Insurance: **Health Insurance**
Subline: **Long Term Care**

Policy Form Number/s:

<u>FORM NUMBER</u>	<u>SCORE</u>
GRP 114914	40.1

**Explanation of Use Language for
Group Long Term Care Insurance
Form GRP 114914**

General References

The enclosed forms contain both variable and illustrative material set forth in brackets.

Illustrative material (e.g. *John Doe*) consists of any entries such as names, contract number, page numbers, dates, amounts, times, age, etc., which would be substituted with case-specific data. The name “ABC Company” is used for illustrative purposes and will be replaced by the actual name of the Group Contract Holder.

The variable material is further explained below.

The terms “Employee” or “Retiree” may be replaced by the terms “Participant” or “Member” or other appropriate term describing a member of the group insured (for example, if the documents were issued to an Association).

The bracketed references and surrounding text will be appropriately modified to reflect proper grammatical form.

The address and phone number of Prudential is intended to be variable to allow for potential new addresses and/or phone numbers.

The term “premium” may be substituted by the word “contribution” in those cases where it is appropriate to use this term.

Time periods may vary, but will not be less than statutory minimums, or greater than statutory maximums.

The remaining bracketed items are intended to vary as follows:

Group Insurability Form – GRP 114914

The state specific fraud warnings will appear as presented or be omitted.

Questions 7 will appear as presented or be omitted.

Question 8 will be presented with only the certification question, with both the certification question and the employer information or be omitted.

The “Attention” statements following questions 7 and 8 will be used in the following situations:

1. Will be used when the applicant is completing the application online through Prudential’s Group Online Website and the functionality (currently in development) is available to move the applicant seamlessly to the required medical questions.
2. Will be used if the above mentioned functionality is not available on Prudential’s Group Online Website.
3. Will be used when the applicant is completing a paper application.

In addition to the above, flexibility has been included to adjust the Attention statement when only question 7 is included on the application form.

Please note: we would like the flexibility to adjust the “Attention” statements so they support any future administrative process changes.



**Karen L. Smyth, FLMI, ACS, AIAA, AIRC,
CLTC, LTCP**
Vice President
Group Insurance

The Prudential Insurance Company of America
Long Term Care Unit
2101 Welsh Road
Dresher, Pennsylvania 19025
Tel 215 658-6279 Fax 888 294-6332

November 30, 2010

The Honorable Jay Bradford
Commissioner of Insurance
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: NAIC Number 304-68241
Group Long Term Care Insurance
Form Number: GRP 114914 (formerly GRP 113700)

Dear Commissioner Bradford:

In support of Prudential's Group Long Term Care Insurance, we enclose for your review and approval, the revised insurance form listed above. This form was previously reviewed and approved by the Department on February 9, 2009 – SERFF Tracking Number: SERT-6LRF6491 and Department File Number: 31882.

This form represents Prudential's group long term care insurance product line. It is a simplified issue form (short form) intended for use with employer and association groups when we offer our currently marketed group long-term care insurance coverage.

Changes to this form are as follows:

- The questions under Section B "Tell Us About Your Insurability," have been expanded to better phrase the questions being asked. In addition, responses to questions 7 and 8 could require the completion of additional medical questions prior to acceptance into the coverage.
- An "actively-at-work" certification has been added under Section B.

Please see the attached Explanation of Use for a description of how the variable sections in the form will be applied.

In view of the above explanation, we are requesting your re-approval of this form with the amendments as explained above. I also certify that with the exception of the changes mentioned above, there have been no other changes made to this form.

The Honorable Jay Bradford
November 30, 2010
Page 2

If there are any additional questions regarding this filing or you require further information, please do not hesitate to contact my associate:

Laura Hughes, CLTC, LTCP
Regulatory Compliance Specialist
The Prudential Insurance Company of America
2101 Welsh Road, LTC Unit
Dresher, PA 19025
(215) 658-6282
Fax: (888) 294-6332
e-mail: laura.hughes@prudential.com

Very truly yours,

A handwritten signature in black ink that reads "Karen L. Smyth". The signature is written in a cursive style with a large, stylized initial "K".

Karen L. Smyth
Vice President

Enclosure