

SERFF Tracking Number: UHLC-126925181 State: Arkansas
Filing Company: Unimerica Insurance Company State Tracking Number: 47414
Company Tracking Number: UMERAPP (02/02)-1 AR
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Stop Loss
Project Name/Number: Application-AR/

Filing at a Glance

Company: Unimerica Insurance Company

Product Name: Stop Loss

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.004 Self-Funded Health Plan

Filing Type: Form

SERFF Tr Num: UHLC-126925181 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 47414

Co Tr Num: UMERAPP (02/02)-1 State Status: Approved-Closed
AR

Authors: Jayne Jackowski, Lynn
Kaisershot

Date Submitted: 11/30/2010

Reviewer(s): Rosalind Minor

Disposition Date: 12/01/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Application-AR

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Overall Rate Impact:

Filing Status Changed: 12/01/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 12/01/2010

Created By: Jayne Jackowski

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Jayne Jackowski

Filing Description:

Stop loss application UMERAPP (02/02)-1 AR, to replace stop loss application UMERAPP (02/02)-1 approved by your department on November 22, 2010. After we received the approval, we found that UMERAPP (02/02)-1 did not contain the notice required by Arkansas Bulletin 6-2008. The notice has been added and the application made state specific.

Company and Contact

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/01/2010	12/01/2010

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Disposition

Disposition Date: 12/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>UHLC-126925181</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unimerica Insurance Company</i>	<i>State Tracking Number:</i>	<i>47414</i>
<i>Company Tracking Number:</i>	<i>UMERAPP (02/02)-1 AR</i>		
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>
<i>Product Name:</i>	<i>Stop Loss</i>		
<i>Project Name/Number:</i>	<i>Application-AR/</i>		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: UMERAPP (02/02)-1 AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	UMERAPP (02/02)-1	Application/Enrollment	Application Form	Revised	Replaced Form #: UMERAPP (02/02)-1 Previous Filing #: 47322		UIC Stop Loss app-UMERAPP_02.02_-1 AR.pdf

UNIMERICA INSURANCE COMPANY

A Stock Company

Administrative Offices: [6300 Olson Memorial Highway, Golden Valley, MN 55427

Phone: 1-800-454-0233]

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Unimerica Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: [ABC Company]

Address: (street, city, state, and zip): [1234 Any Street, Any City, USA]

Key Contact: [John Doe] **Telephone:** [123-456-6789] **Tax ID:** [123456]

Applicant is a: Corporation Labor Union Partnership Association Proprietorship Other:

Nature of Business of the Group to be Insured: [Banking] **Requested Effective Date:** [1/1/2002]

Total number of eligible persons: [Employees: 150 Retirees: 0]

Are retirees covered: Yes No.

Affiliates or Subsidiaries:

Addresses of Affiliates or Subsidiaries:

[Full Name of Administrator: ABC Third Party]

[Address: _____ (street, city, state, and zip): _____]

[Key Contact: _____ Telephone: _____]

[Agent or Broker: Jane Does]

[Tax ID: 123-66-6789]

[Address: 1234 Any Street, Any City, USA]

SPECIFIC EXCESS LOSS INSURANCE: YES NO

Benefit Period: [Covered Expenses Incurred from _____ through _____ and Paid from _____ through _____.]

[If this Policy has a Subsequent Policy Period, the Benefit Period is changed to:

Covered Expenses Incurred from _____ through _____ and Paid from _____ through _____. or, through any termination within the next Benefit Period, whichever is earlier.]

[Covered Expenses Incurred from _____ through _____ will be limited to _____ per Covered Person.]

Specific Deductible per [Covered Person { family}: \$ _____]

Specific Percentage Reimbursable: [_____]

Maximum Specific Benefit per [Covered Person { family}: \$ Unlimited Other \$ _____]

Covered Expenses Under Specific Excess Loss: [Medical Stand Alone Prescription Drug Program]

{[Common Accident Provision: Yes No]}

Description:	Rates: {the rates below will increase by ₃ [5%]- if the Access To ₄ [OptumHealth Care Solutions] Agreement is not signed}
[Employee	\$ _____
	\$ _____
	\$ _____
	\$ _____]

{Minimum Specific Premium \$ _____ }

{[1. Specific Accommodation Reimbursement Endorsement Yes No

2. Specific Step-Down Deductible Endorsement Yes No

3. Specific Terminal Liability Endorsement Yes No

4. Aggregating Specific Deductible Endorsement Yes No]}

- g. [Other: {The undersigned Employer understands the rates for Specific Excess Loss Benefits includes the use [OptumHealth Care Solutions Network] and has signed the Access To Transplant Services Agreement. If the Access To Transplant Services Agreement is not signed and attached to this application, the rates for Specific Excess Loss Benefits will be increased by [5%-15%].}]
- h. Other: []
- i. **NOTICE:** Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: _____

Signature of Authorized Person: _____

Print Name: _____ Title: _____

Date: _____

Signature of Agent or Broker: _____

Print Name of Agent or Broker: _____

FRAUD WARNING NOTICE:

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.

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Supporting Document Schedules

		Item Status:	Status
			Date:
Bypassed - Item:	Application	Approved-Closed	12/01/2010
Bypass Reason:	See Form Schedule		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	12/01/2010
Bypass Reason:	Flesch score not needed for application.		
Comments:			