

SERFF Tracking Number: MNNL-126490166 State: Arkansas
Filing Company: Minnesota Life Insurance Company State Tracking Number: 44768
Company Tracking Number: PJM-412
TOI: H03G Group Health - Accidental Death & Dismemberment Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment
Product Name: Accidental Death & Dismemberment
Project Name/Number: Protecor Plus AD&D/PJM-412

Filing at a Glance

Company: Minnesota Life Insurance Company

Product Name: Accidental Death & Dismemberment SERFF Tr Num: MNNL-126490166 State: Arkansas

TOI: H03G Group Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved- Closed State Tr Num: 44768

Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment Co Tr Num: PJM-412 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Jeanine Berfeldt, Paula Moris

Disposition Date: 02/10/2010

Date Submitted: 02/05/2010

Disposition Status: Approved-Closed

Implementation Date Requested: 03/12/2010

Implementation Date:

State Filing Description:

General Information

Project Name: Protecor Plus AD&D

Project Number: PJM-412

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/10/2010

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Trust

Explanation for Other Group Market Type:

State Status Changed: 02/10/2010

Created By: Paula Moris

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Paula Moris

Filing Description:

Please reference the Supporting Documentation Tab for the cover letter.

Company and Contact

Filing Contact Information

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/10/2010	02/10/2010

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Dismemberment Dismemberment
Product Name: Accidental Death & Dismemberment
Project Name/Number: Protecor Plus AD&D/PJM-412

Disposition

Disposition Date: 02/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Accidental Death and Dismemberment Insurance Request Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 09-50596

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/10/2010	09-50596	Application/Enrollment Form	Accidental Death and Dismemberment Insurance Request Form	Initial			09-50596.jd.pdf

Accidental Death [and Dismemberment] Insurance [Request]

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

[**Reserved Exclusively For:**]

[**Yes**, activate my \$_____ Single Insurance coverage, paid for by [ABC Financial Institution]
for

[**Call _____ to enroll today.**]

[**Additional Coverage** - Choose Family or Single coverage]

[**Send no money now**]

[**Family Coverage** - Provides benefit for you, your spouse and your dependent children.

[**Single Coverage** - Provides benefit for you alone.]

[**Choose your Coverage** - (See additional coverage rate schedule for monthly costs.)

- \$300,000
- \$250,000
- \$150,000
- \$100,000]

Name

[Date of birth] [Telephone number]

Name of beneficiary Relationship

By signing below I:

1. Verify that I am at least age 18[, but not more than age [65]] and would like to apply for this Accidental Death [and Dismemberment] Insurance Plan underwritten by Minnesota Life Insurance Company;
2. Understand that coverage begins on the effective date stated on the [Schedule of Coverage] that I will receive with my certificate provided the first premium is paid and received by Minnesota Life;
3. Understand that fees may be paid by the insurer in connection with this coverage to the plan sponsor and/or its affiliates or designates;
4. Authorize [my lender] to [debit] my [checking account] [quarterly] for any additional coverage I select [and to provide the information contained on this form to Minnesota Life Insurance Company, [a non-affiliate of [lender]] to activate my coverage];
5. Acknowledge that I have reviewed [the fraud statement and] exclusions [on the back of this application]; and
6. Acknowledge that I have received, read and understand the [Consumer Protection Disclosures] [on the back of this application].

Signature Today's date
x /s/ JOHN C. DOE 02/01/2010

09-50596

For Office Use Only

[**Fraud Warning: (applies to all states unless specified below):** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **AR, LA, RI, WV:** 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. **CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies. **DC:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny benefits if false information materially related to a claim was provided by the applicant. **FL:** 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. **KY:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime. **ME, WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MD:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NM:** 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 civil fines and criminal penalties. **OK:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **PA:** 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, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. **VA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. The fraud statements above do not apply to residents of **OR.**]

General Description of Coverage: The ProtectorPlus plan provides benefits only when the insured's accidental death or accidental dismemberment results directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen.

Electronic Funds Premium Disclosure: The first premium payment may be more than the monthly premium since the premium from the date of approval until the first of the following month will be added to the first month's payment. This authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to cancel.

[**Consumer Protection Disclosures:** Insurance products are not deposits or other obligations of, or guaranteed by, the financial institution or any of its affiliates. Insurance products are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, the financial institution, or any of its affiliates. The financial institution may not condition an extension of credit on either: (1) your purchase of an insurance product from the financial institution or any of its affiliates; or (2) your agreement not to obtain, or a prohibition on you from obtaining, an insurance product from an unaffiliated entity. By signing this application, you acknowledge your receipt of these disclosures.]

[**Exclusions:** In no event will we pay a benefit where your loss or injury is caused directly or indirectly by, results from, or there is contribution from, any of the following: 1. self-inflicted injury or self destruction, whether sane or insane; 2. suicide or attempted suicide, whether sane or insane; 3. your participation in or your attempt to commit a crime, assault or felony; 4. bodily or mental infirmity, illness or disease; 5. the use of alcohol, drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected, unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage; 6. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of the outcome of any legal proceedings connected thereto; 7. infection, other than infection occurring simultaneously with, and as a direct result of, the accidental injury; 8. medical or surgical treatment or diagnostic procedures or any resulting complications; 9. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; 10. war or any act of war, whether declared or undeclared; 11. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis. **AL:** 5. intoxication, as defined in the jurisdiction where the accident took place, drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected, unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage. Exclusion #11 deleted. **CT:** 3. your participation in or your attempt to commit an assault or felony; 5. the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by your physician for you. **IL and WV:** the accidental death benefit is not payable when death results from or is caused directly by the causes shown above. **LA:** 5. your being intoxicated or under the influence of narcotics unless administered on the advice of a physician. **MA:** 10. war or any act of war, while serving in the military, or within six (6) months after termination of service in the military forces. **MO:** 1. suicide or attempted suicide, while sane; 9. war or any act of war. **MT:** 5. the voluntary use of alcohol, drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected, unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage. **ND:** the use of alcohol, drugs, any narcotic, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected, unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage. **NH:** 6. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred. **OK:** the accidental death benefit is not payable when death results from or is caused directly by the causes shown above. 10. war or any act of war, whether declared or undeclared, while serving in the military service or any auxiliary unit attached thereto. **OR:** The accidental death must occur within 180 days after the date of the accidental injury. The accidental death benefit is not payable when death results from or is caused directly by the causes shown above. 5. the voluntary use of drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested, or injected, unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage; 6. the voluntary use of alcohol where your blood alcohol level meets or exceeds the level at which intoxication is defined by the laws of the state where said alcohol use occurred; 7. motor vehicle collision or accident where you are the operator of a motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of the outcome of any legal proceedings connected thereto; 8. infection, other than infection occurring simultaneously with, and as a direct result of, the accidental injury; 9. medical or surgical treatment or diagnostic procedures or any resulting complications; 10. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier. **SD:** 5. the use of poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected, unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage. Exclusion #6 deleted. **WA:** 1. intentionally self-inflicted injury; 5. alcoholism and drug addiction; 6. the use of poisons, gases, fumes or other substances taken, absorbed, ingested or injected; Exclusion #7 deleted. **WI:** 3. your participation in a criminal act that results in a felony conviction. 5. the voluntary use of alcohol, drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, injected or injected, unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage.]

Family Coverage Benefit Schedule: If you elect family coverage, a benefit in the amount of 60 percent of coverage you choose will be paid in the event of your spouse's covered loss, if you do not have dependent children or 50 percent if you have dependent children. A benefit in the amount of 20 percent of coverage you choose will be paid in the event of your dependent child's covered loss.

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	02/10/2010
Bypass Reason:	This is an application only filing submission, therefore this requirement does not apply and has bypassed.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/10/2010
Bypass Reason:	This is an application only filing submission, therefore this requirement does not apply and has bypassed.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Explanation of Variables	Approved-Closed	02/10/2010
Comments:	Attached are the Explanation of Variables.		
Attachment:	Explanation of Variables.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	02/10/2010
Comments:	Attached is the Cover Letter.		
Attachment:	CoverLetter.pdf		

Explanation of Variables
Minnesota Life Insurance Company
Form 09-50596

1. **Form Title:**

- [and Dismemberment] will be removed if dismemberment coverage is not being offered.
- [Request] may be changed to be [Application], [Activation Form], [Enrollment] or something similar.

2. [Reserved Exclusively For:] may vary depending on marketing approach used for a specific client.

3. [Yes, activate my [\$1,000] Single Insurance coverage, paid for by [ABC Financial Institution] will be removed if the non-contributory benefit is not offered.

4. [Call XXX-XXX-XXXX to enroll today.] will be removed if enrollment by phone is not an option.

5. [Additional Coverage – Choose Family or Single coverage] will vary depending on the marketing approach used for a specific client.

6. The choices for types and amounts of insurance may vary by client.

7. [Date of birth] and [Telephone Number] may be removed.

8. **Authorization:**

- The phrase [, but not more than age [65]] will be removed if there is no maximum eligibility age, or if a different eligibility age is being used.
- The phrase [Schedule of Coverage] may be changed to Benefit Schedule or something similar.
- The text “Authorize [my lender] to [debit] my [checking account] [quarterly] for any additional coverage I select] [and to provide the information contained on this form to Minnesota Life Insurance Company, [a non-affiliate of [lender]] to activate my coverage” will vary based on marketing approach used for a specific client.

The premium payment options that are available for this plan include escrow, EFT (electronic funds transfer), credit card or direct billing.

- The text “[the fraud statement and] exclusions [on the back of this application]” will vary based on the location of the fraud statement within the marketing package. That item might appear on a separate page, or it may be included on either the front or back page of the application.
- The text [Consumer Protection Disclosures] will vary if a client chooses to re-title the disclosures to be something similar, such as Federal Disclosures.
- The phrase “[on the back of this application]” will vary based on the location of the Consumer Protection Disclosures within the marketing package. Those disclosures may appear on the front of the application, the back of the application, or on a separate piece within the package.

9. **General Variability:**

- The general placement and format of information may vary depending on marketing and client needs (i.e. paper size, organization of information, method of distribution or production, etc.)
- Various sections of the form may be printed in color.
- Graphics or images may be added depending on marketing and client needs.

February 5, 2010

Mr. Dan Honey, Deputy Commissioner
Life and Health Division
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

NAIC: 66168
Group: 869

RE: Minnesota Life Filing No. PJM-XXX
09-50596 Accidental Death and Dismemberment Insurance Request Form

Dear Mr. Honey:

A copy of the above-referenced form is attached for your review and approval. This form is new and will not replace any forms previously approved by your Department.

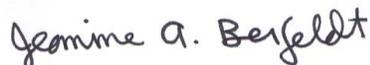
Form 09-50596 is an insured's application intended to be used by eligible accountholders/members of participating financial institutions and credit unions who are applying for coverage under the following accidental death and dismemberment insurance policies, which were approved by your Department:

<u>Form Number</u>	<u>Approval Date</u>	<u>Filing Number</u>
05-50274T, et al	05-17-2005	SERFF No. USPH-6BWKK8589
05-50285, et al	05-31-2005	SERFF No. USPH-6CNMLU255

Variable text has been marked with brackets. If text is changed, it will never be less favorable than your state's laws allow. An Explanation of Variables is also being provided describing the bracketed material. Minnesota Life Insurance Company reserves the right to change the color, font, sequential order and layout of the attached form.

I look forward to your approval of the above-referenced form in the State of Arkansas. If you have any questions, please contact me. Thank you.

Sincerely,



Jeanine A. Berfeldt
Product Compliance Analyst
Tel: 651.665.4460
Fax: 651.665.5424
Email: jeanine.berfeldt@securian.com