

SERFF Tracking Number: UHLC-126483077 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 44740
Company Tracking Number: ABC-AR APP (REV 10)
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
Product Name: Student Blanket Injury and Sickness
Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: Student Blanket Injury and Sickness SERFF Tr Num: UHLC-126483077 State: Arkansas

TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed-Approved- Closed State Tr Num: 44740

Sub-TOI: H04.000 Health - Blanket Accident/Sickness Co Tr Num: ABC-AR APP (REV 10) State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor
Author: Jackie Lovelady Disposition Date: 02/10/2010
Date Submitted: 02/02/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Policyholder Applications
Project Number: ABC-AR APP (Rev 10)
Requested Filing Mode:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: These forms are specific to Arkansas

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 02/10/2010

Market Type: Group
Group Market Size: Large
Group Market Type: Blanket
Explanation for Other Group Market Type:
State Status Changed: 02/10/2010

Deemer Date:
Submitted By: Jackie Lovelady
Filing Description:

Created By: Jackie Lovelady
Corresponding Filing Tracking Number:

New applications to be used with previously approved policy ABC-06-AR. Please see the Cover Letter for further information. Thank you.

Company and Contact

Filing Contact Information

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Jackie Lovelady, Compliance Analyst jlovelady@uhcsr.com
 UnitedHealthcare StudentResources 866-808-8305 [Phone] 6551 [Ext]
 2301 West Plano Parkway 469-229-5506 [FAX]
 Suite 300
 Plano, TX 75075

Filing Company Information

UnitedHealthcare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
450 Columbus Boulevard	Group Code: 707	Company Type: Life and Health
PO Box 150450	Group Name:	State ID Number:
Hartford, CT 06115-0450	FEIN Number: 36-2739571	
(860) 702-5000 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 for all forms.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$50.00	02/02/2010	33929682

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Correspondence Summary

Dispositions

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

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	02/05/2010	02/05/2010	Jackie Lovelady	02/08/2010	02/08/2010
Pending Industry Response	Rosalind Minor	02/03/2010	02/03/2010	Jackie Lovelady	02/04/2010	02/04/2010

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Disposition

Disposition Date: 02/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Thank you for reminding me that this is a Blanket product and not an individual product.

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	Cover Letter	Approved-Closed	Yes
Supporting Document	NAIC Trasmittal Form	Approved-Closed	Yes
Supporting Document	Response Letter to 02-03-10 Objection	Approved-Closed	Yes
Supporting Document	Response Letter to 02-05-10 Objection	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form (revised)	Mandated Offer Page	Approved-Closed	Yes
Form	Mandated Offer Page	Replaced	Yes
Form	Policy Endorsement	Approved-Closed	Yes

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Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 02/05/2010

Submitted Date 02/05/2010

Respond By Date

Dear Jackie Lovelady,

This will acknowledge receipt of the captioned filing.

Objection 1

- Policy Endorsement, ABC-06MOE-AR (7) (Form)

Comment:

The wording in the endorsement for the mandated offering for hearing aid indicates that an additional premium will be charged. Please submit the actuarial memorandum for this benefit and the premium rates.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 02/08/2010

Submitted Date 02/08/2010

Dear Rosalind Minor,

Comments:

Thank you for your letter of February 5, 2009 regarding the above referenced filing. For your ease of reference, I have restated your comments and referenced the description of the checklist followed by my response.

Response 1

Comments: I apologize but I am unable to find in the Arkansas Insurance Code or Regulations where an Actuarial Memorandum and premium rates are required to be filed for blanket accident and sickness insurance. Can you possibly point me to this requirement? Policy ABC-06-AR and related forms previously approved were filed based on Arkansas Insurance Code 23-86-101(3), as are the above referenced forms. Also, please note the language, " In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows", is a general statement included on all our standard endorsements including all Mandatory Offer

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Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

Endorsements.

Related Objection 1

Applies To:

- Policy Endorsement, ABC-06MOE-AR (7) (Form)

Comment:

The wording in the endorsement for the mandated offering for hearing aid indicates that an additional premium will be charged. Please submit the actuarial memorandum for this benefit and the premium rates.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Response Letter to 02-05-10 Objection

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We appreciate your continued consideration in review and approval of these applications. Should you have any questions or need further information, please feel free to contact me. I can be reached by phone at (866) 808-8305, extension 6551. You may also e-mail me directly at jlovelady@uhcsr.com.

Sincerely,
Jackie Lovelady

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Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 02/03/2010

Submitted Date 02/03/2010

Respond By Date

Dear Jackie Lovelady,

This will acknowledge receipt of the captioned filing.

Objection 1

- Mandated Offer Page, ABC-AR APP2 (Rev 10) (Form)

Comment: Before final review is given to the submission, I wanted to inquire about the mandated offerings for hearing aids. Did you want to add this offering, or does the product have this benefit written in to the policy?

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 02/04/2010

Submitted Date 02/04/2010

Dear Rosalind Minor,

Comments:

Thank you for your letter of February 3, 2009 regarding the above referenced filing. For your ease of reference, I have restated your comments and referenced the description of the checklist followed by my response.

Response 1

Comments: Please see the revised Mandated Offer Page, form ABC-AR APP2 (Rev 10). The option to elect or decline benefits for Hearing Aids has been added to this form. Please also see the new Policy Endorsement, form ABC-06MOE-AR (7), for the Benefits for Hearing Aids. This new form is attached in the Forms Schedule of the above referenced SERFF tracking number.

Related Objection 1

Applies To:

- Mandated Offer Page, ABC-AR APP2 (Rev 10) (Form)

SERFF Tracking Number: UHLC-126483077 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 44740
 Company Tracking Number: ABC-AR APP (REV 10)
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: Student Blanket Injury and Sickness
 Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

Comment:

Before final review is given to the submission, I wanted to inquire about the mandated offerings for hearing aids. Did you want to add this offering, or does the product have this benefit written in to the policy?

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Response Letter to 02-03-10 Objection

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Mandated Offer Page	ABC-AR APP2 (Rev 10)		Application/Enrollment Form	Initial			ABC-AR APP2 (Rev 10).pdf

Previous Version

Mandated Offer Page	ABC-AR APP2 (Rev 10)		Application/Enrollment Form	Initial			ABC-AR APP2 (Rev 10).pdf
Policy Endorsement	ABC-06MOE-AR (7)		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial			ABC-06MOE-AR END (7) Hearing Aids.pdf

No Rate/Rule Schedule items changed.

We appreciate your continued consideration in review and approval of these applications. Should you have any questions or need further information, please feel free to contact me. I can be reached by phone at (866) 808-8305, extension 6551. You may also e-mail me directly at jlovelady@uhcsr.com.

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Sincerely,
Jackie Lovelady

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 Product Name: Student Blanket Injury and Sickness
 Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

Form Schedule

Lead Form Number: ABC-AR APP (Rev 10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 02/10/2010	ABC-AR APP (Rev 10)	Application/ Enrollment Form	Application	Initial			ABC-AR APP (Rev 10).pdf
Approved- Closed 02/10/2010	ABC-AR APP ACSI 10)	Application/ Enrollment Form	Application	Initial			ABC-AR APP ACSI.pdf
Approved- Closed 02/10/2010	ABC-AR APP2 (Rev 10)	Application/ Enrollment Form	Application/Mandated Offer Page	Initial			ABC-AR APP2 (Rev 10).pdf
Approved- Closed 02/10/2010	ABC- 06MOE-AR (7)	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Policy Endorsement	Initial			ABC-06MOE- AR END (7) Hearing Aids.pdf

UnitedHealthcare Insurance Company [P.O. Box 809027 Dallas, TX 75380-9027]

PLEASE TYPE OR PRINT

Section 1

Name of School/District: ANY School District Policy #: 00-0000-00
(leave blank if unknown)

Contact Name: John Doe Title: Any

Address: 123 Any Street City: Any

State: Any Zip: 00000 Phone: (000)000-0000 Fax: (000)000-0000

Email Address: Any@any.com

Section 2 Voluntary Plans – see Voluntary Rate page attached

Estimated [2010-2011] School Enrollment: _____ (Total number of students)

Grades (Mark one): (PK – 12) (E) Elementary School (M) Middle School
 (EM) Elementary & Middle School (MH) Middle & High School
 (H) High School

Effective Date/First Class Day: [08-01-10] Last Class Day: [06-01-11]
(leave blank if unknown)

*Note: Athletic coverage begins August 1st if the signed application is received prior to the first athletic start date.
 Exception: Dates set by state governing organization which are prior to August 1st.*

High School Football Information (complete if applicable)

Is Offseason Program Permitted? _____ Athletic Effective: [06-01-10] to [06-01-11]

Is Contact Practice Permitted? _____ (leave blank if unknown)

Who pays Football Premium? School or Parents

Section 3 Mandatory Plans – Coverage Selected by School/District

	Product/Option	Grades	Total # of Insured	Rate	Premium
At-School Including Athletics & Activities	[High]	[Pk-12]	[500]	[\$5.00]	[\$2,500]
At-School Excluding Athletics & Activities					
Athletics & Activities					
Other (Specify): _____					

Does district want invoices for Mandatory coverages separated by campus? Yes No NA

Mail Invoices to: District Office Each Campus Other Address

Section 4 – Notes _____

Section 5: 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.

X _____ Date Signed: _____
 Signature of Official Authorized to Contract for School/District

Printed Name: _____ Title: _____

Agent Signature: _____ Date Signed: _____

Agent Name: _____ Agent # _____

Mail ALL completed and signed forms to:

UnitedHealthcare **StudentResources** [c/o Health Special Risk, Inc. 4100 Medical Parkway Carrollton, TX 75007-1517]

UnitedHealthcare Insurance Company

Voluntary Rates

Plan Description	Demographic	Marketing Plan	Premium Per Student	Earliest Effective Date
[[At-School Accident Only]	[PK – 12]	[High Option]	[\$22.00]	[Date Application Received]
[[At-School Accident Only including Athletics (except High School Football)]	[9 – 12]	[High Option]	[\$22.00]	[8/1/2010]
[[At-School Accident Only]	[PK – 12]	[Low Option]	[\$15.00]	[Date Application Received]
[[At-School Accident Only including Athletics (except High School Football)]	[9 – 12]	[Low Option]	[\$15.00]	[8/1/2010]
[[24-Hour Accident Only]	[PK – 12]	[High Option]	[\$95.00]	[Date Application Received]
[[24-Hour Accident Only including Athletics (except High School Football)]	[9 – 12]	[High Option]	[\$95.00]	[8/1/2010]
[[24-Hour Accident Only]	[PK – 12]	[Low Option]	[\$62.00]	[Date Application Received]
[[24-Hour Accident Only including Athletics (except High School Football)]	[9 – 12]	[Low Option]	[\$62.00]	[8/1/2010]
[[24-Hour Accident Only Summer Only]	[PK – 12]	[High Option]	[\$25.00]	[Date Application Received]
[[24-Hour Accident Only Summer Only]	[PK – 12]	[Low Option]	[\$16.00]	[Date Application Received]
[[Football – High School]	[9 – 12]	[High Option]	[\$165.00]	[8/1/2010]
[[Football – High School]	[9 – 12]	[Low Option]	[\$106.00]	[8/1/2010]
[[Football – High School Spring Only]	[9 – 12]	[High Option]	[\$66.00]	[Date Application Received]
[[Football – High School Spring Only]	[9 – 12]	[Low Option]	[\$42.00]	[Date Application Received]
[[Extended Dental]	[PK – 12]	[One Option Only]	[\$7.00]	[First Day of Class]
[[Injury and Sickness per policy year]	[K – 12]	[One Option Only]	[\$588.00]	[Date Application Received]
[[Injury and Sickness per 3 month period]	[K – 12]	[One Option Only]	[\$147.00]	[Date Application Received]
[[Injury and Sickness per 2 month period]	[K – 12]	[One Option Only]	[\$98.00]	[Date Application Received]

Please include a copy of this Voluntary Rates page with your completed application by mail to:
 UnitedHealthcare **Student**Resources [c/o Health Special Risk, Inc. 4100 Medical Parkway Carrollton, TX 75007-1517]

UnitedHealthcare Insurance Company

[P.O. Box 809027 Dallas, TX 75380-9027]

Mail ALL completed and signed forms to:

[UnitedHealthcare **StudentResources**
Attn: K12 Sales
P.O. Box 42299
St. Petersburg, FL 33742-9936]

*Payment Note - You may mail a check with your application, or UnitedHealthcare **StudentResources** will send you an invoice after your application is processed.*

PLEASE TYPE OR PRINT

Section 1

Name of School: ANY School District Policy #: 00-0000-00
(leave blank if unknown)
Contact Name: John Doe Title: Any
Address: 123 Any Street City: Any
State: Any Zip: 00000 Phone: (000)000-0000 Fax: (000)000-000
Email Address: Any@any.com
Physical address for shipping (if different): 123 Any Street
City: Any State: Any Zip: 00000

Section 2 School Information

Estimated [2010-2011] School Enrollment: _____ (Total number of students)
Grades (Mark one): (PK – 12) (E) Elementary School (M) Middle School
 (EM) Elementary & Middle School (MH) Middle & High School
 (H) High School
Effective Date/First Class Day: [08-01-10] Last Class Day: [06-01-11]

Note: Sports/Athletics/Activities coverage (including Football) begins July 1.

High School Football Information *(complete if applicable)*

Is Offseason Program Permitted? _____ Football Effective: [06-01-10] to [06-01-11]
Is Contact Practice Permitted? _____ *Leave blank if unknown*
Who pays Football Premium? School or Parents

Section 3 Coverage Selected and Premium Calculation (See worksheet on page 2 for calculating your premium.)

Select only one plan from plans 1-4 for all students. All enrolled students must be covered.

- [Plan 1 - At-School Accident - Excluding Athletics & Activities - \$10,000 Maximum Benefit] Premium [\$ _____]
 [Plan 2 - At-School Accident - Excluding Athletics & Activities - \$25,000 Maximum Benefit] Premium [\$ _____]
 [Plan 3 - At-School Accident - Including Athletics & Activities - \$10,000 Maximum Benefit] Premium [\$ _____]
 [Plan 4 - At-School Accident - Including Athletics & Activities - \$25,000 Maximum Benefit] Premium [\$ _____]
 [Voluntary Coverage - Optional for parents - No cost to school. You may select this in addition to one At-School Accident plan.]

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.

Section 4 We hereby apply for the plans of insurance selected above. We understand that insurance will be in force if this is accepted by UnitedHealthcare Insurance Company, and the required premium is received by UnitedHealthcare **StudentResources** when due.

X _____ Date Signed: _____
Signature of Official Authorized to Contract for School

Printed Name: _____ Title: _____

Agent Signature: _____ Date Signed: _____
UnitedHealthcare **StudentResources** representative Agent Name: _____

Please include a copy of this signature page with your completed application by mail.

For assistance with your application, please call 800-237-0903 x 6281.

UnitedHealthcare Insurance Company

Insurance Premium Rate Calculation Worksheet

Mandatory Rates – At-School Accident coverage for all enrolled students

Products: [ACSI Accident/Injury - Usual and Customary] [2010/2011] Options Plans [1-4]

Select only one plan for entire school. Multiply your estimated quantity of students per grade level by the rate per student. Tally the right hand column for Total Premium Due. Re-write the total premium in the appropriate space on the application (page 1, section 3). **Please include a copy of this worksheet with your completed application by mail to [UnitedHealthcare StudentResources, Attn: K12 Sales, P.O. Box 42299, St. Petersburg, FL 33742-9936].**

School Name: _____ City: _____ State: _____

Select Plan 1, 2, 3 or 4 for your school. All enrolled students must be covered.

[Plan 1 - At-School Accident with no sports coverage (Excludes Athletics & Activities) - \$10,000 Maximum Benefit]

Grade Level	Est. # of Students	x	Rate per Student	=	Premium Subtotal
A [Pre K – K]	_____	x	[\$2.10]	=	\$ _____
B [Grades 1-6]	_____	x	[\$5.30]	=	\$ _____
C [Grades 7-8]	_____	x	[\$5.30]	=	\$ _____
D [Grades 9-12]	_____	x	[\$6.95]	=	\$ _____
E [Teachers/Admin].	_____	x	[\$12.60]	=	\$ _____
F [Overnight Field Trips – [\$210] per school/school year (if applicable)]				=	\$ _____
Total Premium Due (for the benefits shown above) Add A – F					\$ _____

[Plan 2 - At-School Accident with no sports coverage (Excludes Athletics & Activities). - \$25,000 Maximum Benefit]

Grade Level	Est. # of Students	x	Rate per Student	=	Premium Subtotal
A [Pre K – K]	_____	x	[\$2.40]	=	\$ _____
B [Grades 1-6]	_____	x	[\$5.85]	=	\$ _____
C [Grades 7-8]	_____	x	[\$5.85]	=	\$ _____
D [Grades 9-12]	_____	x	[\$7.50]	=	\$ _____
E [Teachers/Admin].	_____	x	[\$15.25]	=	\$ _____
F [Overnight Field Trips – [\$210] per school/school year (if applicable)]				=	\$ _____
Total Premium Due (for the benefits shown above) Add A – F					\$ _____

[Plan 3 - At-School Accident with sports coverage (Includes Athletics & Activities). - \$10,000 Maximum Benefit

Sports excludes interscholastic football. Football coverage requires a separate premium per player (see letter E below). High School Football coverage is available only with plans 3 or 4.]

Grade Level	Est. # of Students	x	Rate per Student	=	Premium Subtotal
A [Pre K – K]	_____	x	[\$2.10]	=	\$ _____
B [Grades 1-6]	_____	x	[\$5.30]	=	\$ _____
C [Grades 7-8]	_____	x	[\$9.75]	=	\$ _____
D [Grades 9-12]	_____	x	[\$12.85]	=	\$ _____
E [Gr. 9-12 Football]	_____	x	[\$76.65]	=	\$ _____
F [Teachers/Admin.]	_____	x	[\$12.60]	=	\$ _____
G [Overnight Field Trips – [\$210] per school/school year (if applicable)]				=	\$ _____
Total Premium Due (for the benefits shown above) Add A – G					\$ _____

[Plan 4 - At-School Accident with sports coverage (Includes Athletics & Activities). - \$25,000 Maximum Benefit

Sports excludes interscholastic football. Football coverage requires a separate premium per player (see letter E below). High School Football coverage is available only with plans 3 or 4.]

Grade Level	Est. # of Students	x	Rate per Student	=	Premium Subtotal
A [Pre K – K]	_____	x	[\$2.40]	=	\$ _____
B [Grades 1-6]	_____	x	[\$5.85]	=	\$ _____
C [Grades 7-8]	_____	x	[\$11.35]	=	\$ _____
D [Grades 9-12]	_____	x	[\$19.80]	=	\$ _____
E [Gr. 9-12 Football]	_____	x	[\$92.60]	=	\$ _____
F [Teachers/Admin.]	_____	x	[\$15.25]	=	\$ _____
G [Overnight Field Trips – [\$210] per school/school year (if applicable)]				=	\$ _____
Total Premium Due (for the benefits shown above) Add A – G					\$ _____

[Voluntary Rates - See Voluntary Rate page for details on voluntary 24-Hour Accident and Injury & Sickness plans.]

UnitedHealthcare Insurance Company

Voluntary Rates

Plan Description	Premium per Student
[24-Hour Accident with Extended Dental Coverage - High Option]	[\$102.00]
[24-Hour Accident with Extended Dental Coverage - Low Option]	[\$69.00]
[Injury and Sickness per policy year]	[\$588.00]
[Injury and Sickness per 3 month period]	[\$147.00]
[Injury and Sickness per 2 month period]	[\$98.00]

[Parent Information Supply Requisition

If you elect to offer additional coverage for parents to purchase on a voluntary basis (at no extra cost to the school), UnitedHealthcare **StudentResources** will provide informational flyers to the school to make available to parents. The [2010/2011] plan options offer two levels of coverage for 24-Hour Accident and a health plan for Injury and Sickness. Enrollment may be completed by parents online at www.K12StudentInsurance.com after [July 1, 2010].

By your request below, UnitedHealthcare **StudentResources** will ship a supply of flyers that you may hand out to every student with other parental information on the first day of school and/or you may make the flyers available as a "take-one" item within an area likely to have high parent traffic. Quantity of flyers requested should be the same number used as your estimated total number of students on the application (page 1, section 2).

Voluntary Plan Flyer Supply Requisition *(Please Complete)*

School Name: _____

Estimated [2010-2011] School Enrollment: _____ *(Number of students)*

Voluntary Plan Flyer preferred delivery date *(when someone can sign for delivery)*: _____

Physical address for shipping: _____

City: _____ State: _____ Zip: _____

Please include a copy of this voluntary rates page with your completed application by mail to

*[UnitedHealthcare **StudentResources***

Attn: K12 Sales

P.O. Box 42299

St. Petersburg, FL 33742-9936.]]

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

BENEFITS FOR HEARING AIDS

[If elected by the Policyholder,]benefits will be paid for Hearing Aids or hearing instruments sold by a professional licensed by the state to dispense Hearing Aids or hearing instruments. Benefits begin on the first day of coverage and will not exceed [\$1,400] maximum per year for each three year period.

“Hearing Aid” means an instrument or device, including repair and replacement parts, that: a) is designed and offered for the purpose of aiding Covered Persons with or compensating for impaired hearing; b) is worn in or on the body; and c) is generally not useful to a Covered Person in the absence of a hearing impairment.

Benefits shall not be subject to the Deductible and copayments. All other coinsurance, limitations, or any other provisions of the policy shall apply.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

ABC-06MOE-AR END (7)

SERFF Tracking Number: UHLC-126483077 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 44740
 Company Tracking Number: ABC-AR APP (REV 10)
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: Student Blanket Injury and Sickness
 Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/10/2010
Comments:			
Attachment:			
	Cert. of Read.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/10/2010
Bypass Reason:	Please see Form Schedule as these are being filed for approval		
Comments:			

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

		Item Status:	Status Date:
Satisfied - Item:	NAIC Trasmittal Form	Approved-Closed	02/10/2010
Comments:			
Attachment:			
	NAIC Trasmittal Form.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Response Letter to 02-03-10 Objection	Approved-Closed	02/10/2010
Comments:			

SERFF Tracking Number: UHLC-126483077 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 44740
Company Tracking Number: ABC-AR APP (REV 10)
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
Product Name: Student Blanket Injury and Sickness
Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

Attachment:

Response Letter 02-04-10.pdf

	Item Status:	Status
Satisfied - Item: Response Letter to 02-05-10 Objection	Approved-Closed	Date: 02/10/2010

Comments:

Attachment:

Response Letter 02-08-10.pdf

**UNITED HEALTHCARE INSURANCE COMPANY
STATE OF ARKANSAS
CERTIFICATE OF READABILITY**

RE: Policy Form No. ABC-AR APP (Rev 10), ABC-AR APP ACSI, ABC-AR APP2 (Rev 10)

1. We hereby certify that we have carefully scored the forms listed above and obtained a Flesch score of 49.8
2. The policy was printed in 10 point type, one point leaded.
3. The number of words contained in the policy text are 8516.
4. The entire form was analyzed excluding the name and address of the Insurer, the name, number and title of the form, captions and subscriptions, and benefit descriptions.
5. To the best of our knowledge and belief, we find that the said form complies to the standards of Arkansas Code Ann. 23-80-206.

By 

Allen Sorbo
President

Date: February 2, 2010_____

February 2, 2010

Honorable Jay Bradford
Commissioner of Insurance
Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company NAIC 79413

Form No:	ABC-AR APP (Rev 10)	General Application for Insurance
	ABC-AR APP ACSI	ACSI Application for Insurance
	ABC-AR APP2 (Rev 10)	Mandatory Offers Application for Insurance

Dear Commissioner of Insurance:

Enclosed for your consideration and approval is our original submission of the above-referenced Policyholder Applications for Blanket Student Insurance. These forms are new and do not replace any forms previously approved by your Department.

We intend to use these applications with previously approved blanket student injury & sickness policy ABC-06-AR, which was approved by your Department on December 20, 2006, under SERFF tracking number MGST-125046400.

Application ABC-AR APP (Rev 10) will be used on a general basis for School Districts who wish to apply for blanket insurance coverage under the approved policy mentioned above.

The ABC-AR APP ACSI Application will be used with schools who are members of the Association of Christian Schools. Member schools will each complete an application for coverage under the approved policy mentioned above.

The ABC-AR APP2 (Rev 10) Mandatory Offers Application will be used in conjunction with both the ABC-AR APP (Rev 10) and the ABC-AR APP ACSI. This application includes the Mandatory Offer elections required by your state.

We appreciate your consideration in review and approval of these applications. Should you have any questions or need further information, please feel free to contact me. I can be reached by phone at (866) 808-8305, extension 6551. You may also e-mail me directly at jlovelady@uhcsr.com.

Sincerely,

Jackie Lovelady
Compliance Analyst
UnitedHealthcare StudentResources

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
-----------	----------------------------------	----------

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	United HealthCare Insurance Co. 2301 West Plano Pkwy, Suite 300, Plano, TX 75075	Connecticut	LAH	707	79413	36-2739571	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Jackie Lovelady	866-808-8603, ext 6551	469-229-5506	jlovelady@uhcsr.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	ABC-AR APP (Rev 10)
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7.	<input checked="" type="checkbox"/> New Submission	<input type="checkbox"/> Resubmission	Previous file # _____
-----------	---	--	-----------------------

8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	<input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large
		Group <input type="checkbox"/> Employer <input type="checkbox"/> Association <input checked="" type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____	

9.	Type of Insurance (TOI)	H04 Health – Blanket Accident/Sickness
-----------	--------------------------------	--

10.	Sub-Type of Insurance (Sub-TOI)	H04.001 – Student
------------	--	-------------------

11.	Submitted Documents	<p><input checked="" type="checkbox"/> FORMS</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Policy</td> <td><input type="checkbox"/> Outline of Coverage</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input checked="" type="checkbox"/> Application/Enrollment</td> <td><input type="checkbox"/> Rider/Endorsement</td> <td><input type="checkbox"/> Advertising</td> </tr> <tr> <td><input type="checkbox"/> Schedule of Benefits</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>Rates</p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate	<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input checked="" type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising	<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other		
<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate										
<input checked="" type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising										
<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other											
		<input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____										
		<p>SUPPORTING DOCUMENTATION</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Articles of Incorporation</td> <td><input type="checkbox"/> Third Party Authorization</td> </tr> <tr> <td><input type="checkbox"/> Association Bylaws</td> <td><input type="checkbox"/> Trust Agreements</td> </tr> <tr> <td><input type="checkbox"/> Statement of Variability</td> <td><input type="checkbox"/> Certifications</td> </tr> <tr> <td><input type="checkbox"/> Actuarial Memorandum</td> <td></td> </tr> <tr> <td><input checked="" type="checkbox"/> Other_Cover Letter _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization	<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements	<input type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications	<input type="checkbox"/> Actuarial Memorandum		<input checked="" type="checkbox"/> Other_Cover Letter _____	
<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization											
<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements											
<input type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications											
<input type="checkbox"/> Actuarial Memorandum												
<input checked="" type="checkbox"/> Other_Cover Letter _____												

12.	Filing Submission Date	February 2, 2010	
13	Filing Fee (If required)	Amount	\$50.00
		Check Date	02/02/2010
		Retaliatory	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		Check Number	EFT
14.	Date of Domiciliary Approval	Concurrently being filed in domiciliary state of CT	
15.	Filing Description:		
	<p>Enclosed for your consideration and approval is our original submission of the above-referenced Policyholder Applications for Blanket Student Insurance. These forms are new and do not replace any forms previously approved by your Department.</p> <p>We intend to use these applications with previously approved blanket student injury & sickness policy ABC-06-AR, which was approved by your Department on December 20, 2006, under SERFF tracking number MGST-125046400.</p> <p>Application ABC-AR APP (Rev 10) will be used on a general basis for School Districts who wish to apply for blanket insurance coverage under the approved policy mentioned above.</p> <p>The ABC-AR APP ACSI Application will be used with schools who are members of the Association of Christian Schools. Member schools will each complete an application for coverage under the approved policy mentioned above.</p> <p>The ABC-AR APP2 (Rev 10) Mandatory Offers Application will be used in conjunction with both the ABC-AR APP (Rev 10) and the ABC-AR APP ACSI. This application includes the Mandatory Offer elections required by your state.</p>		

16.	Certification (If required)		
	<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
	Print Name	<u>Jackie Lovelady</u>	Title <u>Compliance Analyst</u>
	Signature	_____	Date: <u>February 2, 2010</u>

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		ABC-AR APP (Rev 10)
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Application	ABC-AR APP (Rev 10)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Application	ABC-AR APP ASCI	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Mandatory Offer Page	ABC-AR APP2 (Rev 10)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1

February 4, 2010

Rosalind Minor
Commissioner of Insurance
Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company NAIC 79413

Form No:	ABC-AR APP (Rev 10)	General Application for Insurance
	ABC-AR APP ACSI	ACSI Application for Insurance
	ABC-AR APP2 (Rev 10)	Mandatory Offers Application for Insurance
SERFF No:	UHLC-126483077	

Dear Ms. Minor,

Thank you for your letter of February 3, 2009 regarding the above referenced filing. For your ease of reference, I have restated your comments and referenced the description of the checklist followed by my response.

ABC-AR APP2 (Rev 10), Application/Enrollment Form, Mandated Offer Page (Form)

Comment: Before final review is given to the submission, I wanted to inquire about the mandated offerings for hearing aids. Did you want to add this offering, or does the product have this benefit written in to the policy?

Please see the revised Mandated Offer Page, form ABC-AR APP2 (Rev 10). The option to elect or decline benefits for Hearing Aids has been added to this form. Please also see the new Policy Endorsement, form ABC-06MOE-AR (7), for the Benefits for Hearing Aids. This new form is attached in the Forms Schedule of the above referenced SERFF tracking number.

We appreciate your continued consideration in review and approval of these applications. Should you have any questions or need further information, please feel free to contact me. I can be reached by phone at (866) 808-8305, extension 6551. You may also e-mail me directly at jlovelady@uhcsr.com.

Sincerely,

Jackie Lovelady
Compliance Analyst
UnitedHealthcare StudentResources

February 8, 2010

Rosalind Minor
Commissioner of Insurance
Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company NAIC 79413

Form No:	ABC-AR APP (Rev 10)	General Application for Insurance
	ABC-AR APP ACSI	ACSI Application for Insurance
	ABC-AR APP2 (Rev 10)	Mandatory Offers Application for Insurance
SERFF No:	UHLC-126483077	

Dear Ms. Minor,

Thank you for your letter of February 5, 2009 regarding the above referenced filing. For your ease of reference, I have restated your comments and referenced the description of the checklist followed by my response.

ABC-06MOE-AR (7), Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider, Policy Endorsement (Form)

Comment:

The wording in the endorsement for the mandated offering for hearing aid indicates that an additional premium will be charged. Please submit the actuarial memorandum for this benefit and the premium rates.

I apologize but I am unable to find in the Arkansas Insurance Code or Regulations where an Actuarial Memorandum and premium rates are required to be filed for blanket accident and sickness insurance. Can you possibly point me to this requirement? Policy ABC-06-AR and related forms previously approved were filed based on Arkansas Insurance Code 23-86-101(3), as are the above referenced forms. Also, please note the language, "In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows", is a general statement included on all our standard endorsements including all Mandatory Offer Endorsements.

We appreciate your continued consideration in review and approval of these applications. Should you have any questions or need further information, please feel free to contact me. I can be reached by phone at (866) 808-8305, extension 6551. You may also e-mail me directly at jlovelady@uhcsr.com.

Sincerely,

Jackie Lovelady
Compliance Analyst
UnitedHealthcare StudentResources

SERFF Tracking Number: UHLC-126483077 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 44740
 Company Tracking Number: ABC-AR APP (REV 10)
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: Student Blanket Injury and Sickness
 Project Name/Number: Policyholder Applications/ABC-AR APP (Rev 10)

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)
02/02/2010	Form	Mandated Offer Page	02/04/2010	ABC-AR APP2 (Rev 10).pdf (Superseded)

