

SERFF Tracking Number: GRTT-126493123 State: Arkansas
Filing Company: United National Life Insurance Company of America State Tracking Number: 44784
Company Tracking Number: U1041G-AR
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 Sub-TOI: MS08I.007 Plan G 2010
Product Name: 2010 Medicare Supplement Plan G
Project Name/Number: /U1041G-AR

Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: 2010 Medicare Supplement Plan G SERFF Tr Num: GRTT-126493123 State: Arkansas

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved-Closed State Tr Num: 44784

Sub-TOI: MS08I.007 Plan G 2010

Co Tr Num: U1041G-AR

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Stephanie Fowler

Author: Joan Jannotta

Disposition Date: 03/11/2010

Date Submitted: 02/09/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date: 06/01/2010

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number: U1041G-AR

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/11/2010

Explanation for Other Group Market Type:

State Status Changed: 03/11/2010

Deemer Date:

Created By: Joan Jannotta

Submitted By: Joan Jannotta

Corresponding Filing Tracking Number: GRTT-126492897, GRTT-126493057, GRTT-126493089

Filing Description:

Re: Individual Medicare Supplement Insurance

2010 Standardized Medicare Supplement Plan G

Policy Form U1041G-AR

Actuarial Memorandum and Rates

SERFF Tracking Number: GRTT-126493123 *State:* Arkansas
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NAIC #92703 903

Dear Sir or Madam:

We are submitting the above referenced form for your review and approval.

Form U1041G-AR is our 2010 standardized Medicare Supplement Plan G policy. It will replace policy form U9740G-4, which was approved by your Department on June 15, 1998.

We are also submitting policy forms U1041A-AR, U1041D-AR and U1041F-AR under separate serff filings. The corresponding serff filing numbers are shown on the General Information tab.

We are submitting Outline of Coverage form UOC1041, which will be used in the solicitation of this product, with our filing for policy form U1041A.

Our premium rates are submitted in the corresponding file. The serff number is on the General Information tab.

We will use application form UAPPH7-08, which was approved by your Department on October 1, 2009 with these forms.

We will also use previously approved "Notice To Applicant Regarding Replacement Of Medicare Supplement Insurance Or Medicare Advantage" form UMS-HRF96 in the case of a replacement. Form UMS-HRF96 will be printed in 3 part NCR so that a signed copy may be left with the applicant and we will retain the remaining copies in the applicant's file.

These forms have been printed by our computer and laser printer. We reserve the right to change the font (typeset) when and if a new font becomes available. We are filing these forms concurrently in Illinois, our state of domicile.

We would appreciate any consideration you could extend toward the prompt approval of this submission. If I can be of further assistance in the approval process, please contact me directly by E-mail or at our toll-free number shown below.

Sincerely,
Joan Jannotta
Product Manager
Product Approval and Compliance (PAC)
Direct Phone: 1-847-904-5730

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 Toll-Free: 1-800-338-7452, extension #5730
 E-mail: jjannotta@gtlic.com
 Fax: 847-699-0093

Company and Contact

Filing Contact Information

Joan Jannotta, jjannotta@gtlic.com
 1275 Milwaukee Ave. 847-904-5730 [Phone]
 Glenview, IL 60025 847-699-0093 [FAX]

Filing Company Information

United National Life Insurance Company of America CoCode: 92703 State of Domicile: Illinois
 1275 Milwaukee Ave. Group Code: 903 Company Type:
 Glenview, IL 60025 Group Name: State ID Number:
 (847) 803-5252 ext. [Phone] FEIN Number: 37-1095206

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: 1 form = \$50
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United National Life Insurance Company of America	\$50.00	02/09/2010	34079644

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	03/11/2010	03/11/2010

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America
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Standard Plans 2010
Product Name: 2010 Medicare Supplement Plan G
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Disposition

Disposition Date: 03/11/2010

Implementation Date: 06/01/2010

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	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Replacement Notice for your information	Accepted for Informational Purposes	Yes
Supporting Document	Important Notice	Accepted for Informational Purposes	Yes
Supporting Document	Guaranty Association Notice	Accepted for Informational Purposes	Yes
Supporting Document	Certificate of Compliance	Accepted for Informational Purposes	Yes
Form	Plan G	Approved	Yes
Rate	Rates	Approved	Yes

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Form Schedule

Lead Form Number: U1041G-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/11/2010	U1041G-AR	Policy/Cont	Plan G ract/Fratern al Certificate	Initial		47.490	U1041G-AR.pdf

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

A Stock Company - P. O. Box 1154 - Glenview, Illinois 60025-1154 - (847) 803-5252

We, **United National Life Insurance Company of America**, promise to pay You, the benefits described in this Policy for loss which results from Injury or Sickness while this Policy is in force. All benefits are subject to its definitions, provisions, limitations and exceptions. We make this promise in consideration of the application for this Policy and the payment of the Premium. Your application is attached to and made a part of this Policy.

Important Notice About Statements in the Application – Please read the copy of the application which is a part of this Policy. Check to see if any medical history requested has been left out. Write Us if any information shown isn't right or complete. We issued this Policy on the basis that the answers to all the questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

Right To Examine Policy For 30 Days – If You are not satisfied with this Policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this Policy will be void.

Effective Date – This Policy begins at 12:01 a.m. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the grace period, at 12:01 a.m. on the date any renewal premium is due.

Guaranteed Renewable for Life - You may keep this Policy in force during Your entire lifetime by paying premiums when due or within the grace period. We can't cancel or refuse to renew this Policy because of a change in Your health. This Policy may be cancelled for nonpayment of premium or material misrepresentation in Your application.

Renewal Premium – We will change the premium rates for this Policy, but only if they are changed for all policies like Yours in Your state on a class basis. The change may be due to a change in Your benefits or a new table or rates. As Your Policy benefits are tied to Medicare's benefits, Your Policy benefits and premiums are expected to change each year due to a change in Medicare's benefits. We will tell You in advance of any change in premium.

Notice to Buyer: This Policy may not cover all of Your medical expenses.

Signed at United National Life Insurance Company of America in Glenview, Illinois by



President



Secretary

Licensed Resident Agent (If Required): _____

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN G

This Policy is a legal contract between You and Us.

Read Your Policy carefully.

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SUSPENSION OF BENEFITS

If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify us and request a suspension, we'll suspend Your benefits and premiums for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

If You are eligible for, and have purchased this Policy by reason of disability and You later become covered by an employer or union-based group health plan, the benefits and premiums under Your Policy can be suspended, if requested, while You are covered under the employer or union-based group health plan.

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility or the effective date of Your employer or union-based group health plan. When We get the timely notice, to the extent permitted by applicable law or regulation, We'll refund any premium paid covering a period beyond the date of eligibility for Medicaid or effective date of Your employer or union-based group health plan. Any refund will be subject to adjustment for paid claims.

If you lose entitlement to Medicaid benefits or Your employer or union-based group health plan during the suspension period and notify Us so within ninety (90) days, then, effective the date Medicaid entitlement or employer or union-based group health plan terminated, We'll (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; and (b) charge a premium at least as favorable as if the coverage had not been suspended.

DEFINITIONS

Actual Charge means the Actual Charge made by the provider for services or supplies in the absence of insurance, but not to exceed the maximum actual allowable charge determined by Medicare for non-participating providers.

Benefit Period means the time used to measure in-hospital benefits for expenses covered by Medicare. A Benefit Period begins after the effective date of coverage with the first day You receive Medicare covered services in a Hospital. The date it ends is determined by Medicare.

Doctor means a legally qualified practitioner of the healing arts, other than You or a Family Member, approved by Medicare to treat the type of condition for which claim is made.

Family Member means a person who is related to You in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild). A Family Member includes an individual who normally lives in Your household.

Hospice Care means a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. The goal of such care is to achieve the highest quality of life as defined by the patient and his or her family through the relief of suffering and control of symptoms.

Hospital means a Hospital that is either approved for payment of Medicare benefits or could receive such approval if so requested.

Injury means an accidental bodily Injury which occurs while this Policy is in force and causing loss which commences while this Policy is in force.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as medically necessary and reasonable by Medicare. These expenses may or may not be fully covered by Medicare.

Medicare Part A Deductible means the initial fixed amount Medicare does not pay for Part A inpatient Hospital services during a Benefit Period. This amount is determined by Medicare.

Medicare Part B Annual Deductible means the initial fixed amount Medicare does not pay under Part B for expenses covered by Medicare in each Calendar Year. This amount is determined by Medicare.

Policy or Contract means this legal agreement between You and Us.

Respite Care means professional care given to You in order to temporarily relieve unpaid Informal Caregivers.

Sickness means an illness or disease of an insured person which first manifests itself after the effective date of coverage and causes loss which commences while this Policy is in force.

Skilled Nursing Copayment means the fixed amount per day Medicare does not pay during a Medicare covered Skilled Nursing stay. The amount of Skilled Nursing Copayment is set each year by Medicare.

You or Your means the person who is insured under this Policy and named in the Schedule.

We, Our or Us means United National Life Insurance Company of America.

BENEFIT PROVISIONS

MEDICARE SUPPLEMENT BENEFITS

We'll pay benefits for covered Medicare Eligible Expenses You incur due to Injury or Sickness. Covered expenses and Policy benefits and limits are explained below. To be covered, the Medicare Eligible Expense must be incurred while coverage under this Policy is in force.

Any claim for a continuous loss that begins while this Policy is in force won't be affected by the ending of this Policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable.

We'll pay benefits listed below as though You have coverage under both Medicare hospital and medical insurance, and as though Medicare paid its share of the covered expense. We won't impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

Explanation of Medicare Benefits Form - before We can pay any benefits for expenses covered under Medicare Part B, You or Your health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits form. It's a form sent by Medicare's Benefit Department. It shows the Medicare Eligible Expenses.

We will pay as follows:

Basic Benefits

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period;
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept Our payment in full and may not bill You for any balance;

Basic Benefits (cont.)

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
5. Coverage for the Coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible;
6. Hospice Care: Coverage of the cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

Additional Benefits

1. Medicare Plan A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing facility care eligible under Medicare Part A.
3. One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare approved Part B charge.
4. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Doctor, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250) and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Before Part A and Part B Policy benefits are payable, benefits must be payable under Part A and Part B of Medicare for its part of the expenses.

Benefit and Premium Change

The risk We assumed on this Policy's Issue Date was based on Medicare's benefit structure at that time. Medicare benefits change from time to time. When Medicare changes its deductible or co-payment amounts, or limits under its benefit structure that was in effect on the Effective Date, We'll change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this Policy's coverage. We will make such a change by adding an endorsement or new schedule page to the Policy or both. Before We make any such change, We'll get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk we assumed on this Policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after We give You the advance notice Your state requires.

LIMITATIONS AND EXCLUSIONS

Exclusions

This Policy does not cover or consider for payment any service or supply, or any portion of a service or supply that is not a Medicare Eligible Expense, nor will this Policy duplicate any benefit paid by Medicare.

UNIFORM PROVISIONS

Entire Contract; Changes:

This Policy, a copy of the application, and any attached papers, is the Entire Contract between You and Us. No change in this Policy will be effective until approved by two of Our executive officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

Time Limit On Certain Defenses

After 2 years from the Effective Date only fraudulent misstatements in the application may be used to void this Policy or deny any claims for loss which starts after the 2 year period.

Grace Period

This policy has a 31 day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period, this Policy will stay in force. If a premium is not paid during the Grace Period, this Policy will terminate as of the due date of the unpaid premium. If You send written notice to Us that You are not renewing Your coverage, then the Grace Period will not apply after the date the non-renewal is to be effective.

Reinstatement

If the premium isn't paid before the Grace Period ends, this Policy will lapse. Later acceptance of premium by Us or by Your agent without requiring an application for reinstatement, will reinstate this Policy.

If You were asked to complete an application, You'll be given a conditional receipt for the premium. If the application is approved, this Policy will be reinstated as of the approval date. Lacking such approval, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated Policy will cover loss which results from an Injury sustained after the date of reinstatement or sickness that starts after such date. In all other aspects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

Premium Refund at Death

We will refund within 30 days after we receive proof of Your death, that portion of the premium paid covering the period beyond the month of death.

Notice of Claim

You must give Us written notice of claim within 20 days after a covered loss starts or as soon as possible. The notice can be given to Us at Our home office in Glenview, Illinois, or to Your agent. Notice should include Your name and Policy number.

Claim Forms

When we get notice of claim, We'll send You forms for filing proof of loss. If these forms aren't given to You within 15 days, You'll meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proofs of Loss section.

Proofs of Loss

Written proof of loss must be given to Us within ninety (90) days of such loss. If it was not reasonably possible to give Us written proof in the time required, we won't reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one (1) year from the time specified unless You were legally unable to act.

Time of Payment of Claims

We will pay all benefits then due under this Policy as soon as we get proper written proof of loss.

Payment of Claims

We will pay the benefits to You or to the health care provider. Any unassigned benefits due and unpaid at Your death may be paid, at our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who can't give valid release, We may pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We'll be discharged to the extent of any such payment made in good faith.

Physical Examinations

We, at Our own expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

Legal Action

A legal action may not be brought to recover on this Policy within sixty (60) days after written proof of loss has been given as required by this Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

Other Insurance With Us

You may have only one Policy like this one with us. If through error, We issue more than one like Policy to You, only one Policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We'll return the money You paid for the other Policies.

Conformity With State Statutes

Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

A Stock Company

P.O. Box 1154

Glenview, Illinois 60025-1154

(847) 803-5252

**MEDICARE SUPPLEMENT
INSURANCE**

SERFF Tracking Number: *GRTT-126493123* State: *Arkansas*
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Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved Rates 03/11/2010		U1041G-AR	New		AR Annual Rate.pdf AR Monthly Rate.pdf

United National Life Insurance Company
Standardized Medicare Supplement Premium Rates
 Annual Rates - Effective 6/1/2010

ARKANSAS

	Preferred					Standard			
Age	Plan A	Plan D	Plan F	Plan G		Plan A	Plan D	Plan F	Plan G
All Ages	1,268.40	1,666.80	1,814.40	1,701.60		1,409.30	1,852.00	2,016.00	1,890.70

A discount factor of 0.93 is applied for married applicants

<u>Zip Codes</u>	<u>Area Factors</u>
720-722	0.93
716-719, 723-729	0.80

United National Life Insurance Company
Standardized Medicare Supplement Premium Rates
 Annual Rates - Effective 6/1/2010

ARKANSAS

	Preferred					Standard			
Age	Plan A	Plan D	Plan F	Plan G		Plan A	Plan D	Plan F	Plan G
All Ages	105.70	138.90	151.20	141.80		117.44	154.33	168.00	157.56

A discount factor of 0.93 is applied for married applicants

<u>Zip Codes</u>	<u>Area Factors</u>
720-722	0.93
716-719, 723-729	0.80

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	03/11/2010
Comments:			
Attachment:	readcert Plan G.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	03/11/2010
Comments:			
Attachment:	Application UAPPH7-08.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	03/11/2010
Comments:			
Attachments:	UOC1041 Chart (10).pdf UOC1041.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Replacement Notice for your information	Accepted for Informational Purposes	03/11/2010
Comments:			
Attachment:	UMS-HRF96.pdf		

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Satisfied - Item:	Important Notice	Item Status:	Status Date:
		Accepted for Informational Purposes	03/11/2010
Comments:			
Attachment:			
UNOT-03-AR (Rev. 11-09).pdf			

Satisfied - Item:	Guaranty Association Notice	Item Status:	Status Date:
		Accepted for Informational Purposes	03/11/2010
Comments:			
Attachment:			
GANT_AR(Rev1_04).pdf			

Satisfied - Item:	Certificate of Compliance	Item Status:	Status Date:
		Accepted for Informational Purposes	03/11/2010
Comments:			
Attachment:			
AR_sub-Cert for UNLPlan G.pdf			

CERTIFICATE OF READABILITY

Form Number(s): U1040G-AR

Flesch Test Score(s): 47.49

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA



Arthur G Fess
President

Date February 8, 2010

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICANT		Last Name			First Name			M.I.
Soc. Security #	Age	Date of Birth / /	Sex	Height /	Weight lbs	Phone Number ()	Email	
ADDRESS Number & Street				City		State	Zip Code	
MAILING ADDRESS (if different from above)				City		State	Zip Code	

PLAN & PAYMENT INFORMATION

<p>1. Requested Effective Date or Replacement Date: _____</p> <p>2. I am applying for: a. Medicare Supplement Plan: Plan: <input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> G</p>	<p>3. Premium Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft*</p> <p>Requested Draft Date _____</p> <p>Application Fee: \$ _____</p> <p>Total Modal Premium: \$ _____</p> <p>Premium Paid with Application: \$ _____</p> <p>* (1 month's premium required for bank draft)</p>
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MEDICARE COVERAGE QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER QUESTIONS 4 THROUGH 9 COMPLETELY.

Please mark Yes or No with an "X". To the best of your knowledge:

<p>4. Are you covered or will you be covered under Medicare Parts A & B? (If the answer is "No", do not submit the application) If yes, what is your Medicare claim number? (exactly as it appears on your Medicare Card) _____</p> <p>5. a. Did you turn age 65 in the last 6 months? b. Did you enroll in Medicare Part B in the last 6 months or will you enroll in Medicare Part B in the next 6 months?.... If yes, what is/was the effective date? _____</p> <p>6. Are you covered for medical assistance through the state Medicaid program? (If the answer to 6a. or 6b. is "yes", do not submit the application.) NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. If you answer yes, a. Will Medicaid pay your premiums for this Medicare supplement policy? b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....</p> <p>7. a. Do you have another Medicare supplement policy in force?..... b. If so, with what company and what plan do you have? _____ c. If so, do you intend to replace your current Medicare supplement policy with this policy?..... d. If yes, what is the Termination Date of your other Medicare Supplement Policy? _____</p> <p>8. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____ b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? c. Was this your first time in this type of a Medicare plan? d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? e. If your coverage has not ended please fill in a planned termination date? ____/____/____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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9. Have you had coverage under any other health insurance within the past 63 days?.....
 (For example, Railroad Retirees, teachers plans, an employer union, group major medical or individual plan)
 a. If so, with what company and what kind of policy?

 b. What are your dates of coverage under the other policy?
 START _____/_____/_____ END _____/_____/_____
 (If you are still covered under the other policy, leave the "END" blank.
 c. If your coverage has not ended, please fill in a planned termination date? _____/_____/_____

Yes No

HEALTH QUESTIONS

You do not have to answer questions 10 through 24 if you have enrolled in Medicare Part B within the past 6 months or are in a guarantee issue period. If not, and you answer "yes" to questions 10 through 23 below, you are not eligible for coverage

10. Are you currently hospitalized or confined to a nursing facility, or, are you bedridden or confined to a wheelchair? Yes No

11. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? Yes No

12. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, degenerative bone disease, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? Yes No

13. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? Yes No

14. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

15. Do you have diabetes, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, congestive heart failure, heart disease, or high blood pressure with three or more medications? Yes No

16. Do you have diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral)? Yes No

17. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation? Yes No

18. Within the past two years have you been treated, been advised to have treatment, been prescribed new medication or had changes in existing medication(s) for coronary or carotid artery disease, heart rhythm disorders including pacemakers or a defibrillator, a heart attack, congestive heart failure, or enlarged heart, stroke, transient ischemic attack (TIA), heart valve surgery, or peripheral vascular disease? Yes No

19. Within the past two years have you been treated for crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes No

20. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? Yes No

21. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes No

22. Have you been hospital confined three or more times in the last two years? Yes No

23. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No

24. Have you used any tobacco products in the past 12 months? Yes No

25. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes No
 If, "YES", please list the drug and the condition in the following table.

Applicant (please attach a separate sheet if needed)	
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition

DISCLOSURE & AUTHORIZATION

DISCLOSURE: You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy, (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for the outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

APPLICANT'S AUTHORIZATION & AGREEMENT: I authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc.. This Authorization includes all information about drugs, alcoholism, and mental illness. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by the Company in accordance with federal or state law. I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

ACKNOWLEDGEMENTS: The Applicant represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete. 2) Any coverage issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No agent or any other person is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of the application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime. 5) Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan which has been applied for, have been explained and are understood. 6) The applicant shall be owner of any insurance applied for. 7) The applicant acknowledges receipt of the Outline of Coverage, and has read the authorization and received copies of the "Notice to Applicant, Parts 1 and 2" describing the Medical Information Bureau and explaining the rights of the applicant under the Fair Credit Reporting Act.

AGREEMENT: I have read, or had read to me, the completed application. I hereby agree that: 1) all the statements and answers in this application are complete and true to the best of my knowledge and belief; and 2) **no insurance will be effective until my policy is issued.**

Caution: If your answers on this application are incorrect or untrue, United National Life Insurance Company of America may deny benefits or rescind your policy.

We are required to give you this notice: Any person who, with the intent to defraud or knowledge that he is facilitating a fraud against the insurer, submits an application or files a claim containing false, incomplete, or deceptive statements of material fact may be guilty of insurance fraud.

Applicant's Signature

City & State signed

Date

MAIL POLICY TO: Agent Insured

AGENT'S REPORT: List of health policies or certificates I have sold to the Applicant in the last 5 years which are either in force or no longer in force:

NAME OF INSURER	POLICY TYPE

AGENT'S STATEMENT

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given an Outline of Coverage for the policy being applied for and the Medicare Supplement Buyer's Guide to the Applicant; 3) I am or am not aware the policy applied for will replace an existing health insurance policy; and 4) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Agent's Signature **Agent's Name (please print)** **Agent Code**

Agent's E-mail Address *(Agent signature not required if sold through the mail.)*

TYPE OF SALE: In Person Telephone On-line Mail

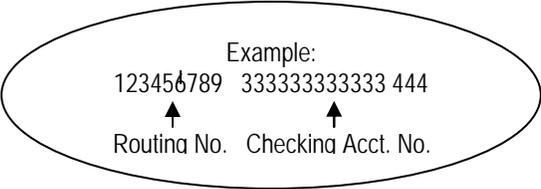
MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by United National Life Insurance Company of America.

TO _____
 Name of my Bank

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of United National Life Insurance Company of America, Glenview, Illinois, provided there are sufficient funds in my account to pay the same upon presentation.

Bank Routing #: _____ Checking Acct. #: _____
 Account Type Checking Account *(Attach a Voided "Sample" check)* Savings Account *(Attach a Voided "Sample" check if applicable, or a Deposit slip)*



I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

Benefit Chart of Medicare Supplement Plans Sold For Effective Dates On or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

[Plans E, H, I and J are no longer available for sale.]

Basic Benefits:

- * **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- * **Medical Expenses** - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- * **Blood** – First three pints of blood each year.
- * **Hospice** – Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER			
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$[4,620]; paid at 100% after limit reached.	Out-of-pocket limit \$[2,310]; paid at 100% after limit reached.		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

PREMIUM INFORMATION

We, United National Life Insurance Company of America, can only raise your premium if we raise the premium for all policies like yours in this State on a class basis.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to P. O. Box 1154, Glenview, Illinois 60025-1154. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither United National Life Insurance Company of America nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days</p> <p>-Beyond the additional 365 days</p>	<p>All but \$[1,100] All but \$[275] a day</p> <p>All but \$[550] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0 \$[275] a day</p> <p>\$[550] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$[1,100] (Part A Deductible) \$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$[137.50] a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0 Up to \$[137.50] a day All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare co-payment/coinsurance</p>	<p>\$0</p>

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[155] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 20%	 \$0 \$[155] (Part B Deductible) \$0
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PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-ayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES-PER CALENDAR YEAR

* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN D
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS-NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not receive skilled care in any other facility for 60 days in a row.

[** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,000] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO \$[2,000] DEDUCTIBLE**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-ayment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

(continued)

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) – MEDICAL SERVICES-PER CALENDAR YEAR

* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,000] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO \$[2,000] DEDUCTIBLE **] YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[155] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[155] (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,000] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO \$[2,000] DEDUCTIBLE **] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS-NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar Year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co/payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	0%	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN G
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS-NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**NOTICE TO APPLICANT
REGARDING REPLACEMENT OF**

MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

United National Life Insurance Company of America – P. O. Box 1154, Glenview, Illinois 60025-1154

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by United National Life Insurance Company of America. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and health insurance you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and health coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURER, AGENT

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s),

(check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

- Other. (please specify)

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Agent's Signature: _____ Date: _____

Typed Name and Address of Agent: _____

Applicant's Signature: _____ Date: _____

IMPORTANT NOTICE

Policyholder Service Office: United National Life Insurance Company of America

Address: 1275 Milwaukee Avenue, Glenview, IL 60025

Telephone Number: (847) 803-5252 *or* Toll-Free 1-800-207-8050

Name of Agent _____

Address: _____

Telephone Number: _____

If we at United National Life Insurance Company of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the **Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association")**. The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals).
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Re: Policy Form U1040G-AR

The United National Insurance Company of America, Glenview, Illinois does hereby certify that this policy form submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements for this category of insurance pursuant to the Arkansas Department of Insurance.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA



Arthur G Fess
President

Date February 8, 2010