Filing at a Glance

Company: The Union Labor Life Insurance Company

Product Name: ULLA-LIF-1109	SERFF Tr Num: ULCC-126529868	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 45116
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: ULLA-LIF-1109	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Karen Whitham, Kevin Ross, Carla Wallace	Disposition Date: 03/10/2010
	Date Submitted: 03/05/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	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: 03/10/2010	Explanation for Other Group Market Type:
	State Status Changed: 03/10/2010
Deemer Date:	Created By: Karen Whitham
Submitted By: Karen Whitham	Corresponding Filing Tracking Number:

Filing Description:

Attached for your review and approval is the individual life insurance application form, ULLA-LIF-1109. This is a new application form and does not replace any existing forms.

This application will be used with individual whole life or term life policies as approved by the Department. These policies have not yet been filed with the Department, but will be submitted for review and approval separately.

The products will be marketed by direct response mail to members of labor unions; no agents will be involved. No premium is required with the application.

Please contact me with any questions.

Company and Contact

Filing Contact Information

Karen Whitham,	kwhitham@ullico.com
8403 Colesville Road	202-682-4683 [Phone]
Silver Spring, MD 20910	202-682-4682 [FAX]

Filing Company Information

The Union Labor Life Insurance Company	CoCode: 69744	State of Domicile: Maryland
8403 Colesville Road	Group Code: 781	Company Type: Life and Heallth
Silver Spring, MD 20910	Group Name:	State ID Number:
(202) 682-0900 ext. [Phone]	FEIN Number: 13-1423090	

Filing Fees

Fee Required?	Yes
Fee Amount:	$125.00
Retaliatory?	Yes
Fee Explanation:	1 form @ $125 (Maryland fee)
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Union Labor Life Insurance Company	$125.00	03/05/2010	34632860

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/10/2010	03/10/2010

Disposition

Disposition Date: 03/10/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ULCC-126529868*	*State:*	*Arkansas*
Filing Company:	*The Union Labor Life Insurance Company*	*State Tracking Number:*	*45116*
Company Tracking Number:	*ULLA-LIF-1109*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*ULLA-LIF-1109*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Variable Memorandum		Yes
Form	Individual Life Insurance Application		Yes

Form Schedule

Lead Form Number: ULLA-LIF-1109

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ULLA-LIF-1109	Application/ Enrollment Form	Individual Life Insurance Application	Initial		50.200	ULLA-LIF-1109.pdf

INDIVIDUAL [WHOLE] LIFE INSURANCE APPLICATION
THE UNION LABOR LIFE INSURANCE COMPANY
[8403 Colesville Road
Silver Spring, MD 20910]

[John Q. Sample
Street Road
Second Address Line
Anytown, US 00000]

Member of:
[International Union Personalized]

1. Please tell us about yourself [and your spouse or domestic partner (if applying)]:

Member Date of Birth _____ / _____ / _____
MONTH DAY YEAR

☐Male ☐ Female

Phone (_____) _____ ☐ Day ☐ Evening
AREA CODE

Social Security # ☐☐☐■☐☐■☐☐☐☐

[Driver's License # _____ State of Issue _____]

E-Mail Address* _____

[International Union _____]

* If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

[Spouse or Domestic Partner Name

_____

Date of Birth _____ / _____ / _____
MONTH DAY YEAR

☐Male ☐ Female

Phone (_____) _____ ☐ Day ☐ Evening
AREA CODE

Social Security # ☐☐☐■☐☐■☐☐☐☐

[Driver's License # _____ State of Issue _____]

E-Mail Address* _____]

2. Please select the benefits you would like:

Products: Member:

[☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000
☐$75,000 ☐ $50,000 ☐ $25,000]

[Spouse or Domestic Partner:

☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000
☐$75,000 ☐ $50,000 ☐ $25,000]

[Additional benefits:

☐Children's Term Life ☐ Accidental Death $_____ ☐ Automatic Loan Provision (Whole Life only)]

Please specify if you [or your spouse or domestic partner, if applying], have existing life insurance or annuity contracts in force with our company or any other insurance company. ____Yes _____No. Will this insurance replace or change any life insurance or annuity contract in force with our company or any other insurance company? ___ Yes ___ No

The beneficiary for your coverage [and/or spouse or domestic partner's coverage] will be a spouse or domestic partner, if living. Otherwise, the beneficiary will be your children, parents, brothers and sisters, or estate in that order. If you'd like to name a different beneficiary, please complete below:

Covered Person	Beneficiary	Relationship to Covered Person

3. Please answer the following questions for you [and your spouse or domestic partner (if applying)]:

MEMBER Height _____ FEET/INCHES Weight _____ LBS.

[SPOUSE DOMESTIC PARTNER Height _____ FEET/INCHES Weight _____ LBS]

	YOU	[SPOUSE/ DOMESTIC PARTNER
[1. Have you pled guilty to or been convicted of driving under the influence of alcohol or drugs, or had your driver's license suspended or revoked for any reason in the past 3 years?	☐Yes ☐ No	☐Yes ☐ No
2. Have you used any tobacco or nicotine based products in the past 12 months?	☐Yes ☐ No	☐Yes ☐ No
3. In the past 3 years, has a medical professional diagnosed you with, treated you for, or told you to seek treatment because of: disease or disorder of the heart, blood or circulatory system, lungs, liver, bowel or kidneys, high blood pressure, diabetes [requiring insulin], stroke or cancer, mental or nervous disorders [requiring hospitalization]; or told you that you tested positive for HIV infection or to reduce or discontinue use of any drug or alcohol?	☐Yes ☐ No	☐Yes ☐ No
4. Other than those conditions covered above, have you been advised by a medical professional regarding any chronic illness or condition which requires periodic medical care or may require future surgery?	☐Yes ☐ No	☐Yes ☐ No]

If you [or your spouse or domestic partner] answered "Yes" to questions 3 or 4, please provide details in the space below. Attach a separate sheet if needed.

_____
_____
_____
_____]

4. Read below and sign --- Then return in the envelope provided:

I have read the application and all statements and answers as they pertain to it. I understand and affirm by my signature below that, to the best of my knowledge and belief, the information in this entire application is true and complete. I understand that the statements and answers in the application are the basis for any policy issued by the company and that no information about me will be considered given unless stated in the application. I understand that a separate Policy will be issued to each applicant and that no insurance is in effect until I am issued my Policy and my first premium is paid before my effective date and during my lifetime. I understand that if I fail to give true and complete answers on this application, benefits may be denied.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

[To determine my insurability, or for claims purposes, I authorize any physician, medical practitioner, institution, VA Hospital, or other medically related facility, insurance company, the Medical Information Bureau, or any Consumer Reporting Agency to give any information about my physical or mental health to The Union Labor Life Insurance Company or its reinsurers. This authorization or its photocopy is valid for 30 months from the application date and I or my beneficiary may request a copy. I have read the applicable fraud notice and the Notice to Applicant enclosed with this form as required by the Fair Credit Reporting Act. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.]

X _____ [X _____

YOUR SIGNATURE DATE SPOUSE'S OR DOMESTIC PARTNER'S SIGNATURE (IF APPLYING) DATE]

[HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize my health care providers, including pharmacies and pharmacists, any person engaged in the sale or dispensing of prescription drugs, and any other person who prepares, collects or maintains health information about me to disclose all records pertaining to my receipt of health care services or supplies, including prescription drugs to The Union Labor Life Insurance Company ("the Company") to be used by the Company to determine my eligibility for insurance and any claim for insurance benefits. I acknowledge that the provision of health care services or supplies by a person authorized to make disclosure under this Authorization may not be conditioned upon my signing this Authorization; however, the Company may decline my application for insurance or my claim for benefits if I refuse to sign or revoke this Authorization. I further acknowledge that I may revoke this Authorization at any time by submitting a written revocation request to The Union Labor Life Insurance Company, but the revocation will not affect actions taken before receipt of the revocation or any legal right the Company has to contest my policy or certificate or a claim under my policy or certificate based on information obtained prior to the revocation. I understand that the information disclosed pursuant to this Authorization may be redisclosed and no longer protected by the privacy regulations under the Health Insurance Portability and Accountability Act. This Authorization will expire one year after the date of execution below.

X _____ [X _____

YOUR SIGNATURE DATE SPOUSE'S OR DOMESTIC PARTNER'S SIGNATURE (IF APPLYING) DATE]

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Certification of Readability ULLA-LIF-1109.pdf

AR Certification Rule 19.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: not applicable

Comments:

Item Status: **Status Date:**

Satisfied - Item: Variable Memorandum

Comments:

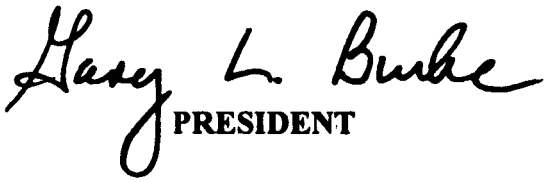
Attachment:

Variable Memorandum ULLA-LIF-1109.pdf

CERTIFICATION
OF READABILITY

Individual Life Insurance Application Form ULLA-LIF-1109

I certify that the forms submitted with this filing achieved a minimum Flesch Test Reading Score of at least 50.



Gary L. Burke
The Union Labor Life Insurance Company

December 15, 2009
Date

CERTIFICATE OF COMPLIANCE WITH ARKANSAS RULE & REGULATION 19

Insurer: The Union Labor Life Insurance Company

Form Number(s): ULLA-LIF-1109

I hereby certify that the filing above meets all applicable Arkansas requirements including the applicable requirements of Rule & Regulation 19.

Charles H. MacPhaul
AVP Compliance Life and Health

March 3, 2010
Date

THE UNION LABOR LIFE INSURANCE COMPANY
VARIABLE MEMORANDUM
Individual Whole Life Insurance Application ULLA-LIF-1109

Variable data is bracketed. Variable data will never exclude or limit provisions required by the governing jurisdiction.

1. "Individual Life Insurance Application" will always be in title, but modifiers may be changed to reflect the product offered. i.e. "Individual Term Life Insurance to Age 80 Application" or "Individual Whole Life Insurance Application." The company address may be revised to reflect current information.

2. If the product being offered doesn't provide coverage for a Member's Spouse or Domestic Partner, all Spouse/Domestic Partner information will be omitted. We may extend coverage to Spouses but not to Domestic Partners and in those cases Domestic Partner will be removed from the joint Spouse/Domestic Partner designations.

3. Driver's License information will only be included on underwritten cases where motor vehicle records are reviewed as part of underwriting process.

4. International Union may not be asked and/or it may be preprinted if available in advance of offer.

5. The products and amounts shown in the Product lines in Section 2 of the application are illustrative, and will vary according to the products being offered. Additional products may be added in the future as they become available.

6. For Guaranteed Issue Products, Section 3 will be eliminated in its entirety. The only exception being that the Tobacco question may be included if we offer a Guaranteed Issue product with Tobacco Distinct Rates.

   Question 1 may not be included with an offer for a product if the Underwriters feel it is not necessary.

   Question 2 may not be included if Tobacco Distinct Rates are not used.

   In Question 3 the modifiers "requiring insulin" and "requiring hospitalization" will only be included for "yes/no" underwriting. i.e. For full underwriting we will ask about "diabetes" and let the underwriter use that information in his rate consideration whether it requires insulin or not. On a "yes/no" product, we wouldn't want to decline all diabetes, but we would decline all "diabetes requiring insulin".

7. The HIPAA Authorization language will be deleted for guaranteed issue products.

8. The Medical Authorization paragraph is not variable but would not be included on an offer where we do not intend to request medical information or MIB's.

9. The number in the lower right corner will vary according to the product offered.

10. General – Type sizes may be increased to fill available space, but will NOT be decreased. Section dividers may be colored instead of black, and may be reformatted. Some text may be in color instead of black. The form may be printed on paper other than white, but will NOT be printed with any ink/paper combination that would obscure any question or instruction.