

SERFF Tracking Number: ASWX-126587054 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45436
 Company Tracking Number: IHAR01145FIF02
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: Time Insurance-Base Chassis
 Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF02

Filing at a Glance

Company: Time Insurance Company

Product Name: Time Insurance-Base Chassis SERFF Tr Num: ASWX-126587054 State: Arkansas
 TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 45436
 Closed

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: IHAR01145FIF02 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Author: SPI Disposition Date: 04/20/2010
 AssurantHealthandEmployeeBenef
 Date Submitted: 04/15/2010 Disposition Status: Approved-Closed
 Implementation Date Requested: 05/13/2010 Implementation Date:

State Filing Description:

General Information

Project Name: Time Insurance-Base Chassis
 Project Number: IH AR01145FIF02
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 04/20/2010

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type:
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 04/20/2010
 Created By: SPI
 AssurantHealthandEmployeeBenef
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI AssurantHealthandEmployeeBenef
 Filing Description:

The above-referenced form is submitted for your review and approval: Enrollment Form for Medical Insurance for Individuals and Families, 29500 (Rev. 4/2010). This form will replace, in its entirety, Form 29500 (Rev. 2/2010), which was recently approved by the Department on February 17, 2010 under SERFF tracking number ASWX-126478651. The only difference between Form 29500 (Rev. 2/2010) and the current version is to correct the reference to "Medical Information Bureau" with "MIB, Inc." on the Acceptance of Offer and Attestation (page 1).

Company and Contact

SERFF Tracking Number: ASWX-126587054 *State:* Arkansas
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Filing Contact Information

Christine Fleming, Senior Contract Compliance christine.fleming@assurant.com

Analyst

501 W. Michigan St. 414-299-1306 [Phone] 1306 [Ext]
 Milwaukee, WI 53203 414-299-6168 [FAX]

Filing Company Information

Time Insurance Company	CoCode: 69477	State of Domicile: Wisconsin
501 W. Michigan St.	Group Code: 19	Company Type:
Milwaukee, WI 53203	Group Name:	State ID Number:
(800) 800-1212 ext. [Phone]	FEIN Number: 39-0658730	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	\$50.00	04/15/2010	35695462

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/20/2010	04/20/2010

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Disposition

Disposition Date: 04/20/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Application for Individual Medical Insurance	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 29500 (Rev. 4/2010)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 04/20/2010	29500 (Rev. 4/2010)	Application/ Enrollment Form	Application for Individual Medical Insurance	Initial		0.000	29500 (Rev_ 4_2010).PDF

Policy #: _____

Acceptance of Offer and Attestation

I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. My recorded Personal Health History, the enrollment form and any amendments shall be the basis for the offer of coverage. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. I shall sign the enrollment form and obtain the signatures of my Spouse [Domestic Partner] [Civil Union] and any covered dependents over the age of 18, and return it to Time Insurance Company within 30 days of the contract issue. If acceptance is not received within 30 days, Time Insurance Company reserves the right to revoke any and all such offers. The first full premium must be paid. The contract may only be effective prior to the contract delivery and acceptance, if all the terms of the Conditional Receipt have been fulfilled.

I agree that a photocopy of this authorization shall be valid for two years from the date signed. I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding [MIB, Inc.,] the Privacy statement concerning my personal health information, the Abbreviated Notice of Insurance Information Practices, and the Outline of Coverage for Health Insurance, if required.

We, the undersigned proposed insured(s) and agent acknowledge that the proposed insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

Signature of Proposed Insured

Date Signed

State

Signature of Spouse or Other Insured

Signature(s) of Other Dependents 18 or Over

Guardian's Signature

[If Life Insurance is issued, complete this section.]

Beneficiary for Primary Insured:

Full Name and Relationship

Contingent Beneficiary:

Full Name and Relationship

(The Primary Insured is the Beneficiary of any spouse [/domestic partner] [/civil union] or child(ren) life insurance.)

Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____
 Agent Number: _____ E-mail Address: _____
 Key Agency Contact: _____ Agency Name: _____
 Fax Number: _____ Agency Number: _____

TYPE OF ACTIVITY (Please check appropriate box.)

NEW If not a new enrollee, check appropriate box and list affected policy number.

CHANGE/ADDITION TO AN EXISTING POLICY. POLICY # _____

Internal Replacement Conversion (over age dependent/divorce)

PERSON(S) TO BE INSURED

	Last	Name First	M.I.	Sex	Age	Birthdate MM/DD/YY	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S)	Last	Name First	M.I.	Sex	Age	Birthdate MM/DD/YY	Full-Time Student?	Height	Weight	Social Security Number

4a. Resident Address: _____
(Street) (City) (State) (ZIP)

4b. E-mail Address: _____

[5.] [Does any proposed insured live outside the above household? Yes No
 If "Yes," explain. _____]

[6.] [Phone Number: (_____) _____ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (_____) _____]

[7a.] **Primary Insured Occupation:** _____
 Company Name: _____ Work Number: (_____) _____
 Duties: _____
 Is the Primary Insured [self-employed] [or] [a sole proprietor]?..... Yes No
 Is the Primary Insured covered by Workers' Compensation?..... Yes No

[7b.] **Spouse[/Domestic Partner] [/Civil Union] Occupation:** _____
 Company Name: _____ Work Number: (_____) _____
 Duties: _____
 Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]?..... Yes No
 Is the Spouse[/Domestic Partner] [/Civil Union] covered by Workers' Compensation? Yes No

OTHER COVERAGE IN FORCE OR APPLIED FOR

[8.] [Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? Yes No]
 [If "Yes," complete the section below.]

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

[9.] [Were all proposed insureds covered under the prior plan listed above? Yes No]

[10.] [Have any of the proposed insureds within the last [10] years been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance? Yes No]
 If "Yes," give details. _____
 _____]

HAZARDOUS ACTIVITIES AND DRIVING

[11.] [In the last [10] years, have any of the proposed insureds participated in any motorized vehicle racing (includes drivers, pit crew, owners or mechanics) or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rock or mountain climbing or rodeo participation? Yes No]

[12.] [In the last [10] years, have any of the proposed insureds been cited for operating a motor vehicle under the influence of alcohol or drugs? Yes No]

BILLING

Monthly Check-O-Matic] Quarterly] Semi-Annual] Annual] List Bill (monthly only)]

[Credit Card:] First Payment Only*] Monthly] Quarterly] Semi-Annual] Annual]

[*With this option, you must select a secondary billing mode other than list bill for subsequent payments. Please make selection above and provide all necessary information.]

If billing address is different than resident address, please complete:

Payor Name _____ Address _____ City _____ State _____ ZIP _____

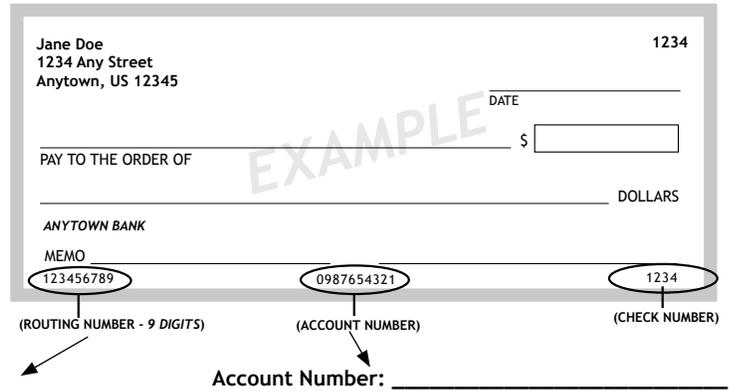
AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY - Choose the following option that applies:

To begin Check-O-Matic withdrawals:

Select a desired withdrawal day (1-28): _____
 Bank Name: _____
 City: _____ State: _____

To add this policy to an existing Check-O-Matic:

Existing COM Number: _____
 Associated Policy Number: _____



Routing Number: _____

Account Number: _____

Check-O-Matic (Complete authorization below)

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor _____

Date Signed _____

[AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

VISA Card Number: _____

MasterCard Number: _____

Exp. Date: ____ / ____ [Security Code Number (3 digits on back of credit card): ____]

Name as it appears on card: _____

Signature of Payor: _____ Date: _____

HEALTH STATEMENT

For Questions [13]-[25,] WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:

[Note: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be disclosed.]

- [13.] [Had surgery [in a hospital or outpatient facility]? Yes No]
- [14.] [Had medical treatment in a hospital or outpatient facility? Yes No]
- [15.] [Had any urgent care or emergency room visits? Yes No]
- [16.] [Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider? [Do NOT include annual physical exams]. Yes No]
- [17.] [Had any testing [with abnormal findings] or tests for which you have not received results? Yes No]
- [18.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed? Yes No]
- [19.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? Yes No]
- [20.] [Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use? Yes No]

Additional Questions

- [21.] [Has any proposed insured taken or been advised to take any prescription medication in the last [[10] years] [[12] months]? Yes No]
- [22.] [Has any proposed adult [ever] used tobacco products in any form or nicotine substitutes within the last [10] years? Yes No]
- [23.] [Has any proposed insured had a diagnosis, treatment or follow-up for cancer in the last [10] years? Yes No]
- [24.] [Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? Yes No]
- [25.] [Have you fully disclosed all medical conditions for you and your family within the last [10] years? ... Yes No]

ADDITIONAL NOTICES

[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the [MIB, Inc.], [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB,] upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of the information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

ADDITIONAL NOTES

Empty space for additional notes.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR - READABILITY CERTIFICATION.PDF	Approved-Closed	04/20/2010

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: The application is the form being submitted. Please see forms schedule. Comments:	Approved-Closed	04/20/2010

	Item Status:	Status Date:
Satisfied - Item: Cover Letter Comments: Attachment: Cover Letter.PDF	Approved-Closed	04/20/2010

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: Statement of Variability.PDF	Approved-Closed	04/20/2010

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
29500 (Rev. 4/2010)	52.3

Signed: 
Name: Julia Hix-Royer
Title: VP Regulatory Compliance & AH
Compliance Officer
Date: April 15, 2010



ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

April 15, 2010

www.assurant.com

Arkansas Department of Insurance
1200 W. Third Street
Arkansas Department of Insurance

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Tele-App Part 2 Enrollment Form for Medical Insurance for Individuals and
Families: 29500 (Rev. 4/2010)

Dear Sir or Madam:

The above-referenced form is submitted for your review and approval: Enrollment Form for Medical Insurance for Individuals and Families, 29500 (Rev. 4/2010). This form will replace, in its entirety, Form 29500 (Rev. 2/2010), which was recently approved by the Department on February 17, 2010 under SERFF tracking number ASWX-126478651. The only difference between Form 29500 (Rev. 2/2010) and the current version is to correct the reference to "Medical Information Bureau" with "MIB, Inc." on the Acceptance of Offer and Attestation (page 1).

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Upon approval, the amended forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

Best Regards,

A handwritten signature in black ink that reads "Christine R. Fleming". The signature is written in a cursive style with a large, stylized initial 'C'.

Christine R. Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168



ASSURANT
Health

501 West Michigan
P.O. Box 3050
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www.assurant.com

STATEMENT OF VARIABILITY

- A number of benefit options and/or items which customarily vary according to the Policyholder's specific plan of insurance, which will allow us to deliver a customized contract to our customers reflecting all benefit options selected, helping to alleviate any ambiguity on the part of the customers as to what is covered and how it is covered.
 - Flexibility in utilizing provisions when filing diverse products.
 - Future flexibility to adjust to changing regulatory and market needs.
1. All bracketed numbers (excluding form numbers) are variable, subject to the confines of state and federal law. Bracketed benefit amounts, illustrated as a range, list of amounts or otherwise, are variable and can fluctuate to provide a richer benefit to the insured than what is represented in the approved document.
 2. All bracketed text varies to the extent that such language may be:
 - a. included as shown;
 - b. omitted in its entirety;
 - c. rearranged; or
 - d. transferred to another provision, section or page.
 3. All bracketed numbers and/or text will be varied only:
 - a. within any statutory or regulatory requirements; and
 - b. under the condition that the numerical value(s) and benefit language is within the intent and framework of the actual approved provision.

We also reserve the right to amend the form(s) to correct any minor clerical or typographical errors we may have overlooked prior to approval, and to revise any phraseology to clarify the intent within the confines of the law.

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