

SERFF Tracking Number: GRTT-126758139 State: Arkansas
 Filing Company: United National Life Insurance Company of America State Tracking Number: 46410
 Company Tracking Number: RUA10-04
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity
 Project Name/Number: /RUA10-04

Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: Hospital Indemnity SERFF Tr Num: GRTT-126758139 State: Arkansas
 TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved- Closed State Tr Num: 46410

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: RUA10-04 State Status: Approved-Closed
 Filing Type: Form/Rate Reviewer(s): Rosalind Minor
 Author: Joan Jannotta Disposition Date: 08/10/2010
 Date Submitted: 08/06/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:
 Project Number: RUA10-04
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 08/10/2010

Status of Filing in Domicile: Not Filed
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 08/10/2010
 Created By: Joan Jannotta
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Joan Jannotta
 Filing Description:
 Re: Individual Accident and Sickness
 Amendment Rider RUA10-04
 Outline of Coverage U0552-OC(CR)(LS)
 Application UAPPH2-08(LS)
 Actuarial Memorandum and Rates

NAIC #64211 687

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Dear Sir or Madam:

We are submitting the above referenced forms and premium rates for your review and approval.

Amendment Rider RUA10-04 is new and will not replace any forms currently on file with your Department. The purpose of this rider is to broaden the Outpatient Benefit in previously approved policy for U0552-AR to cover benefits in any Outpatient Facility rather than only those received in an outpatient department of a hospital. Policy form U0552-AR was approved by your Department on February 9, 2006 under state tracking number 31213.

The application is new and will be used to add our previously approved Lump Sum Cancer rider, RU07LS, to our Hospital Confinement Indemnity policy U0552-AR. Rider RU07LS was approved by your Department on October 25, 2007 under state tracking number 37214.

Outline of Coverage UG0552-OC(CR)(LS)will be used in the solicitation of this product. The Lump Sum Cancer benefit is shown as variable so that this option may be removed at a later date.

The application will be used by licensed agents appointed by our company to sell our approved products.

For your approval, we are also enclosing the actuarial memorandum and rates for Lump Sum Cancer Rider.

The 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. Any variable information is bracketed.

Your consideration and approval of this filing would be appreciated.

Sincerely,

Joan Jannotta

Product Manager

Product Approval and Compliance (PAC)

Direct Phone: 1-847-904-5730

Toll-Free: 1-800-338-7452, extension #5730

E-mail: jjannotta@gtlic.com

Fax: 847-699-0093

Company and Contact

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Filing Contact Information

Joan Jannotta, jjannotta@gtlc.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: \$200.00
 Retaliatory? Yes
 Fee Explanation: 3 forms x \$50 = \$150
 1 rates x \$50 = \$50
 Total \$200
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United National Life Insurance Company of America	\$200.00	08/06/2010	38567477

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/10/2010	08/10/2010

SERFF Tracking Number: GRTT-126758139 *State:* Arkansas
Filing Company: United National Life Insurance Company of *State Tracking Number:* 46410
America
Company Tracking Number: RUA10-04
TOI: H141 Individual Health - Hospital Indemnity *Sub-TOI:* H141.000 Health - Hospital Indemnity
Product Name: Hospital Indemnity
Project Name/Number: /RUA10-04

Disposition

Disposition Date: 08/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GRTT-126758139 State: Arkansas
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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	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Outline	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

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Form Schedule

Lead Form Number: RUA10-04

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/10/2010	RUA10-04	Policy/Cont rider/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider		Initial		42.000	RUA10-04.pdf
Approved-Closed 08/10/2010)	U0552- OC(CR)(LS	Outline of Coverage	Outline	Initial			U0552- OC(CR)(LS).pdf
Approved-Closed 08/10/2010	UAPPH2- 08(LS)	Application/ Enrollment Form	Application	Initial		49.250	UAPPH2-08 (LS).pdf

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

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

AMENDMENT RIDER

This rider is made a part of your Policy effective as of your Policy's issue date. The Policy is hereby amended as follows:

The "**Outpatient Benefit**" is deleted and replaced with the following:

"Outpatient Benefit: We will pay the Outpatient Benefit Amount shown in the Policy Schedule for any one Sickness or Injury for care and services received in any outpatient facility.

Care and services include, but are not limited to: (1) Doctor's treatment; (2) medical supplies; or (3) x-rays or laboratory tests.

We won't pay more than the Maximum Calendar Year Outpatient Benefit shown in the Policy Schedule in any one Calendar Year. "

The following definition is added.

Outpatient Facility means an institution which is: (a) operated pursuant to law; (b) licensed or approved as an outpatient facility by the responsible state agency; and (c) is primarily engaged in providing medical care and treatment for sick or injured persons on an out-patient basis.

This Rider is subject to all terms, provisions, limitations and exclusions of the Policy except when specifically changed by this rider."

Signed at Guarantee Trust Life Insurance Company in Glenview, Illinois by



President



Secretary

Licensed Resident Agent (If Required): _____

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

P. O. Box 7901, Mount Prospect, Illinois 60056
(847) 803-5252

OUTLINE OF COVERAGE for Policy Form Series U0552

Read Your Policy Carefully – This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Hospital Indemnity Coverage – This category of coverage is designed to provide coverage in the form of a fixed daily benefit during a period of hospital confinement resulting from a covered sickness or injury, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement as shown below. However, this policy provides certain additional benefits as outlined below. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

Benefits – Your policy provides a daily benefit when you are confined to a hospital for a covered sickness or injury. This daily benefit will be paid from the first day of confinement and for each day you are confined for up to 365 days of confinement during your lifetime.

Daily Hospital Benefit See Policy Schedule Page

Additional Benefits – In addition to the above Hospital Benefit, your Policy also provides the following benefits:

Adult Doctor's Office Visit Benefit, per visit, maximum 1 visit per week \$75.00

Maximum Doctor's Office Visits per Calendar Year 10

If the Optional Child Benefit Rider selected:

Child Doctor's Office Visit Benefit, per visit, maximum 1 visit per week \$[75.00]

Maximum Doctor's Office Visits per Calendar Year
for all Dependent Children 5

Outpatient Benefit Amount \$250.00

Maximum Calendar Year Outpatient Benefit \$1,000.00

Ambulance Benefit \$200.00

Exclusions and Limitations – Your policy will not cover loss resulting from pre-existing conditions during the first year that your policy is in force. A "pre-existing condition" is any sickness or injury diagnosed or for which medical advice and/or treatment was received from or recommended by a Physician within a twelve (12) month period prior to the effective date of your policy.

Your policy does not cover any sickness or injury which is the result of: (1) war or act of war whether declared or not; (2) intentionally self-inflicted injury; (3) mental illness or nervous disorders without demonstrable organic disease (loss due to Parkinson's Disease, Alzheimer's Disease or senile dementia is covered); (4) normal pregnancy and childbirth; complications of pregnancy, however, will be covered as a sickness; (5) treatment of an injury that results from your commission of, or attempt to commit a felony, or from you being engaged in an illegal activity; (6) cosmetic surgery; cosmetic surgery does not include reconstructive surgery which is incidental because of previous surgery due to trauma, infection, or other disease of the involved part; (7) confinement in a Hospital located or care received outside of the territorial limits of the United States of America, its commonwealth partners, or the countries of Canada and Mexico; or (8) you being intoxicated or under the influence of alcohol or a narcotic, unless administered on the advice of a Physician.

United National Life Insurance Company of America
Mt. Prospect, Illinois

Hospital Confinement Indemnity Policy
Outline of Coverage for Form Series U0552

OPTIONAL COVERAGE:

[Lump Sum Cancer Rider RG07LS

We will pay the Lump Sum Benefit Amount provided You have:

1. met the conditions set forth in the Eligibility for Benefits provision of this Rider, and
2. satisfied this Rider's Proof of Loss provision.

The Lump Sum Benefit Amount is shown in the Policy Schedule.

Benefits under this Rider are limited to one (1) Lump Sum payment during Your lifetime.

Lump Sum Cancer Rider Amount Selected: \$5,000 \$10,000]

Renewability – The policy is Guaranteed Renewable to Age 65. This means that you may keep your policy in force until age 65 by paying the renewal premiums as they are due or during the 31-day grace period. Once you reach age 65, the policy will terminate and your coverage will end.

We will have the right to change your renewal premium, but only if we: (a) first file and, if required, obtain the approval of the responsible state agency; (b) change the rates for all series U0552 policies in your state; and, (c) give you 31 days advance written notice.

Annual Premium for Your Policy: \$ [XXX.00] . You have paid \$ [XXX.00] with your application, which provides [12] months coverage. Your renewal premium (subject to change) will be \$ [XXX.00] every [12] months.

REMEMBER, if you are not satisfied with your policy, you have 10 days to return it to the Company and get your money back.

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE US AT (847) 803-5252.

If delivered at time of application by an agent:

Agent's Signature _____ Date of Delivery _____

Agent's Name (Printed) _____

Agent's Address and Phone No. _____

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA
P.O. BOX 1154, GLENVIEW, ILLINOIS 60025-1154
APPLICATION FOR A HOSPITAL CONFINEMENT INDEMNITY POLICY - FORM U0552

APPLICANT INFORMATION

Person(s) Applying for Coverage	Age	Date of Birth	Sex	Height	Weight	Occupation	Social Security Number
Applicant (A):							
Spouse (S):							
Child 1 (C):							
Child 2 (C):							
Child 3 (C):							
Child 4 (C):							

Address: _____ Phone: _____
 Email: _____

BENEFITS BEING APPLIED FOR

Hospital Benefit To 365 Days	Lump Sum Cancer	Child Rider	Doctor's Per Visit Benefit	Outpatient Benefit (Per Visit)	Ambulance Benefit
<input type="checkbox"/> \$1,000 Daily, <input type="checkbox"/> \$500 Daily or <input type="checkbox"/> \$100 Daily	Applicant <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 Spouse <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$75.00	\$250.00	\$200.00

QUALIFYING MEDICAL QUESTIONS

1. Within the past 12 months has any person to be insured been confined to a hospital, nursing home or other medical facility or been disabled or been advised to have surgery but have not yet done so? Yes No
 If yes, indicate which person, condition, diagnosis, dates and types of treatment: _____
 2. In the past 24 months has any person to be insured been diagnosed or treated by a medical professional for a heart condition, stroke, internal cancer or malignant melanoma, chronic obstructive lung disease, insulin dependent diabetes chronic liver or chronic kidney disease or drug or alcohol use? Yes No
 If yes, indicate which person, condition, diagnosis, dates and types of treatment: _____
 3. Has any person to be insured been medically diagnosed or receiving or been advised by a doctor to seek treatment for being HIV-positive or having AIDS or AIDS-Related Complex? Yes No
 If yes, indicate which person, condition, diagnosis, dates and types of treatment: _____
- If applying for Lump Sum Cancer coverage, please answer the following questions. If the answer is "YES" that person is not eligible for the cancer benefit.
4. In the past 10 years has any person to be insured had, ever diagnosed as having, received medication for or been treated by a medical practitioner for:
 - a. Cancer, carcinoma, malignant tumor, Leukemia, Lymphoma, Hodgkin's disease, malignant melanoma or sarcoma? Yes No
 - b. Within the past 24 months, has any person to be insured been advised to seek treatment or medical advice from a practitioner but have not done so or experienced any symptoms that would have caused a person to seek medical advice from a medical practitioner for any medical condition in question #2? Yes No
 If Yes, indicate which person, condition, diagnosis, dates and kinds of treatment _____

OTHER HEALTH COVERAGE

5. Please list all existing or pending coverage and indicate who is covered and if this coverage is to be replaced by this certificate. (Attach additional signed & dated sheet if more room needed.)
- | Who Covered? | Replacing? | Company Name | Type of Coverage |
|--|--|--------------|------------------|
| <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> C | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> C | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |

PREMIUM

Insurance Coverage \$ _____	Please make check/money order payable to: <i>United National Life Insurance Company</i>
Administrative Fee \$ _____	
TOTAL PAYMENT DUE \$ _____	

Payment Mode: Annual Semi-Annual Monthly Billing Method: Bank Draft Direct Bill List Bill

APPLICANT'S STATEMENTS

I HEREBY APPLY for an insurance policy as indicated on this Application. I have read or had read to me the completed application. To the best of my knowledge and belief, the answers to the above questions are true and complete.

I UNDERSTAND AND AGREE that: (1) this coverage will be issued based solely and entirely upon my answers to the above questions; (2) no coverage will exist until a Policy is issued, and will be in force only as of the Policy effective date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my Policy; (4) any loss for a pre-existing condition will not be covered for the first 12 months my coverage is in force.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Dated at _____ this _____ day of _____, 20_____

Signature of Applicant: _____

I certify that I have accurately recorded the information supplied by the Applicant. I further certify that I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it.

Witness – Agent's Signature: _____

Agent's Name: _____ Agent's Number(s): _____

E-mail address: _____

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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 Closed 08/10/2010		RU07LS	New		UNL Malin_LumpSum CancerRates_UN L.pdf

United National Life Insurance Company

Lump Sum Cancer Rider

Individual Rates per \$1,000 Benefit

Rider Form: RU07LS

Issue Age	Annual Rate
18-39	\$6.80
40-49	\$11.20
50-55	\$15.96
56-64	\$21.70

Modal Factors	
Annual	1.000
Semi	0.509
Quarterly	0.259
Mo. PAC	0.089

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/10/2010
Comments:			
Attachment:			
Readcert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	08/10/2010
Comments:			
See forms schedule			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	08/10/2010
Comments:			
Please see the forms schedule.			

