

SERFF Tracking Number: HARL-126755161 State: Arkansas
Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 46511
Company Tracking Number: HL-19278(09)REV
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Disability Income Application Supplements
Project Name/Number: Revised Disability Income Application Supplements/HL-19278(09)Rev

Filing at a Glance

Company: Hartford Life and Annuity Insurance Company

Product Name: Disability Income Application SERFF Tr Num: HARL-126755161 State: Arkansas

Supplements

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 46511

Sub-TOI: L08.000 Life - Other

Co Tr Num: HL-19278(09)REV State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Jane Chapman, Roberta
Chu, Barbara Warren, Frank

Disposition Date: 08/18/2010

Durante

Date Submitted: 08/16/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Revised Disability Income Application Supplements

Status of Filing in Domicile: Authorized

Project Number: HL-19278(09)Rev

Date Approved in Domicile: 08/04/2010

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: 08/18/2010

Explanation for Other Group Market Type:

State Status Changed: 08/18/2010

Deemer Date:

Created By: Roberta Chu

Submitted By: Roberta Chu

Corresponding Filing Tracking Number:

Filing Description:

We are submitting the subject forms for your review and approval. These are new forms and are intended to replace two Disability Income Application Supplements, form numbers HL-19278(09) and LA-1254(04), which were approved by your Department in 2009 and 2004, respectively.

The new forms, HL-19278(09)Rev and LA-1254(04)Rev, are identical to the previously approved forms except for the addition of the question asking if the proposed insured has previously or is currently receiving disability income or

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workman's compensation benefits.

We have also attached for informational purposes the Fraud Notice which contains the required fraud statement and will always be used in conjunction with and made a part of the application.

Your prompt review of this submission would be greatly appreciated. Please feel free to contact me if you have any questions.

Best regards,

Roberta M. Chu, AIRC
Sr Compliance Specialist, ILD Compliance
Phone: (800) 503-3150 or direct (860) 843-4317
Fax: (860) 843-5194
E-Mail: roberta.chu@hartfordlife.com

Company and Contact

Filing Contact Information

Roberta Chu, Contract Analyst roberta.chu@hartfordlife.com
200 HopmeadowRd 860-843-4317 [Phone]
Simsbury, CT 06089 860-843-5194 [FAX]

Filing Company Information

Hartford Life and Annuity Insurance Company CoCode: 71153 State of Domicile: Connecticut
200 Hopmeadow Street Group Code: 91 Company Type: Life
Simsbury, CT 06089 Group Name: State ID Number:
(860) 547-5000 ext. [Phone] FEIN Number: 39-1052598

Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life and Annuity Insurance Company	\$50.00	08/16/2010	38798831
Hartford Life and Annuity Insurance Company	\$50.00	08/18/2010	38852408

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/18/2010	08/18/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	08/18/2010	08/18/2010	Roberta Chu	08/18/2010	08/18/2010

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Disposition

Disposition Date: 08/18/2010

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		No
Supporting Document	Application		No
Supporting Document	FYI - Fraud Notice		No
Form	Disability Income Application Supplement		No
Form	Disability Income Application Supplement		No

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/18/2010
Submitted Date 08/18/2010
Respond By Date 09/20/2010

Dear Roberta Chu,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$50.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/18/2010
Submitted Date 08/18/2010

Dear Linda Bird,

Comments:

Thank you for your consideration and request.

Response 1

Comments: The additional \$50.00 has been input in the Fee Schedule.

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$50.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for you continued consideration.

Sincerely,

Barbara Warren, Frank Durante, Jane Chapman, Roberta Chu

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Form Schedule

Lead Form Number: HL-19278(09)Rev

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	HL-19278(09)Rev	Application/Disability Income Enrollment Form	Application Supplement	Initial		51.200	HL-19278(09)Rev Disability Access Rider Application Supplement.pdf
	LA-1254(04)Rev	Application/Disability Income Enrollment Form	Application Supplement	Initial		53.800	LA-1254(04)Rev Disability Application Supplement.pdf



Disability Access Rider Application Supplement

Name of Proposed Insured					
1. IN FORCE COVERAGE					
a. Do you have monthly disability income benefits in force through individual insurance, group or union coverage, retirement plans, government provided, or other benefits?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				If "Yes", provide details in 1(b)	
b. Type	Benefit Amount	Benefit Period	Type	Benefit Amount	Benefit Period
<input type="checkbox"/> Individual			<input type="checkbox"/> Retirement		
<input type="checkbox"/> Group			<input type="checkbox"/> Other		
2. GROUP DI COVERAGE CONTACT INFORMATION (Human Resource or Benefits Department)					
a. Contact Name			b. Phone Number ()		
3. GENERAL					
a. Are you currently receiving or have you ever received disability or workman's compensation benefits? If yes, please provide dates and details.					
b. Annual Earned Income \$ _____ List the proposed insured's annual earned income before taxes from wages or salary. If self-employed, list net annual earned income (after business expenses are deducted)			c. Annual Unearned Income \$ _____ Examples include: interest income, dividends, net rentals, pension benefits, alimony, royalties, etc.		
d. Number of hours worked per week _____			e. Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" complete Section 4		
4. COMPLETE IF SELF-EMPLOYED					
a. Type of Business <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> C-Corporation <input type="checkbox"/> S-Corporation <input type="checkbox"/> Limited Liability Corporation (LLC)			b. Name of the business and type of service provided		
c. Number of Employees			d. Range of duties you perform (administration, manual, etc.)		
e. Time self-employed in this business ___ yrs. ___ mos. (if less than 2 years, list occupation prior to self-employment)			f. Is your business located within your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", list percentage of time working outside of your home _____%		
5. DECLARATIONS AND SIGNATURES					
I declare, understand and agree that:					
1. All statements and answers contained in this Application Supplement are complete and true to the best of my knowledge and belief.					
2. I understand and agree that this Application Supplement becomes part of the Application for life insurance.					
_____			_____		
Signature of Proposed Insured			Signature of Licensed Producer		
Date _____					



DISABILITY INCOME RIDER — APPLICATION SUPPLEMENT

Name of Proposed Insured 1

Name of Proposed Insured 2

1. IN FORCE COVERAGE

a. Does any Proposed Insured listed above have monthly disability income benefits in force through individual private insurance, group or union coverage, retirement plans, or any other benefits that are payable? Proposed Insured 1 Yes No
Proposed Insured 2 Yes No
If "Yes", provide details in 1.b.

b. Proposed Insured 1			Proposed Insured 2		
Type (Check all that apply)	Benefit Amount	Benefit Period	Type (Check all that apply)	Benefit Amount	Benefit Period
<input type="checkbox"/> Individual/Private			<input type="checkbox"/> Individual/Private		
<input type="checkbox"/> Group/Union Coverage			<input type="checkbox"/> Group/Union Coverage		
<input type="checkbox"/> Retirement Plans			<input type="checkbox"/> Retirement Plans		
<input type="checkbox"/> Other			<input type="checkbox"/> Other		

c. Is any proposed insured covered by a State Teacher's System (STRS) or Public Employees Retirement System (PERS)?	Proposed Insured 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	Which System?
	Proposed Insured 2 <input type="checkbox"/> Yes <input type="checkbox"/> No	Which System?

2. GENERAL

a. Are you currently receiving or have you ever received disability or workman's compensation benefits? If yes, please provide dates and details.

b. Proposed Insured 1 Monthly Earned Income *	c. # of hours worked per week	d. Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the self-employment questionnaire.	e. Mortgage Payment **
f. Proposed Insured 2 Monthly Earned Income *	g. # of hours worked per week	h. Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the self-employment questionnaire.	i. Mortgage Payment **

3. CONTACT INFORMATION—Provide a contact in your Human Resource or Benefits Department

Contact Name for Proposed Insured 1	Phone Number ()
Contact Name for Proposed Insured 2	Phone Number ()

4. DECLARATIONS AND SIGNATURES

Each of the undersigned Proposed Insured(s) declare, understand and agree that:

1. All statements and answers contained in this Application Supplement are complete and true to the best of our knowledge and belief.
2. I/We understand and agree that this Application Supplement becomes part of the Application for life insurance.
3. I/We understand, no benefits are payable during the waiting period.

1. _____
Signature of Proposed Insured 1
(Parent or Guardian if under 15 years of age)

2. _____
Signature of Proposed Insured 2
(Parent or Guardian if under 15 years of age)

Date _____

➔ _____
Signature of Witness (Licensed Agent)

* List the proposed insured's monthly income, before taxes, from wages or salary. If self-employed, list monthly income after expenses are deducted.
** Monthly payment including principal, interest, taxes, and insurance.

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Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR Certification - Rule 19.pdf

Readability Certification.pdf

Item Status:

Status

Date:

Satisfied - Item: FYI - Fraud Notice

Comments:

Attachment:

HL-15883(10) FRAUD STATEMENT NOTICE.pdf

**ARKANSAS
POLICY FORM CERTIFICATION**

HARTFORD LIFE AND ANNUITY INSURANCE COMPANY

Form Number(s): HL-19278(09)Rev, LA-1254(04)Rev

Form Title(s): Disability Income Application Supplements

By my signature below, I hereby certify that I have reviewed the enclosed policy form(s) and certify that the form(s) submitted meets the provisions of Rule 19 entitled "Unfair Discrimination in Sale of Insurance" as well as all applicable requirements of the Arkansas Insurance Department.

Signed:



Date

Lenore Paoli, AVP, Business Practices and Compliance

August 16, 2010

Readability Certificate

I hereby certify that the forms referenced below have each been scored in their entirety using the Flesch Ease of Reading Test and have attained the score indicated. I further certify that, to the best of my knowledge and belief, said forms comply with state readability requirements and are printed in not less than ten point type, one point leaded.

The readability score was calculated by computer. The software used for this calculation was Microsoft Word.

<u>Form Number</u>	<u>Flesch Score</u>
HL-19278(09)Rev	51.2
LA-1254(04)Rev	53.8

Hartford Life and Annuity Insurance Company
NAIC Number 71153-091



Signature of Insurance Company Officer

Lenore Paoli, AVP, ILD Business Practices and Compliance
Typed Name and Title

FRAUD STATEMENT NOTICE

THE LAWS OF THE FOLLOWING STATES REQUIRE THAT WE PROVIDE THIS FRAUD STATEMENT NOTICE TO YOU WITH YOUR APPLICATION:

ARKANSAS, LOUISIANA, RHODE ISLAND:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO:

It is unlawful to knowingly provide false, incomplete, or mis-leading 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 de-fraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KENTUCKY:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MARYLAND:

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA:

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 subjects such person to criminal and civil penalties.

TENNESSEE, VIRGINIA:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.