

SERFF Tracking Number: LWEL-126724238 State: Arkansas
Filing Company: Central United Life Insurance Company State Tracking Number: 46294
Company Tracking Number: AP-COMBO-0510
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: CUL Combo Application
Project Name/Number: cAP-COMBO-0510-AR/AP-COMBO-0510-AR

Filing at a Glance

Company: Central United Life Insurance Company

Product Name: CUL Combo Application

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: LWEL-126724238 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 46294

Co Tr Num: AP-COMBO-0510

Author: Rebecca Ewing

Date Submitted: 07/22/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 08/06/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: cAP-COMBO-0510-AR

Project Number: AP-COMBO-0510-AR

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/06/2010

Deemer Date:

Submitted By: Rebecca Ewing

PPACA: Not PPACA-Related

Filing Description:

Re: Central United Life Insurance Company

Form Number: AP-COMBO-0510-AR

Combo Application

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: AR is the Domicile
state

Market Type:

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/06/2010

Created By: Rebecca Ewing

Corresponding Filing Tracking Number:

Dear Sir/Madam:

On behalf of Central United Life Insurance Company, we are submitting this combination application for filing

SERFF Tracking Number: LWEL-126724238 State: Arkansas
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acknowledgment or prior approval, as appropriate. The implementation date will be upon approval by your department.

This application will be used with applicable policy forms previously approved by your department.

We have also included the following filing materials:

- *Filing Authorization Letter
- *Readability Certification

If you have further questions regarding this matter, you may contact me by e-mail at ddillion@lewisellis.com or by telephone (972) 850-0850 collect.

Company and Contact

Filing Contact Information

Brian Stentz, Actuary bstentz@lewisellis.com
 2929 N. Central Expy. 972-850-0838 [Phone]
 Richardson, TX 75080 972-850-0868 [FAX]

Filing Company Information

(This filing was made by a third party - lewisandellisincorporated)

Central United Life Insurance Company	CoCode: 61883	State of Domicile: Arkansas
2727 Allen Parkway Wortham Tower, Suite 500	Group Code:	Company Type: L&H
Houston, TX 77019	Group Name:	State ID Number:
(713) 529-0045 ext. [Phone]	FEIN Number: 42-0884060	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Central United Life Insurance Company	\$50.00	07/22/2010	38218702

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/06/2010	08/06/2010

SERFF Tracking Number: *LWEL-126724238* *State:* *Arkansas*
Filing Company: *Central United Life Insurance Company* *State Tracking Number:* *46294*
Company Tracking Number: *AP-COMBO-0510*
TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *CUL Combo Application*
Project Name/Number: *cAP-COMBO-0510-AR/AP-COMBO-0510-AR*

Disposition

Disposition Date: 08/06/2010

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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form	Combo Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AP-COMBO-0510

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 08/06/2010	AP- COMBO- 0510-AR	Application/ Combo Enrollment Form	Application/ Combo Application Enrollment Form	Initial		55.300	COMBO application FINAL-AR.pdf

New Application

Other

Group No.

CENTRAL UNITED LIFE INSURANCE COMPANY

[10700 Northwest Freeway, Houston, Texas 77092]

COMBINED APPLICATION

Name of Applicant _____ Date of Birth _____ Sex _____
 (last) (first) (m.i.)
 Address of Applicant _____ Phone #: () _____
 City _____ State _____ Zip _____ Soc. Sec. # _____ Area Code _____
 Ht. _____ Wt. _____

Name of Dependent	Ht.	Wt.	Sex	DOB	Name of Dependent	Ht.	Wt.	Sex	DOB
1.					2.				
3.					4.				
5.					6.				

Primary Employer of Applicant _____ Type of Business _____
 Occupation of Applicant _____ Describe Duties _____
 Beneficiary Insured/Relation _____ Beneficiary Spouse/Relation _____

MODE OF PAYMENT List Bill EFT Direct
 Monthly Qtr Semi-Annual 9 Pay 10 Pay 12 Pay
 13 Pay 26 Pay Other _____

CRITICAL ILLNESS/CPR – Answer Health Questions A and I
 Without Cancer With Cancer **Premium** \$ _____
 Employee One Parent Two Parent
 Plan: 5,000 7,500 10,000 _____

BASIC CARE PLUS/MEDCHOICE POLICY–Answer Health Questions A and B
 Plan _____
 Employee Employee/Spouse
 Employee/Children Family **Premiums** \$ _____
OPTIONAL COVERAGE
 Basic Care Dental Rider _____
 Basic Care Surgery Rider - _____
Answer Health Question E
 Basic Care DI Rider – _____
Answer Health Questions A, B and G
 MedChoice RX Rider _____
 MedChoice Outpatient Sickness Rider _____

TOTAL _____

GROUP DISABILITY INCOME POLICY – Answer Health Questions A and H
 Plan _____
 Monthly Benefit _____
 Occupation Classification _____ **Premium:** \$ _____
 Survivor Benefit Rider
 Elimination Period 0/7 7/7 14/14 30/30
 Benefit Period 3 mo. 6 mo. 12 mo. 24 mo.

HEART AND STROKE POLICY – Answer Health Questions A and F
 Individual One Parent Family Two Parent Family
Plan Selected: Plan A Plan B
 Optional: ICU Rider \$300 \$600
 Heart and Stroke Confinement Rider
 Critical Illness Rider \$ _____ **Premium:** \$ _____

This policy does not provide benefits for Loss or Losses due to Pre-Existing Conditions, as defined in the policy, unless waived by the Company by policy endorsement.

CANCER/INTENSIVE CARE/FOB POLICY–Answer Health Questions A, B, C and D
 Cancer Plan _____
 Individual One Parent Two Parent
 IC Policy Individual One Parent Two Parent
 FOB Policy Individual One Parent Two Parent
 Benefit Amount \$ _____ **Premiums** \$ _____
Rider Benefits

24 HR ACCIDENT EXPENSE POLICY – Answer Health Questions A and G **Monthly Premium** \$ _____
Riders Also Answer Health Question H
 Benefit Amount: .5 Unit 1.0 Unit 1.5 Units 2.0 Units
 Plan Type: Individual Individual & Spouse
 Single Parent Family Child(ren) Only
Optional Rider: Accident Disability Yes No Duration:
 Income Benefit 12 months 24 months
 Occupation Type 1 Type 2
 Benefit Amount .5 Unit 1.0 Unit 1.5 Units 2.0 Units

OPTIONAL COVERAGE:
 Critical Care Rider _____
 Intensive Care Rider/Policy \$ _____

TOTAL _____

ACCIDENT POLICY – Answer Health Questions A and G *Rider Also Answer Health Question H*
 Plan I Plan II
 Individual One Parent Family Two Parent Family
Riders (For Individual Only) AC90DI AC180DI
 ACS90DI ACS180DI # of Units _____
Sickness Elim. Pd. 7 14 30 **Premium** \$ _____

BENEFIT BRIDGE HOSPITAL INDEMNITY POLICY – Answer Health Questions A and E
 Individual One Parent Family Two Parent Family
 Benefit Amount \$ _____ **Premiums** \$ _____
Riders:
 Hospital Admission Amount \$ _____
 Outpatient Sickness \$50
 Emergency Accident \$100 \$250

ACCIDENTAL DEATH BENEFIT POLICY – Answer Health Questions A and G
 Benefits Applied For: 60 Month 120 Month
 Waiver of Premium Yes No Birthplace _____
 INSURED – Monthly Benefit: \$ _____ **Premium:** \$ _____
 Spouse Monthly Benefit: \$ _____

DENTAL COVERAGE
 Insured(s) _____
 Plan _____ High Low
Premium: \$ _____

VISION COVERAGE
 Individual Family
Premium: \$ _____

A. FOR ALL COVERAGES		Yes	No
1.	Have you or anyone proposed for the coverage been diagnosed or been treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), "AIDS" related complex (ARC) or "AIDS" related conditions, or tested positive for Human Immunodeficiency virus (HIV) or its antibodies?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do all members to be insured reside in the home of the applicant?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are all applicants citizens of the U.S.? If "no" give details.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has any applicant been declined for insurance due to health reasons?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you or your spouse now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Date of employment with your current employer? _____ Number of hours worked per week _____		
7.	Is this insurance intended to replace any other insurance in force?	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, give Name of Company _____		
	Policy Number: _____		
	Type of Coverage: _____		
B. FOR BASIC CARE/MEDCHOICE		Yes	No
1.	Are you or any members of your family applying for coverage under this insurance policy currently enrolled in Medicaid and/or under 65 and enrolled in Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has any applicant ever had or been told that he or she had:		
a)	any disorder of the lungs, circulatory system, brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
b)	any chronic disorder of the gastrointestinal system?	<input type="checkbox"/>	<input type="checkbox"/>
c)	internal cancer, melanoma or leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
d)	diabetes uncontrolled by diet (requiring medication or insulin)?	<input type="checkbox"/>	<input type="checkbox"/>
e)	uncontrolled high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
C. FOR CANCER/FOB		Yes	No
1.	To the best of your knowledge and belief, no person to be covered under the terms of this policy has now or has ever had cancer in any form including carcinoma in situ, except _____ (if none, so state), who is to be excluded. Any disease or illness listed will require further underwriting review by the home office.	<input type="checkbox"/>	<input type="checkbox"/>
2.	To the best of your knowledge, information and belief, within the last 6 months has any person to be insured: (1) undergone a biopsy; (2) had an elevated PSA (Prostate Specific Antigen) or (3) been diagnosed as having cancer or received treatment including those during course of routine check ups where the results were other than normal or still pending for cancer? If yes, please list the name. _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	Specified Disease: I hereby apply for the type of Specified Disease coverage checked and represent that to the best of my knowledge, information and belief, no person to be insured under this policy is now or has ever been diagnosed or treated as a victim of addison's disease, amyotrophic lateral sclerosis, diphtheria, encephalitis, epilepsy, legionnaire's disease, lupus erythematosus, meningitis, multiple sclerosis, muscular dystrophy, myasthenia gravis, niemann-pick disease, osteomyelitis, poliomyelitis, rey's syndrome, rheumatic fever, rocky mountain spotted fever, sickle cell anemia, tay-sachs disease, tetanus, toxic epidermal necrolysis, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, whipple's disease, except _____ (if none, so state), who is to be excluded from coverage for that disease.		
4.	I represent that no person to be covered under the terms of the policy has applied or is covered by any Medicaid or similar program except _____ (if none, so state), who is to be excluded from coverage.		
D. FOR INTENSIVE CARE		Yes	No
1.	Have you or anyone proposed for coverage been diagnosed, treated, hospital confined or received medical advice from a physician for a heart attack, heart disease, a heart condition or any heart abnormality other than high blood pressure that has been under control for the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
E. FOR BENEFIT BRIDGE HOSPITAL INDEMNITY		Yes	No
1.	In the past five years, have you or any person proposed for insurance had surgery or had surgery advised but not performed? Surgery includes a cardiac catheterization or angioplasty.	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you or any person for insurance been diagnosed as having or been told by a doctor that they have any of the following conditions: diabetes, high blood pressure unless it has been successfully controlled for more than 12 months, heart attack within 5 years, coronary bypass within 5 years, mental or nervous disorder or disease or disorder of the central nervous system, paralysis, internal cancer within 5 years, leukemia, cataract uncorrected, hernia uncorrected, alcoholism & substance abuse, hemophilia, cirrhosis of liver, hepatitis (other than virus A), hodgkin's disease, addison's disease, multiple sclerosis, cerebral palsy, ulcerative colitis, grand mal epilepsy, functionally limiting musculoskeletal disease or lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
F. FOR HEART AND STROKE		Yes	No
1.	Within the past 10 years, has anyone proposed for coverage been diagnosed, treated, received medical advice or taken prescribed medication for stroke, or any disease, disorder or abnormality of the brain, heart or circulatory system (arteries, veins, lymph nodes and vessels)?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Within the past 12 months, has anyone proposed for coverage been diagnosed, treated, received medical advice or taken prescribed medication for high blood pressure or used insulin for diabetes? If yes, provide date of last checkup, blood pressure reading and date of diagnosis.	<input type="checkbox"/>	<input type="checkbox"/>
3.	I represent that no person to be covered under the terms of the policy has applied or is covered by any Medicaid or similar program except _____ (if none, so state), who is to be excluded from coverage.		
G. FOR ACCIDENT/ACCIDENTAL DEATH BENEFIT		Yes	No
1.	Has anyone proposed for coverage had a driver's license suspended or revoked within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has anyone proposed for coverage had a DWI or DUI within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has anyone proposed for coverage a member/participant in a semi-professional or professional sport?	<input type="checkbox"/>	<input type="checkbox"/>

G. FOR ACCIDENT/ACCIDENTAL DEATH BENEFIT (Continued)		Yes	No
4.	Is anyone proposed for coverage currently under treatment or has any person proposed for coverage been under treatment for drug or alcohol abuse in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are all persons proposed for coverage ages 19 to 25 years old enrolled as a full time student in an accredited school or college?	<input type="checkbox"/>	<input type="checkbox"/>
6.	If applying for Non Payroll Coverage: Is anyone proposed for coverage blind, bedridden, confined to a wheelchair, unable to walk without a cane or crutch; or in the past five years, has anyone proposed for coverage had an epileptic seizure, stroke, parkinson's disease or alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>
7.	DI Rider Only: Have you been diagnosed by or received treatment from a member of the medical profession for cancer, heart or vascular disease, chronic obstructive pulmonary disease, renal disease, rheumatoid arthritis, liver disease, sickle cell anemia, asthma requiring steroid therapy, ulcerative colitis, insulin dependent diabetes, parkinson's disease, seizures, mental and/or nervous disorder, musculoskeletal, knee or back disorder?	<input type="checkbox"/>	<input type="checkbox"/>
H. DISABILITY INCOME		Yes	No
1.	Have you ever had any of the following: heart attack, heart bypass, coronary artery disease, stroke, cancer (other than basal cell skin cancer), treatment for back disorders, insulin dependent diabetes, or diagnosed any disease or disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
2.	In the last year, have you been hospitalized for any reason or been recommended to seek: medical advice, treatment, care and/or counseling that has not yet been performed?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Average Monthly Income:		
I. CRITICAL ILLNESS CPR POLICY		Yes	No
1.	Is there any reason you or your spouse are not physically capable of full-time employment?	<input type="checkbox"/>	<input type="checkbox"/>
2.	During the past 10 years, has any person to be insured received medical care for or had:		
	a) any intestinal or urinary tract bleeding, rheumatic fever, heart disease, heart surgery, chest pain, heart attack, stroke, pacemaker implanted, blood vessel surgery or high blood pressure? If "Yes" to high blood pressure, give most current blood pressure reading, date and treatment/medication.	<input type="checkbox"/>	<input type="checkbox"/>
	b) emphysema, chronic bronchitis, tuberculosis, asthma requiring steroid treatment or lung disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	c) liver disease, hepatitis, diabetes, multiple sclerosis or systemic disease such as lupus?	<input type="checkbox"/>	<input type="checkbox"/>
	d) mental illness requiring medication or hospitalization, suicide attempted, more than two fainting episodes, medical treatment for alcoholism or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
	e) kidney failure, internal cancer, malignant melanoma, leukemia, lymphoma or any malignancy prior to this date?	<input type="checkbox"/>	<input type="checkbox"/>
	f) hospitalization, or been advised to have any diagnostic tests or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
	g) any abnormal blood study results, including high cholesterol, triglycerides or liver enzymes?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has any person to be insured ever been declined due to health reasons?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is any person applying for coverage currently taking prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has any parent of any person to be insured at age 50 or less died of colorectal, breast or other internal cancers, diabetes, polycystic kidney disease, heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of Central United's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance.

I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued.

AUTHORIZATION. I hereby AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, its reinsurers or its legal representative, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

WARNING: 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 may be committing a fraudulent insurance act, which is a crime.

Dated at _____ this _____ day of _____, 20 _____

(Signature of Proposed Insured)
AP-COMBO-0510-AR

(Signature of Applicant, if other than Proposed Insured)

Agent's Statement (Individual Policies Only)

Yes No

To the best of your knowledge, will the insurance applied for replace any existing insurance contract or policy in any company(s)?

If a replacement(s), and if state regulations require it, have you:

a. Given "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance"?

b. Completed replacements forms, if required in your state?

c. Have you complied with state regulations on disclosure?

Agent's Certification (All Policies)

All information recorded by me on this application is true and accurate to the best of my knowledge.

Agent No. _____ Soliciting Agent Signature _____ Date _____
Printed Agent Name _____ Agent Phone No. _____
Agent # / % _____ Agent # / % _____
REMARKS OR SPECIAL REQUESTS: _____

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO CENTRAL UNITED LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

AP-COMBO-0510-AR

To obtain further information contact:

Central United Life Insurance Company

[10700 Northwest Freeway, Houston, TX 77092]

Notice of Information Practices

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the above address. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

(CONTINUED ON BACK)

AP-COMBO-0510-AR

PREMIUM DEDUCTION AUTHORIZATION TO THE EMPLOYER

You are hereby authorized to deduct \$ _____ from my pay according to the deduction mode indicated below, until further notice from me, and remit to Central United Life Insurance Company [10700 Northwest Freeway, Houston, Texas 77092].

Premiums will be deducted Weekly Monthly Bi-Monthly Other Specify _____

Name _____ Date _____

Employee's Signature _____ Agent's Signature _____

BANK DRAFT AUTHORIZATION

AUTHORIZATION TO HONOR CHECKS DRAWN BY CENTRAL UNITED LIFE INSURANCE COMPANY

To _____
Your Bank's Address _____

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of Central United Life Insurance Company of [Houston, Texas] provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice I agree that you shall be fully protected in honoring such check. I further agree that if any such checks be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date _____ X _____

Your signature Exactly as it appears on Bank Records Account No.

AP-COMBO-0510-AR

**NOTICE TO APPLICANT REGARDING
REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Central United Life Insurance Company of [Houston, Texas]. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy; or the new policy may also provide for a waiting period for certain specified conditions. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all of the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, 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 health history. Failure to include all material medical information on any 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, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date

AP-COMBO-0510-AR

(Applicant's Signature)

NOTICE OF INFORMATION PRACTICES (continued)

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office at the address on the front of this Notice..

MIB, Inc. Notice

While the information regarding your insurability is treated as confidential, Central United Life Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file. Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone number (781) 751-6000. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

AP-COMBO-0510-AR

CENTRAL UNITED LIFE INSURANCE COMPANY
[10700 Northwest Freeway, Houston, Texas 77092]

AP-COMBO-0510-AR

SERFF Tracking Number: LWEL-126724238 State: Arkansas
 Filing Company: Central United Life Insurance Company State Tracking Number: 46294
 Company Tracking Number: AP-COMBO-0510
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: CUL Combo Application
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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	08/06/2010
Comments:		
Attachment: Combo App - Readability certificate.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	08/06/2010
Comments: The application has been uploaded on the "Form Schedule" Tab.		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	08/06/2010
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	08/06/2010
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	08/06/2010
Bypass Reason: N/A		
Comments:		

SERFF Tracking Number: LWEL-126724238 State: Arkansas
Filing Company: Central United Life Insurance Company State Tracking Number: 46294
Company Tracking Number: AP-COMBO-0510
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: CUL Combo Application
Project Name/Number: cAP-COMBO-0510-AR/AP-COMBO-0510-AR

Item Status: Approved-Closed
Status Date: 08/06/2010
Satisfied - Item: Cover Letter
Comments:
Attachment:
103701 CUL combo App - Cover Letter - AR.pdf

Item Status: Approved-Closed
Status Date: 08/06/2010
Satisfied - Item: Authorization Letter
Comments:
Attachment:
authorzaton letter for Lewis Ellis.pdf

Readability Certification

Insurance Company: Central United Life Insurance Company

<u>Form Number</u>	<u>Description of Form</u>	<u>Score</u>
AP-COMBO-0510	Combo application	55.3

I hereby certify that the above referenced form complies with the readability requirements of this State.

Mary Lou Rainey

Authorized Signature

Mary Lou Rainey

Name

Secretary

Title

July 22, 2010

Date

Dallas

Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
Steven D. Bryson, F.S.A.
Gregory S. Wilson, F.C.A.S.
David M. Dillon, F.S.A.
Bonnie S. Albritton, F.S.A.
Brian D. Rankin, F.S.A.
Sarah A. Hoover, F.S.A.
Wesley R. Campbell, F.S.A.
Jacqueline B. Lee, F.S.A.
Robert E. Gove, A.S.A.
J. Finn Knox-Seith, A.S.A.
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)



Kansas City

Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
David L. Batchelder, A.S.A.
Leon L. Langlitz, F.S.A.
Gary R. McElwain, FLMI
Christopher H. Davis, F.S.A.
Thomas L. Handley, F.S.A.
Anthony G. Proulx, F.S.A.
Karen E. Elsom, F.S.A.
Jill J. Humes, F.S.A.

London / Kansas City

Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

July 22, 2010

Commissioner of Insurance
Arkansas Insurance Department
1200 W 3rd Street
Little Rock, Arkansas

Re: Central United Life Insurance Company
Form Number: AP-COMBO-0510-AR
Combo Application

Dear Sir/Madam:

On behalf of Central United Life Insurance Company, we are submitting this combination application for filing acknowledgement or prior approval, as appropriate. The implementation date will be upon approval by your department.

This application will be used with applicable policy forms previously approved by your department.

We have also included the following filing materials:

- Filing Authorization Letter
- Readability Certification

If you have further questions regarding this matter, you may contact me by e-mail at ddillion@lewisellis.com or by telephone (972) 850-0850 collect.

Sincerely,

A handwritten signature in cursive script that reads 'David M. Dillon'.

David M. Dillon, F.S.A., M.A.A.A.
Lewis & Ellis, Inc.



CENTRAL UNITED LIFE

January 12, 2009

Filing Authorization
Lewis & Ellis, Inc.
2929 N. Central Expressway, Suite 200
P.O. Box 851857

RE: Central United Life Insurance Company

To Whom It May Concern:

We hereby authorize Lewis & Ellis, Inc. to submit state filings of insurance forms/rates/products on behalf of Central United Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Central United Life Insurance Company.

Sincerely,

CENTRAL UNITED LIFE INSURANCE COMPANY



Signature of Company Officer/Representative