

SERFF Tracking Number: GRTT-126789030 State: Arkansas
Filing Company: United National Life Insurance Company of America State Tracking Number: 46626
Company Tracking Number: UAPPH2-08(LS)
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Application filing
Project Name/Number: /UAPPH2-08(LS)

Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: Application filing SERFF Tr Num: GRTT-126789030 State: Arkansas
TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved- State Tr Num: 46626
Closed

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: UAPPH2-08(LS) State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Joan Jannotta Disposition Date: 09/02/2010
Date Submitted: 08/26/2010 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
Project Number: UAPPH2-08(LS) Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: Resubmission Previous Filing Number: GRTT-126758139
Group Market Size: Overall Rate Impact:
Group Market Type: Filing Status Changed: 09/02/2010
Explanation for Other Group Market Type: Deemer Date:
State Status Changed: 09/02/2010 Submitted By: Joan Jannotta
Created By: Joan Jannotta
Corresponding Filing Tracking Number:
Filing Description:
Re: Individual Accident and Sickness
Application UAPPH2-08(LS)

NAIC # 92703 903

Dear Sir or Madam:

SERFF Tracking Number: GRTT-126789030 State: Arkansas
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We are submitting the above referenced form for your review and approval.

We filed this application under serf filing number GRTT-126758139 and received approval on August 10, 2010. The company has now decided that it wants to make the sentence above question 4. variable so that the sentence can be deleted. This is the only change.

We have not used this application, so we have not changed the form number.

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

The form has 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. The 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

Filing Contact Information

Joan Jannotta, jjannotta@gtlic.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

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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: 1 form = \$50
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United National Life Insurance Company of America	\$50.00	08/26/2010	39052570

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/02/2010	09/02/2010

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Disposition

Disposition Date: 09/02/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *GRTT-126789030* State: *Arkansas*
 Filing Company: *United National Life Insurance Company of America* State Tracking Number: *46626*
 Company Tracking Number: *UAPPH2-08(LS)*
 TOI: *H141 Individual Health - Hospital Indemnity* Sub-TOI: *H141.000 Health - Hospital Indemnity*
 Product Name: *Application filing*
 Project Name/Number: */UAPPH2-08(LS)*

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
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: UAPPH2-08(LS)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/02/2010	UAPPH2-08(LS)	Application/Enrollment Form	Application/ Enrollment	Revised	Replaced Form #: UAPPH2-08(LS) Previous Filing #: GRTT-126758139	49.250	UAPPH2-08(LS).pdf

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

- 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: _____
 - 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: _____
 - 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.]
- 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:
 - Cancer, carcinoma, malignant tumor, Leukemia, Lymphoma, Hodgkin's disease, malignant melanoma or sarcoma? Yes No
 - 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

- 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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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/02/2010
Comments:			
Attachment:			
Readcert.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/02/2010
Bypass Reason:	Please see the fiorms tab. This filing is for the application.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/02/2010
Bypass Reason:	Does not affect the rates.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/02/2010
Bypass Reason:	This is an application filing, not a form filing.		
Comments:			

CERTIFICATE OF READABILITY

Form Number(s): UAPPH2-08(LS)

Flesch Test Score(s): 49.25

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA



Arthur G Fess President

Date August 26, 2010