

SERFF Tracking Number: GRTT-127761290 State: Arkansas
Filing Company: United National Life Insurance Company of America State Tracking Number: 50104
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: UAPPH8-11
Project Name/Number: Medicare Supplement Application/

Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: UAPPH8-11

SERFF Tr Num: GRTT-127761290 State: Arkansas

TOI: MS09 Medicare Supplement - Other 2010 SERFF Status: Closed-Approved-
Closed State Tr Num: 50104

Sub-TOI: MS09.000 Medicare Supplement
Other 2010

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Author: Ann Ryan

Reviewer(s): Stephanie Fowler

Date Submitted: 10/25/2011

Disposition Date: 10/25/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Medicare Supplement Application

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This application
was filed in IL, our state of domicile, on 10-25-
11

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 10/25/2011

Deemer Date:

State Status Changed: 10/25/2011

Submitted By: Ann Ryan

Created By: Ann Ryan

Filing Description:

Corresponding Filing Tracking Number:

Re: Individual Medicare Supplement Insurance
Application Form UAPPH8-11

NAIC #92703 903, FEIN #37-1095206

Dear Sir or Madam:

SERFF Tracking Number: GRTT-127761290 State: Arkansas
 Filing Company: United National Life Insurance Company of America State Tracking Number: 50104
 Company Tracking Number:
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
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We are submitting the above referenced application for your review and approval.

Application form UAPPH8-11 does not replace any previously approved application form. We are asking for general approval of this application. It will be used with our currently approved, as well as future generations of Medicare Supplement plans.

These 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.

We would appreciate any consideration you could extend toward the prompt approval of this submission. If I can be of further assistance in the approval process, please contact me directly by E-mail or at our toll-free number shown below.

Company and Contact

Filing Contact Information

Ann Ryan, aryan@gtlic.com
 1275 Milwaukee Ave. 847-904-5587 [Phone] 5587 [Ext]
 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: 687 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: \$50.00
 Retaliatory? Yes
 Fee Explanation: AR filing fee is \$50, IL filing fee is \$50 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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SERFF Tracking Number: GRTT-127761290 State: Arkansas
Filing Company: United National Life Insurance Company of State Tracking Number: 50104
America
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: UAPPH8-11
Project Name/Number: Medicare Supplement Application/
United National Life Insurance Company of \$50.00 10/25/2011 53168930
America

SERFF Tracking Number: GRTT-127761290 State: Arkansas
Filing Company: United National Life Insurance Company of America State Tracking Number: 50104
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: UAPPH8-11
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	10/25/2011	10/25/2011

SERFF Tracking Number: *GRTT-127761290* State: *Arkansas*
 Filing Company: *United National Life Insurance Company of America* State Tracking Number: *50104*
 Company Tracking Number:
 TOI: *MS09 Medicare Supplement - Other 2010* Sub-TOI: *MS09.000 Medicare Supplement Other 2010*
 Product Name: *UAPPH8-11*
 Project Name/Number: *Medicare Supplement Application/*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes

SERFF Tracking Number: GRTT-127761290 State: Arkansas
 Filing Company: United National Life Insurance Company of America State Tracking Number: 50104
 Company Tracking Number:
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
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Supporting Document Schedules

Satisfied - Item:	Flesch Certification	Item Status:	Accepted for Informational Purposes	Status Date:	10/25/2011
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Comments:
 Readability Certification

Attachment:
 Readability Certification (UAPPH8-11).pdf

Satisfied - Item:	Application	Item Status:	Approved-Closed	Status Date:	10/25/2011
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Comments:
 UAPPH8-11
Attachment:
 UAPPH8-11.pdf

Bypassed - Item:	Health - Actuarial Justification	Item Status:		Status Date:	
Bypass Reason:	Not applicable				
Comments:					

Bypassed - Item:	Outline of Coverage	Item Status:		Status Date:	
Bypass Reason:	Not applicable				
Comments:					

CERTIFICATE OF READABILITY

Form Number(s): UAPPH8-11

Flesch Test Score(s): 52.73

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 Fess, Vice President

Date: October 25, 2011

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICANT		Last Name			First Name			M.I.
Soc. Security #	Age	Date of Birth / /	Sex	Height /	Weight lbs	Phone Number ()	Email	
ADDRESS Number & Street				City		State	Zip Code	
MAILING ADDRESS (if different from above)				City		State	Zip Code	

PLAN & PAYMENT INFORMATION

<p>1. Requested Effective Date or Replacement Date: _____</p> <p>2. I am applying for: Medicare Supplement Plan: Plan: <input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N</p>	<p>3. Premium Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft*</p> <p>Requested Draft Date _____</p> <p>Application Fee: \$ _____</p> <p>Total Modal Premium: \$ _____</p> <p>Premium Paid with Application: \$ _____</p> <p>* (1 month's premium required for bank draft)</p>
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MEDICARE COVERAGE QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER QUESTIONS 4 THROUGH 9 COMPLETELY.

Please mark Yes or No with an "X". To the best of your knowledge:

<p>4. Are you covered or will you be covered under Medicare Parts A & B? (If the answer is "No", do not submit the application) If yes, what is your Medicare claim number? (exactly as it appears on your Medicare Card) _____</p> <p>5. a. Did you turn age 65 in the last 6 months? b. Did you enroll in Medicare Part B in the last 6 months or will you enroll in Medicare Part B in the next 6 months?.... If yes, what is/was the effective date? _____</p> <p>6. Are you covered for medical assistance through the state Medicaid program? (If the answer to 6a. or 6b. is "yes", do not submit the application.) NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. If you answer yes, a. Will Medicaid pay your premiums for this Medicare supplement policy? b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....</p> <p>7. a. Do you have another Medicare supplement policy in force?..... b. If so, with what company and what plan do you have? _____ c. If so, do you intend to replace your current Medicare supplement policy with this policy?..... d. If yes, what is the Termination Date of your other Medicare Supplement Policy? _____</p> <p>8. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____ b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? c. Was this your first time in this type of a Medicare plan? d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? e. If your coverage has not ended please fill in a planned termination date? ____/____/____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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9. Have you had coverage under any other health insurance within the past 63 days?.....
 (For example, Railroad Retirees, teachers plans, an employer union, group major medical or individual plan)
 a. If so, with what company and what kind of policy?

 b. What are your dates of coverage under the other policy?
 START _____/_____/_____ END _____/_____/_____
 (If you are still covered under the other policy, leave the "END" blank.
 c. If your coverage has not ended, please fill in a planned termination date? _____/_____/_____

Yes No

HEALTH QUESTIONS

You do not have to answer questions 10 through 24 if you have enrolled in Medicare Part B within the past 6 months or are in a guarantee issue period. If not, and you answer "yes" to questions 10 through 23 below, you are not eligible for coverage

- 10. Are you currently hospitalized or confined to a nursing facility, or, are you bedridden or confined to a wheelchair? Yes No
- 11. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? Yes No
- 12. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, degenerative bone disease, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? Yes No
- 13. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? Yes No
- 14. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
- 15. Do you have diabetes, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, congestive heart failure, heart disease, or high blood pressure with three or more medications? Yes No
- 16. Do you have diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral)? Yes No
- 17. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation? Yes No
- 18. Within the past two years have you been treated, been advised to have treatment, been prescribed new medication or had changes in existing medication(s) for coronary or carotid artery disease, heart rhythm disorders including pacemakers or a defibrillator, a heart attack, congestive heart failure, or enlarged heart, stroke, transient ischemic attack (TIA), heart valve surgery, or peripheral vascular disease? Yes No
- 19. Within the past two years have you been treated for crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes No
- 20. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? Yes No
- 21. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes No
- 22. Have you been hospital confined three or more times in the last two years? Yes No
- 23. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No
- 24. Have you used any tobacco products in the past 12 months? Yes No
- 25. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes No
 If, "YES", please list the drug and the condition in the following table.

Applicant (please attach a separate sheet if needed)	
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition
	Medication Name (copy off pharmacy label)
	Date Originally Prescribed
	Frequency and Dosage
	Diagnosis/Condition

DISCLOSURE & AUTHORIZATION

DISCLOSURE: You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy, (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for the outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

APPLICANT'S AUTHORIZATION & AGREEMENT: I authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, pharmacy benefit manager, pharmacy, pharmacy-related facility, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc.. This Authorization includes all information about drugs, alcoholism, and mental illness. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

ACKNOWLEDGEMENTS: The Applicant represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete. 2) Any coverage issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No agent or any other person is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of the application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime. 5) Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan which has been applied for, have been explained and are understood. 6) The applicant shall be owner of any insurance applied for. 7) The applicant acknowledges receipt of the Outline of Coverage, and has read the authorization and received copies of the "Notice to Applicant, Parts 1 and 2" describing the Medical Information Bureau and explaining the rights of the applicant under the Fair Credit Reporting Act.

AGREEMENT: I have read, or had read to me, the completed application. I hereby agree that: 1) all the statements and answers in this application are complete and true to the best of my knowledge and belief; and 2) **no insurance will be effective until my policy is issued.**

Caution: If your answers on this application are incorrect or untrue, United National Life Insurance Company of America may deny benefits or rescind your policy.

We are required to give you this notice: Any person who, with the intent to defraud or knowledge that he is facilitating a fraud against the insurer, submits an application or files a claim containing false, incomplete, or deceptive statements of material fact may be guilty of insurance fraud.

Applicant's Signature

City & State signed

Date

MAIL POLICY TO: Agent Insured

AGENT'S REPORT: List of health policies or certificates I have sold to the Applicant in the last 5 years which are either in force or no longer in force:

NAME OF INSURER	POLICY TYPE

AGENT'S STATEMENT

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given an Outline of Coverage for the policy being applied for and the Medicare Supplement Buyer's Guide to the Applicant; 3) I am or am not aware the policy applied for will replace an existing health insurance policy; and 4) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Agent's Signature **Agent's Name (please print)** **Agent Code**

Agent's E-mail Address *(Agent signature not required if sold through the mail.)*

TYPE OF SALE: In Person Telephone On-line Mail