## Filing at a Glance

Company: Provident Life and Accident Insurance Company

| | | |
|---|---|---|
| Product Name: ISTD Application | SERFF Tr Num: UNUM-127839210 | State: Arkansas |
| TOI: H11I Individual Health - Disability Income | SERFF Status: Closed-Approved | State Tr Num: 50304 |
| Sub-TOI: H11I.002 Short Term - Unrelated to marketing with employer or association groups | Co Tr Num: L-21775-AR-SP | State Status: Approved-Closed |
| Filing Type: Form | | Reviewer(s): Donna Lambert |
| | Authors: Jay Burt, Sandy Kirkman, Julie Mader, Dena Miraldi, Vanessa Vice | Disposition Date: 11/28/2011 |
| | Date Submitted: 11/20/2011 | Disposition Status: Approved |
| Implementation Date Requested: On Approval | | Implementation Date: 12/28/2011 |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: Spanish Translation | Status of Filing in Domicile: Authorized |
| Project Number: | Date Approved in Domicile: |
| Requested Filing Mode: Informational | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Individual Market Type: |
| Overall Rate Impact: | Filing Status Changed: 11/28/2011 |
| | State Status Changed: 11/28/2011 |
| Deemer Date: | Created By: Sandy Kirkman |
| Submitted By: Sandy Kirkman | Corresponding Filing Tracking Number: |

Filing Description:

This is a filing for the Spanish translation of a previously approved English Application for Voluntary Disability Income Insurance. The English version of L-21775-AR-SP, L-21775-AR, was approved August 31, 2006 and is attached under the Supporting Documentation tab along with the Translation Certification.

Feel free to contact me at 1-800-451-8475, extension 47048, or vvice@unum.com, if there is any additional information we can provide to assist in your evaluation of this filing.

Thank you for your help with this submission.

# Company and Contact

**Filing Contact Information**


Vanessa Vice, Contract Consultant
One Fountain Square
Chattanooga, TN 37402
vvice@unum.com
423-294-7048 [Phone]


**Filing Company Information**

| | | |
|---|---|---|
| Provident Life and Accident Insurance Company | CoCode: 68195 | State of Domicile: Tennessee |
| 1 Fountain Square | Group Code: 565 | Company Type: |
| Chattanooga, TN 37402 | Group Name: | State ID Number: |
| (800) 451-8475 ext. [Phone] | FEIN Number: 62-0331200 | |

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# Filing Fees

| | |
|---|---|
| Fee Required? | No |
| Retaliatory? | No |
| Fee Explanation: | |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Provident Life and Accident Insurance Company | $0.00 | 11/20/2011 | |
| Provident Life and Accident Insurance Company | $50.00 | 11/23/2011 | 54038886 |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved | Donna Lambert | 11/28/2011 | 11/28/2011 |

### 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 | Donna Lambert | 11/23/2011 | 11/23/2011 | Sandy Kirkman | 11/23/2011 | 11/23/2011 |

# Disposition

Disposition Date: 11/28/2011

Implementation Date: 12/28/2011

Status: Approved

Comment: Happy holidays to you, too.

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UNUM-127839210* | *State:* | *Arkansas* |
| *Filing Company:* | *Provident Life and Accident Insurance Company* | *State Tracking Number:* | *50304* |
| *Company Tracking Number:* | *L-21775-AR-SP* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.002 Short Term - Unrelated to marketing with employer or association groups* |
| *Product Name:* | *ISTD Application* | | |
| *Project Name/Number:* | *Spanish Translation/* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved | Yes |
| **Supporting Document** | Application | Approved | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved | Yes |
| **Supporting Document** | Outline of Coverage | Approved | Yes |
| **Supporting Document** | Certification of Translation | Approved | Yes |
| **Supporting Document** | L-21775-ND English Version | Approved | Yes |
| **Form** | ISTD Application | Approved | Yes |

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 11/23/2011 |
| Submitted Date | 11/23/2011 |
| Respond By Date | 12/23/2011 |

Dear Vanessa Vice,

This will acknowledge receipt of the captioned filing. Please review the General Instructions for ArkansasLH or Rule and Regulation 57. The fee for this submission is $50 per form. We will begin our review of this submission upon receipt of the filing fee.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Donna Lambert

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 11/23/2011 |
| Submitted Date | 11/23/2011 |

Dear Donna Lambert,

**Comments:**
Thank you for your quick response to this submission.

## Response 1

Comments: Please accept my apology for failing to include the appropriate filing fee initially.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If there is any other item we lack for your review to continue, please let me know and it will be provided at our earliest possible opportunity.

Happy Thanksgiving to you and yours!

Sincerely,
Dena Miraldi, Jay Burt, Julie Mader, Sandy Kirkman, Vanessa Vice

# Form Schedule

**Lead Form Number: L-21775-AR-SP**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved 11/28/2011 | L-21775-AR-SP | Application/ Enrollment Form | ISTD Application | Initial | | | L-21775-AR-SP.pdf |

**PROVIDENT LIFE and ACCIDENT INSURANCE COMPANY**
1 Fountain Square
Chattanooga, TN 37402

# SOLICITUD DE SEGURO VOLUNTARIO DE INGRESOS POR INCAPACIDAD

- ☐ Nueva Póliza
- ☐ Póliza Adicional [Aumento del Beneficio Mensual]
- ☐ Reemplazo de Póliza Interna
- ☐ Cambio a Póliza Vigente

**Por favor, llene en letra imprenta.**

## Sección A: EMPLEADO (Información del Solicitante)

| | | | |
|---|---|---|---|
| 1. Nombre (Primer Nombre) (Segundo Nombre) (Apellido) (Aquí denominado "Usted") | | | 2. N.º de Seguro Social |
| 3. Dirección del Domicilio (Calle/Apartado de Correos) (Ciudad) (Estado) (Código Postal) | | | |
| 4. Fecha de Nacimiento | 5. Edad | 6. Sexo ☐ F ☐ M | 7. N.º de Teléfono del Domicilio |
| 8. Nombre del Empleador | 9. Fecha de Contratación | 10. ¿Se encuentra laboralmente activo? ☐ Sí ☐ No | 11. N.º de Empleado/ Nómina de Pago |
| 12. Ocupación | 13. Horas trabajadas por semana | | 14. Sueldo Mensual $ |

## Sección B: INFORMACIÓN DE LA PÓLIZA

15. Clase de Riesgo: _____
16. Período de Eliminación por Accidentes: _____ días
17. Período de Eliminación por Enfermedades: _____ días
18. Período de Beneficios por Accidentes y Enfermedades: _____ meses
19. Cobertura Seleccionada

| | Beneficio Mensual | Prima |
|---|---|---|
| Enfermedades y Accidentes Fuera del Trabajo | $ _____ | $ _____ |
| ☐ Accidentes en el Trabajo | $ _____ | $ _____ |
| ☐ Otros | $ _____ | $ _____ |

20. Monto total de las Primas: ..... $ _____

21. Prima Deducida del Cheque de Pago:

☐ Semanal ☐ Bisemanal ☐ Semimensual ☐ Mensual ☐ Otro _____

PRIMA TOTAL DEL CHEQUE DE PAGO: ..... $ _____

22. ¿Reemplazará o modificará la cobertura solicitada a algún seguro de incapacidad? Si la respuesta es "sí", proporcione los detalles a continuación, llene y envíe los formularios de sustitución requeridos, si es necesario. ..... ☐ Sí ☐ No

| Compañía de Seguros | Beneficio Mensual | Número de Póliza |
|---|---|---|
| | | |
| | | |

23. ¿Tiene algún seguro de incapacidad (excluyendo el pagado por el empleador) ya sea colectivo o individual, que actualmente esté en vigencia con nosotros o con otra compañía y que no se reemplazará ni modificará? Si la respuesta es "sí", proporcione detalles a continuación. ..... ☐ Sí ☐ No

| Compañía de Seguros | Beneficio Mensual | Período de Eliminación/ Beneficio |
|---|---|---|
| | | |
| | | |

**Sección C: EMISIÓN MODIFICADA (Llene según se requiera además de las preguntas anteriores).**

24. ¿Alguna vez ha tenido usted un resultado positivo en el análisis del virus de inmunodeficiencia humana (VIH) o sus anticuerpos, o se le ha diagnosticado el síndrome de inmunodeficiencia adquirida (SIDA) o el complejo relacionado con el SIDA (CRS), o ha recibido tratamiento contra estas enfermedades? ..... ☐ Sí ☐ No

25. En los últimos 12 meses, por motivos que no hayan sido resfríos, ni gripes, ni embarazo ¿ha tenido que ausentarse del trabajo o tomarse vacaciones durante 5 días consecutivos o más debido a un accidente, enfermedad o problema de espalda, rodilla, cuello, hombro o trastornos de las articulaciones o los músculos? ..... ☐ Sí ☐ No

26. En los últimos 12 meses, ¿ha recibido asesoramiento médico, ha solicitado tratamiento, incluyendo medicamentos, o ha sido hospitalizado por alguno de los siguientes problemas?..... ☐ Sí ☐ No

- Ataque Cardíaco/Cirugía Cardíaca
- Insuficiencia Cardíaca Congestiva
- Derrame Cerebral/Accidente Isquémico Transitorio (AIT)
- Presión Arterial Alta tratada con 3 o más medicamentos
- Diabetes Insulinodependiente
- Cáncer (excepto cáncer basocelular de piel)
- Hepatitis B y C
- Cirrosis

**DECLARACIONES DEL EMPLEADO (SOLICITANTE)**

Yo comprendo que la cobertura emitida se basa en todas las declaraciones y respuestas anteriormente registradas. Estas declaraciones y respuestas están completas y son verdaderas. Comprendo que, en mi carácter de persona abajo firmante, soy el dueño de la cobertura emitida en virtud de esta solicitud.

Yo comprendo que la Fecha de Vigencia de la Cobertura del seguro según se muestra en el Programa de la Póliza se encuentra sujeta a la aceptación de la solicitud en virtud de las normas, los límites y los estándares de Provident, y el seguro es, o habría sido emitido según se solicitó (o si no es emitido según se solicitó, entonces, según sus enmiendas). La Fecha de Vigencia de la Cobertura será después de la fecha en que se firme la solicitud y no más tardar de la fecha en que comiencen las deducciones del cheque de pago o el cobro de las primas para las pólizas, cuyas primas no se deducan del cheque de pago.

Yo autorizo a mi empleador a deducir de mis ingresos las primas de este seguro (a menos que haya llenado formularios adicionales para solicitar un método que no afecte el cheque de pago).

Fecha _____ en _____
(Mes/Día/Año) (Ciudad, Estado)

☐ Si esta casilla está marcada, la solicitud ha sido autorizada mediante una inscripción protegida por número de PIN y no se requiere la firma.

**Firma del Empleado (Solicitante)**

**Toda persona que, con el propósito de estafar a una aseguradora o de, a sabiendas, facilitar el fraude en contra de una aseguradora, presente una solicitud o una reclamación con declaraciones falsas o engañosas es culpable de fraude en materia de seguros.**

**DECLARACIONES DEL AGENTE:** (1) ¿Tiene conocimiento o alguna razón para creer que el seguro propuesto tiene por objetivo sustituir cualquier seguro o anualidad vigentes? ☐ Sí ☐ No (2) A su leal saber y entender, las anteriores declaraciones y respuestas están completas y son verdaderas.

Fecha _____
(Mes/Día/Año)

N.º de Licencia del Agente _____

Nombre del Agente en Letra de Imprenta _____

**Firma del Agente Autorizado**

**Número de Póliza:** _____

# Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Flesch Certification | Approved | 11/28/2011 |
| **Bypass Reason:** | N/A | | |
| **Comments:** | | | |

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Application | Approved | 11/28/2011 |
| **Bypass Reason:** | Filing Spanish translation of previously approved English application. | | |
| **Comments:** | | | |

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Health - Actuarial Justification | Approved | 11/28/2011 |
| **Bypass Reason:** | N/A | | |
| **Comments:** | | | |

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Outline of Coverage | Approved | 11/28/2011 |
| **Bypass Reason:** | N/A | | |
| **Comments:** | | | |

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Certification of Translation | Approved | 11/28/2011 |
| **Comments:** | | | |
| **Attachment:** | | | |

Certification for L-21775-AR-SP-7-15-11-Zary.pdf

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UNUM-127839210* | *State:* | *Arkansas* |
| *Filing Company:* | *Provident Life and Accident Insurance Company* | *State Tracking Number:* | *50304* |
| *Company Tracking Number:* | *L-21775-AR-SP* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.002 Short Term - Unrelated to marketing with employer or association groups* |
| *Product Name:* | *ISTD Application* | | |
| *Project Name/Number:* | *Spanish Translation/* | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | L-21775-ND English Version | Approved | 11/28/2011 |

**Comments:**

**Attachment:**

L-21775-AR.pdf

unum

CERTIFICATION

I, Zary Colón, an employee of Unum Group, do hereby certify the following document as a true and accurate translation from English into Spanish:

Form L-21775-AR-SP

*Unum Group affirms that Zary Colón is qualified to translate and review insurance related documents from English to Spanish.*

Zary Colón

Zary Colón

Dated: 7-15-2011

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

**PROVIDENT LIFE and ACCIDENT INSURANCE COMPANY**
1 Fountain Square
Chattanooga, TN 37402

# APPLICATION FOR VOLUNTARY DISABILITY INCOME INSURANCE

- ☐ New Policy
- ☐ Additional Policy [Increase Monthly Benefit]
- ☐ Internal Policy Replacement
- ☐ Change to Existing Policy

**Please Print**

## Section A: EMPLOYEE (Applicant Information)

| | | | |
|---|---|---|---|
| 1. Name (First) (Middle) (Last) (Herein called You) | | | 2. Social Security No. |
| 3. Residence Address (Street/Box No.) (City) (State) (Zip) | | | |
| 4. Birthdate | 5. Age | 6. Sex ☐ F ☐ M | 7. Home Phone Number |
| 8. Employer's Name | 9. Employment Date | 10. Are you actively at work? ☐ Yes ☐ No | 11. Employee/Payroll No. |
| 12. Occupation | | 13. Hours worked per Week | 14. Monthly Salary $ |

## Section B: POLICY INFORMATION

15. Risk Class: _____
16. Elimination Period for Accidents: _____ days
17. Elimination Period for Sickness: _____ days
18. Benefit Period for Accidents and Sickness: _____ months
19. Coverage Selected

| | Monthly Benefit | Premium |
|---|---|---|
| Sickness and Off Job Accidents | $ _____ | $ _____ |
| ☐ On Job Accidents | $ _____ | $ _____ |
| ☐ Other | $ _____ | $ _____ |

20. Total Premium Amount: ..... $ _____
21. Payroll Premium Deducted:

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

TOTAL PAYROLL PREMIUM: ..... $ _____

22. Will coverage applied for replace or modify any disability insurance? If "yes," provide details below and complete and submit required replacement forms if needed. ..... ☐ Yes ☐ No

| Insurance Company | Monthly Benefit | Policy Number |
|---|---|---|
| | | |
| | | |

23. Do you have any group (excluding employer paid) or individual disability insurance now in force with us or any other company that <u>will not</u> be replaced or modified? If "yes," give details below. ..... ☐ Yes ☐ No

| Insurance Company | Monthly Benefit | Elimination/Benefit Period |
|---|---|---|
| | | |
| | | |

**Section C: MODIFIED ISSUE (Complete as required in addition to previous questions)**

24. Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? ..... ☐ Yes ☐ No

25. In the past 12 months, other than colds, flu or pregnancy, have you taken time off from work or taken vacation for 5 or more consecutive days due to an accident, sickness, back, knee, neck, shoulder, joint or muscular disorder?..... ☐ Yes ☐ No

26. In the past 12 months have you received medical advice, sought treatment, including medication, or been hospitalized for any of the following:..... ☐ Yes ☐ No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- High Blood Pressure treated with 3 or more medications
- Insulin Dependent Diabetes
- Cancer (except basal cell skin cancer)
- Hepatitis B&C
- Cirrhosis

**EMPLOYEE (APPLICANT) STATEMENTS**

I understand that coverage issued is based on all statements and answers recorded above. These statements and answers are complete and true. I understand that as the undersigned, I am the owner of any coverage issued under this application.

I understand the Coverage Effective Date of insurance as shown in the Policy Schedule is subject to the application being acceptable under Provident's rules, limits and standards and the insurance is, or would have been issued as applied for (or if not issued as applied for, then as modified). The Coverage Effective Date will be no earlier than the application signed date and no later than the date payroll deductions begin or premiums are collected for non-payroll deducted policies.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless I have completed additional forms for a non-payroll method).

Dated _____ at _____
(Month/Day/Year) (City, State)

☐ If this box is checked, a PIN # secured enrollment has authorized the application and a signature is not required.

**Employee (Applicant) Signature**

**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 false or deceptive statements is guilty of insurance fraud.**

**AGENT STATEMENTS:** (1) Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing insurance or annuities? ☐ Yes ☐ No (2) To the best of your knowledge and belief, the above statements and answers are complete and true.

Dated _____
(Month/Day/Year)

Agent's License No. _____

Printed Name of Agent _____

**Licensed Agent's Signature**

**Policy Number:** _____