

SERFF Tracking Number: UHLC-127641579 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 49844
Company Tracking Number: S07H49MNWBAR01 01B
TOI: MS08G Group Medicare Supplement - Standard Sub-TOI: MS08G.001 Plan A 2010
Plans 2010
Product Name: GROUP MEDICARE SUPPLEMENT
Project Name/Number: ENROLLMENT APPLICATION/S07H49MNWBAR01 01B

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: GROUP MEDICARE SUPPLEMENT SERFF Tr Num: UHLC-127641579 State: Arkansas

TOI: MS08G Group Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved- Closed State Tr Num: 49844

Sub-TOI: MS08G.001 Plan A 2010 Co Tr Num: S07H49MNWBAR01 State Status: Approved-Closed 01B

Filing Type: Form

Reviewer(s): Stephanie Fowler

Authors: Michelle Ambach, Bobbie Walton Disposition Date: 12/09/2011

Date Submitted: 09/21/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: ENROLLMENT APPLICATION

Status of Filing in Domicile: Not Filed

Project Number: S07H49MNWBAR01 01B

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Association

Overall Rate Impact:

Filing Status Changed: 12/09/2011

State Status Changed: 12/09/2011

Deemer Date:

Created By: Bobbie Walton

Submitted By: Bobbie Walton

Corresponding Filing Tracking Number: S07H49MNWBAR01 01B

Filing Description:

Submitted for your review is an enrollment application for use in connection with the AARP group health insurance plans. The enclosed enrollment application is new and does not replace any previously submitted enrollment application.

The enclosed materials will be utilized with the following which were approved by the Department on 11/5/09, under

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State Tracking #43459.

Standardized Medicare Supplement Certificates: MDA 0001 – MDN 0007 (Mass Marketed)
Standardized Medicare Supplement Certificates: MAA 0010 – MAN 0016 (Agent Sales only)
Standardized Medicare Select Certificate: MDSC 0008, MDSF 0009 (Mass Marketed)
Standardized Medicare Select Certificate: MASC 0017, MASF 0018 (Agent Sales only)
Plan Benefit Tables: BT25 – BT33
BT002 ST AB, CF, KLN
BT002 ST CCSelect,
BT002 ST FFSelect
Plan Overviews: POV3, POV4
Rules & Disclosures: RD4, RD5
Premium Rate Pages: MRP0001 (Med Supp), MRP0002 (Med Select) - - (All Non-Agent Marketing Channels)
MRP0003 (Med Supp), MRP0004 (Med Select) - - (All Marketing Channels)
Medicare Select Plan of Operation: PO3

The definitions, disclosures, eligibility requirements, exclusions, limitations, Group Policy Form No. GRP 79171 GPS-1, as well as, the statement, "...not connected with, or endorsed by, the U.S. Government or the federal Medicare program," can be found in BA25014ARWB which was approved by your Department on 1/28/10 under State Tracking Number 44550.

Company and Contact

Filing Contact Information

Susan Cipollo, Director Susan_J_Cipollo@uhc.com
680 Blair Mill Rd. 215-902-8444 [Phone]
Horsham, PA 19044 215-902-8813 [FAX]

Filing Company Information

UnitedHealthcare Insurance Company CoCode: 79413 State of Domicile: Connecticut
185 Asylum Street Group Code: 707 Company Type: Life and Health
Hartford, CT 06103 Group Name: State ID Number:
(860) 702-5000 ext. [Phone] FEIN Number: 36-2739571

Filing Fees

SERFF Tracking Number: UHLC-127641579 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50 PER FORM
Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|------------------------------------|---------|----------------|---------------|
| UnitedHealthcare Insurance Company | \$50.00 | 09/21/2011 | 51958850 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|------------------|------------|----------------|
| Approved-Closed | Stephanie Fowler | 12/09/2011 | 12/09/2011 |

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 | Stephanie Fowler | 11/08/2011 | 11/08/2011 | Michelle Ambach | 12/09/2011 | 12/09/2011 |
| Pending Industry Response | Stephanie Fowler | 10/05/2011 | 10/05/2011 | Bobbie Walton | 10/28/2011 | 10/28/2011 |

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Disposition

Disposition Date: 12/09/2011

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 | Accepted for Informational Purposes | Yes |
| Supporting Document | Application | | Yes |
| Supporting Document | Health - Actuarial Justification | | Yes |
| Supporting Document | Outline of Coverage | | Yes |
| Supporting Document | SOV | Accepted for Informational Purposes | Yes |
| Supporting Document | Response letter | Accepted for Informational Purposes | Yes |
| Supporting Document | Response letter | Accepted for Informational Purposes | Yes |
| Form (revised) | ENROLLMENT APPLICATION | Approved-Closed | Yes |
| Form | ENROLLMENT APPLICATION | Disapproved | No |

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Project Name/Number: ENROLLMENT APPLICATION/S07H49MNWBAR01 01B

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 11/08/2011
Submitted Date 11/08/2011
Respond By Date 12/08/2011

Dear Susan Cipollo,

Thank you for your response to our prior objection; however, we have considered your explanation and have come to the conclusion that the required disclosure needs to be included on the application. With that being said, please revise this application as previously requested.

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,

Stephanie Fowler

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 12/09/2011
 Submitted Date 12/09/2011

Dear Stephanie Fowler,

Comments:

Please see attached

Response 1

Comments: see attached

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Response letter
 Comment:

Form Schedule Item Changes

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|-------------------------|----------------------------|--------------|-----------------------------|---------|----------------------|-------------------|--------------------------------|
| ENROLLMENT APPLICATION | S07H49M NWBAR0 1 01B | | Application/Enrollment Form | Initial | | 50.000 | S07H49M NWBAR0 1 01B.pdf |
| Previous Version | | | | | | | |
| ENROLLMENT APPLICATION | S07H49M NWBAR0 1 01B | | Application/Enrollment Form | Initial | | 50.000 | S07H49M NWBAR0 1 01B.pdf |

No Rate/Rule Schedule items changed.

Thank you

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Sincerely,
Bobbie Walton, Michelle Ambach

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/05/2011
Submitted Date 10/05/2011
Respond By Date 11/07/2011

Dear Susan Cipollo,

This will acknowledge receipt of the captioned filing.

Objection 1

- ENROLLMENT APPLICATION, S07H49MNWBAR01 01B (Form)

Comment: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Questions regarding tobacco use should have the same statement unless the question is in the health section.

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,

Stephanie Fowler

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/28/2011
Submitted Date 10/28/2011

Dear Stephanie Fowler,

Comments:

Please review the following response letter.

Response 1

Comments: Please review the following response letter.

Related Objection 1

Applies To:

- ENROLLMENT APPLICATION, S07H49MNWBAR01 01B (Form)

Comment:

R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Questions regarding tobacco use should have the same statement unless the question is in the health section.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Response letter

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thanks!

Sincerely,

Bobbie Walton, Michelle Ambach

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Form Schedule

Lead Form Number: S07H49MNWBAR01 01B

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------------------------|---------------------------|------------------------------------|---------------------------|---------|----------------------|-------------|-------------------------------|
| Approved- Closed 12/09/2011 | S07H49MN WBAR01 01B | Application/ Enrollment Form | ENROLLMENT APPLICATION | Initial | | 50.000 | S07H49MNW BAR01 01B.pdf |

About You

AARP Membership Number (If you are already a member)

Prefix

First

MI

Last

Suffix

Address Line 1

Address Line 2

City

ST

Zip

Date of Birth

Gender

Phone Number (Primary)

Phone Number (Secondary)

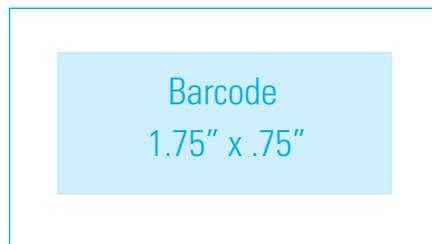
E-mail Address

Medicare ID (Claim) Number:

Hospital (Part A) Effective Date

Medical (Part B) Effective Date

Are both Medicare Parts A & B active? (Yes or No)



Note: You must be an AARP Member in order to enroll in an AARP Medicare Supplement Insurance Plan. The information you provide, including your email address and phone number, may be used to contact you.

Plan Selection and Start Date

The following plans are available: **A B C F K L N Select Plan C Select Plan F**

Your choice is: _____

You are eligible to enroll if **all** of these are true:

- you are an AARP member,
- you are age 65 or older,
- you are enrolled in Medicare Parts A&B,
- you are not duplicating Medicare supplement coverage.

Requested Starting Date:

Your coverage will start on the 1st of a month. Once your application has been approved, you will receive a "Certificate of Coverage" confirming your plan start date.

I request my coverage to start on the following date:

Guaranteed Acceptance Questions

The questions in this section are used to determine if you qualify for guaranteed acceptance for an AARP Medicare Supplement Insurance Plan.

1. Did you turn 65 in the last 6 months?

Yes or No

2. Did you enroll in Medicare Part B in the last 6 months?

Yes or No

3. Will your requested plan start date be within 6 months after you turn age 65 and are enrolled in Medicare Part B?

Yes or No

Please Read

If you answered **YES** to question **1, 2** or **3** above your acceptance is guaranteed. You can move directly to the **Past and Current Insurance Coverage** section.

If you answered **NO** to questions **1, 2** and **3** please continue to question **4**.

4. Have you lost other health insurance coverage and are you considered an "eligible person" as defined within the termination notice you received from your previous insurer?

Yes or No

Please Read

If you answered **YES** to question **4** above you may have guaranteed acceptance in certain AARP Medicare Supplement Plans. You can move directly to the **Past and Current Insurance Coverage** section. *Please submit a copy of your termination notice with your application.*

If you answered **NO** to questions **1, 2, 3** and **4** please continue to the **Eligibility Health Questions** section.

Under Open Enrollment, you are not required to answer questions regarding Tobacco Usage.

Tobacco Usage

Have you smoked cigarettes or used any tobacco product at any time within the past twelve months? _____
Yes or No

Eligibility Health Questions

(You do not have to answer these questions if you answered **YES** to any of the questions in the Guaranteed Acceptance Questions section.)

1. Do any of the following apply to you?

- I have end stage renal (kidney) disease.
- I am currently receiving dialysis.
- I have been diagnosed with kidney disease that may require dialysis.
- I have been admitted to a hospital as an inpatient within the past 90 days.

 Yes or No

2. Within the past 2 years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed?

- Hospital admittance as an inpatient
- An organ transplant
- Back or spine surgery
- Joint replacement
- Surgery for cancer
- Heart surgery
- Vascular surgery

 Yes or No

Please Read

If you answered **NO** to questions 1 and 2, please **continue to Health History Questions**.

If you answered **YES** to either question in this section, you are **NOT** eligible for these plans at this time.

If your health status changes in the future, allowing you to answer **NO** to these questions, please submit a new application at that time.

For information on plans that may be available please contact your local state department on aging.

Under Open Enrollment, health questions are not required to be answered.

Health History Questions

The questions in this section are used to determine your rate. Please indicate **YES** or **NO** if you have been diagnosed, treated or had any of these conditions within the past 2 years. If you are unsure how to respond, please speak to your doctor.

(Note: if you enrolled in Medicare Part B less than 7 months ago you do not have to answer these questions and can skip to the **Past and Current Insurance Coverage** section.)

1A. Heart or Vascular Conditions

Aneurysm _____
Arteriosclerosis or Atherosclerosis _____
Artery or Vein Blockage _____
Atrial Fibrillation or Atrial Flutter _____
Cardiomyopathy _____
Carotid Artery Disease _____
Congestive Heart Failure (CHF) _____
Coronary Artery Disease (CAD) _____
Heart Attack _____
Peripheral Vascular Disease or Claudication _____
Stroke, Transient Ischemic Attack (TIA), or mini-stroke _____
Ventricular Tachycardia _____

1B. Diabetes

With any of the following complications: Circulatory Problems, Kidney Problems, Retinopathy _____

1C. Lung/Respiratory Conditions

Chronic Obstructive Pulmonary Disease (COPD) _____
Emphysema _____

1D. Cancer or Tumors

Cancer (other than skin cancer) _____
Leukemia or Lymphoma _____
Melanoma _____

1. - continued. Read the conditions listed below carefully.

Please indicate **YES** or **NO** if you have been diagnosed, treated or had any of these conditions within the past 2 years. If you are unsure how to respond, please speak to your doctor. (Note: if you enrolled in Medicare Part B less than 7 months ago you do not have to answer this question and can skip to the **Past and Current Insurance Coverage** section.)

1E. Kidney Conditions

Chronic Renal Failure or Insufficiency _____

Polycystic Kidney Disease _____

Renal Artery Stenosis _____

1F. Liver

Cirrhosis of the Liver _____

1G. Transplants

Bone marrow or organ transplant _____

1H. Gastrointestinal Conditions

Chronic Pancreatitis _____

Esophageal Varices _____

1I. Musculoskeletal Conditions

Amputation due to disease _____

Rheumatoid Arthritis _____

Spinal Stenosis _____

1J. Substance Abuse

Alcohol Abuse or Alcoholism _____

Drug Abuse or use of illegal drugs _____

1K. Brain or Spinal Cord Conditions

Paraplegia, Quadriplegia or Hemiplegia _____

1L. Psychological/Mental Conditions

Bipolar or Manic Depressive _____

Schizophrenia _____

1M. Eye Condition

Macular Degeneration _____

1N. Nervous System Conditions

Amyotrophic Lateral Sclerosis (ALS) _____

Alzheimer's Disease or Dementia _____

Multiple Sclerosis (MS) _____

Parkinson's Disease _____

Systemic Lupus Erythematosus (SLE) _____

10. Immune System Conditions

AIDS _____

HIV positive _____

PLEASE READ

If you have indicated **YES** to any of the medical conditions in question in the **Health History Questions** section, your rate will be the level 2 rate.

Please continue to **Past and Current Insurance Coverage**.

Past and Current Insurance Coverage

Please review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare Supplement insurance policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- 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 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).

For your protection, you are required to answer the following questions. Please click "I have read and agree to the above" at the end of this section.

1. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.)

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.

Yes or No

2. Will Medicaid pay your premiums for this Medicare supplement policy?

Yes or No

3. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

Yes or No

PLEASE READ

If you indicated **YES** to question **1** please answer questions **2** and **3**.

If you indicated **NO** to question **1** please skip to question **4**.

Past and Current Insurance Coverage - continued

4. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

Yes or No

PLEASE READ

If you indicated **YES** to question 4 please enter your coverage start and end dates below and continue to questions 5, 6 and 7. (Note: if you are still covered under this plan, leave the End Date blank.)

If you indicated **NO** to question 4 please skip to question 8.

Start Date

End Date

5. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

Yes or No

6. Was this your first time in this type of Medicare plan?

Yes or No

7. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

Yes or No

8. Do you have another Medicare Supplement policy in force?

Yes or No

PLEASE READ

If you indicated **YES** to question 8 please continue to question 9.

If you indicated **NO** to question 8 please skip to question 10.

9. **If YES**, do you intend to replace your current Medicare Supplement policy with this policy?

Yes or No

10. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

Yes or No

PLEASE READ

If you indicated **YES** to question 10, please list with what company and what type of policy in the space provided below and continue to questions 11 and 12.

If you have indicated **NO** to question 10, please click "I have read and agree to the above" at the end of this section and move to the **Review and Submit** portion of the application.

Company Name

Policy Type

(HMO/PPO, Major Medical, Employer Plan, Union Plan or Other)

11. What are your dates of coverage under the policy you listed in 10? Leave the end date blank if you are still covered under the other policy.

Start Date

End Date

12. Are you replacing this health insurance?

Yes or No

I have read and agree to the above.

Today's Date

Review and Submit

Please read carefully and click “I have read and agree to the above” at the end of this section.

- My electronic signature indicates I have read and understand the contents of this application form.
- I declare the answers on this application form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this application form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- 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 when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I acknowledge that I have reviewed the **Guide to Health Insurance for People with Medicare**.
- I understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.
- If you are enrolling in a Medicare Select Plan: I acknowledge that I have reviewed the Outline of Coverage, Grievance Procedure, Provider Directory and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.

Authorization for the Release of Medical Information

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates (“The Company”) any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage and rate. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. This authorization is valid for 24 months from the date of my signature.

Please see “Your Guide” to determine if the following pre-existing condition waiting period applies to you.

I understand the plan will not pay for stays beginning or medical expenses incurred during the first 3 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 3 months prior to the insurance effective date.

Note: If you are signing as the legal representative for the applicant, please submit a copy of the appropriate legal documentation.

I have read and agree to the above.

Today's Date

Review and Submit - *continued*

Please read carefully and click “I have read and agree to the above” at the end of this section.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates (“The Company”) any data or records about me or my mental or physical health. I understand the purpose of this disclosure and

use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

Note: If you are signing as the legal representative for the applicant, please submit a copy of the appropriate legal documentation.

| |
|---|
| <input type="checkbox"/> I have read and agree to the above. _____ Today's Date |
|---|

SERFF Tracking Number: UHLC-127641579 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 49844
 Company Tracking Number: S07H49MNWBAR01 01B
 TOI: MS08G Group Medicare Supplement - Standard Sub-TOI: MS08G.001 Plan A 2010
 Plans 2010
 Product Name: GROUP MEDICARE SUPPLEMENT
 Project Name/Number: ENROLLMENT APPLICATION/S07H49MNWBAR01 01B

Supporting Document Schedules

| | | | |
|--------------------------|----------------------|-------------------------------------|-------------------------|
| | | Item Status: | Status |
| Satisfied - Item: | Flesch Certification | Accepted for Informational Purposes | Date: 12/09/2011 |

Comments:

Attachment:

READABILITY CERTIFICATION FORM.pdf

| | | | |
|--|--|---------------------|---------------|
| | | Item Status: | Status |
| | | | Date: |

Bypassed - Item: Application
Bypass Reason: Application attached under form schedule.

Comments:

| | | | |
|--|--|---------------------|---------------|
| | | Item Status: | Status |
| | | | Date: |

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: N/A

Comments:

| | | | |
|--|--|---------------------|---------------|
| | | Item Status: | Status |
| | | | Date: |

Bypassed - Item: Outline of Coverage
Bypass Reason: N/A

Comments:

| | | | |
|--------------------------|-----|-------------------------------------|-------------------------|
| | | Item Status: | Status |
| Satisfied - Item: | SOV | Accepted for Informational Purposes | Date: 12/09/2011 |

Comments:

SERFF Tracking Number: UHLC-127641579 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 49844
 Company Tracking Number: S07H49MNWBAR01 01B
 TOI: MS08G Group Medicare Supplement - Standard Sub-TOI: MS08G.001 Plan A 2010
 Plans 2010
 Product Name: GROUP MEDICARE SUPPLEMENT
 Project Name/Number: ENROLLMENT APPLICATION/S07H49MNWBAR01 01B

Attachment:

Web Application Statement of Variability.pdf

| | | Item Status: | Status Date: |
|--------------------------|-----------------|-------------------------------------|---------------------|
| Satisfied - Item: | Response letter | Accepted for Informational Purposes | 12/09/2011 |

Comments:

Attachment:

AR 11-424 oleGI.pdf

| | | Item Status: | Status Date: |
|--------------------------|-----------------|-------------------------------------|---------------------|
| Satisfied - Item: | Response letter | Accepted for Informational Purposes | 12/09/2011 |

Comments:

Attachment:

AR 11-465 oleGI.pdf

UNITED HEALTHCARE INSURANCE COMPANY
READABILITY CERTIFICATION

THIS IS TO CERTIFY THAT THE FOLLOWING FORM(S) HAVE ACHIEVED A
FLESCH READING EASE TEST SCORE OF:

FORM NUMBER

FLESCH SCORE

S07H49MNWBAR01 01B

50



SIGNATURE

Paul Kallmeyer, Assistant Secretary, UHIC
NAME AND TITLE

September 21, 2011
DATE

AARP Medicare Supplement Web Application
Statement of Variability

These are the conditions of variable text within this component:

- Page 1 – The Barcode position shown at bottom of page supports the hash-id and will vary according to the how the application is submitted.
- Page 1 – the phone number shown at the bottom of the page will vary based on the access point from where the user came to the application.
- Page 2 – Showing Plans D, G, and M will vary based on availability.

October 28, 2011

Stephanie Fowler, Reviewer
Arkansas Department of Insurance
VIA SERFF

RE: UnitedHealthcare Insurance Company
NAIC #: 0707-79413
Form #: S07H49MNWBAR01 01B
State Tracking Number: 49844

Dear Ms. Fowler:

This letter is in response to your October 5th objection. You had asked us to add additional language, directly above the application's health questions, regarding the ability for some to skip those questions, as well as the question regarding tobacco use. Based on the following, we respectfully request that this application be approved without revision.

The form at issue here will be used by consumers to complete their application online. We have placed the questions regarding eligibility for Guaranteed Issue / Open Enrollment above the health and tobacco questions, and any applicant who responds "yes" to the GI / OE questions will not, as a technical matter, even be able to respond to the health or tobacco questions; the answer space will not be fillable. That is in addition to our inclusion of clear directional copy within the GI / OE section which instructs eligible individuals to skip over and to not answer the health or tobacco questions.

Based on the mechanisms and safeguards already in place, we ask that this filing be approved for use in your state. Please contact our office if you have further questions or concerns.

Sincerely,



Judah Rosenstein, Compliance Consultant



December 8, 2011

Stephanie Fowler, Reviewer
Arkansas Department of Insurance
VIA SERFF

RE: UnitedHealthcare Insurance Company
NAIC #: 0707-79413
Form #: S07H49MNVBAR01 01B
State Tracking Number: 49844

Dear Ms. Fowler:

This letter is in response to your November 8th objection which reiterated the need for additional language above the tobacco usage question. Based on the following, we respectfully request that this application be approved.

Pursuant to your request, we added the following statement above the tobacco usage question:

“Under Open Enrollment, you are not required to answer questions regarding Tobacco Usage.”

A revised copy of the application is attached for your review. Please contact our office if you have further questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read 'Judah Rosenstein', written in a cursive style.

Judah Rosenstein, Compliance Consultant