

SERFF Tracking Number: RSLI-127024251 State: Arkansas
Filing Company: Reliance Standard Life Insurance Company State Tracking Number: 47930
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Multi-Line
Project Name/Number: New Enr and Health Statement/LRS-9457-0111

Filing at a Glance

Company: Reliance Standard Life Insurance Company

Product Name: Multi-Line

SERFF Tr Num: RSLI-127024251

State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-Closed

State Tr Num: 47930

Sub-TOI: H21.000 Health - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Barbara Walker

Disposition Date: 02/22/2011

Date Submitted: 02/08/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: New Enr and Health Statement

Project Number: LRS-9457-0111

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type:

Filing Status Changed: 02/22/2011

State Status Changed: 02/22/2011

Created By: Barbara Walker

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Submitting:

An enrollment and statement of health form for general use.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Barbara Walker

Form:

Enrollment and Statement of Health

Form Number

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LRS-9457-0111

The captioned form is a new general use form and does not replace any form(s) currently on file. It will be used for enrollments and, when required, for medical underwriting.

The form will be used with our Group Life and Group Health plans. It is not part of a Group Policy, nor is it attached to an individual Certificate.

As submitted, the form includes variability (indicated by surrounding brackets) as to inclusion and/or text. This variability will enable us to tailor the form on a case-specific basis and/or plan-specific basis. For example, if the only plan on a case is an accidental death/dismemberment plan, then the Health Questions section will not print because that plan does not involve medical underwriting.

You will note that there is no fraud notice on the submitted form. This is because we have grouped all fraud notices on a separate page that will be included with the Enrollment and Statement of Health form. I have included an informational copy of the fraud notice page for your reference.

The form is submitted in final print format, having been printed on a laser printer. Printing is subject to changes in ink, paper stock, formatting, margins and positioning. In addition to a paper form, the form may also be presented in electronic format for client and/or applicant access via the Internet.

I trust this filing is in order and you will find the submitted form acceptable.

Company and Contact

Filing Contact Information

Barbara Walker, Senior Compliance Specialist barbara.walker@rsli.com
2001 Market Street 800-351-7500 [Phone] 3607 [Ext]
Suite 1500 267-256-3546 [FAX]
Philadelphia, PA 19103-7090

Filing Company Information

Reliance Standard Life Insurance Company	CoCode: 68381	State of Domicile: Illinois
2001 Market Street	Group Code:	Company Type:
Suite 1500	Group Name:	State ID Number:
Philadelphia, PA 19103-7090	FEIN Number: 36-0883760	
(800) 351-7500 ext. [Phone]		

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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: Domicile state (IL) fee = \$50.00 per form

1 form X \$50.00 = \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reliance Standard Life Insurance Company	\$50.00	02/08/2011	44509117

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/22/2011	02/22/2011

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Disposition

Disposition Date: 02/22/2011

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Reviewed-No Actuary

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	Important Information Regarding Applications for Insurance	Approved-Closed	Yes
Form	Enrollment and Statement of Health	Approved-Closed	Yes

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Form Schedule

Lead Form Number: LRS-9457-0111

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/22/2011	LRS-9457-0111	Application/Enrollment and Enrollment Form	Statement of Health	Initial			LRS-9457-0111 Version V.9.pdf

[Employee/Member] Name	Date of Birth
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Health Questions

Answer all questions on this page [for each person being underwritten for insurance]. For any "Yes" answer, underline the condition and record details in the space provided on the next page. Failure to provide details of a condition will cause a delay in the review of your application.

	EMPLOYEE	[SPOUSE
Enter height and weight.	Ht. __ft. __in. Wt. _____ lbs	Ht. __ft. __in. Wt. _____ lbs
1. In the past [10 years], have you or your spouse been treated for or diagnosed as having: heart, liver (biliary cirrhosis) or kidney disorder; an abnormal colonoscopy, requiring follow-up; neurological disorder; diabetes; high blood pressure; thyroid disorder; stroke; transient ischemic attack (TIA); cancer and/or tumor malignant or benign; mental or nervous disorder; or been advised to have treatment for drug abuse (illegal or prescription drugs) or alcoholism?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past [10 years], have you or your spouse been diagnosed with or treated for: chronic pain; arthritis (lupus, rheumatoid or osteoarthritis); musculoskeletal (back, neck or muscle) condition; respiratory disorder including asthma, chronic obstructive pulmonary disease (COPD); or emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you or your spouse: (a) in the past [year] had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); or lymphadenopathy (enlarged or swollen glands)? or (b) in the past [10 years] ever tested positive or been treated for HIV (Human Immunodeficiency Virus) antibodies, AIDS or AIDS-related complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past [10 years], have you or your spouse: (a) consulted with or been examined or treated by a physician, practitioner or specialist (include routine physicals only when there is an existing or newly diagnosed medical condition)? (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation? or (c) been prescribed medication(s) (other than for colds, flu or allergies)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you currently pregnant? In the past [10 years], have you or your spouse been diagnosed with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Answer question 6 only if applying for Critical Illness insurance.		
6. Have two or more of your or your spouse's biological parents, brothers or sisters (either living or dead) been diagnosed with the same condition from the following list of conditions: diabetes, heart disease, stroke, kidney disease or cancer (other than skin cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]

[Employee/Member] Primary Care Physician's Full Name	Office Phone Number
Address	

[Spouse Primary Care Physician's Full Name	Office Phone Number
Address]	

[Employee/Member] Name	Date of Birth
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[Details]

Please provide all names used for medical records (if different than the names provided on this form): _____

For each "Yes" response to a health question, please provide details below.

Question #	Illness or Nature of Injury	Date	Physician's Full Name and Address (if different than Primary)	Check One Employee or Spouse	

If you need more space, check here . Complete, sign and date a separate sheet of paper and attach it to this page.]

Read, Sign and Date Below

I understand and agree that:

- The information provided on this [Enrollment and Statement of Health] form is true and correct to the best of my knowledge.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy [; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request]. [Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.]
- Benefits are subject to terms and conditions of the Policy.
- For age-banded rate plans, premiums increase as an employee [(or spouse, if applicable)] moves from one age band to the next.
- [If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.]

[I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.]

I acknowledge receipt of the ["Designation of Beneficiary" form and], "Important Information Regarding Applications for Insurance" [and "Notice Regarding Information Practices".] [If a Designation of Beneficiary form is not completed or one is not on file with the Plan Administrator, the provisions of the Policy will determine to whom benefits, if any, will be payable.]

[AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the Medical Information Bureau (MIB) to release any information or record(s) on me or my health to be used in determining the acceptability of my application for insurance. I authorize any such information or record(s) to be released to Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize Reliance Standard or its reinsurers to make a brief report to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding [twelve (12)] months from this date. I understand that I (or my authorized representative) will be sent a copy of this Authorization upon request.]

[Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself [(and/or your spouse, if applicable)]; or b) during your present service with your employer or an affiliate, you [(and/or your spouse, if applicable,)] have not, with respect to insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.]

X _____ [Employee's/Member's] Signature (required at all times)	_____ Date	[X _____ Spouse's Signature (required if spouse Statement of Health required)]	_____ Date
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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	02/22/2011
Bypass Reason:	Not applicable to thi filing.		
Comments:			
Bypassed - Item:	Application	Approved-Closed	02/22/2011
Bypass Reason:	Not applicable to this filing.		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	02/22/2011
Bypass Reason:	Not applicable to this filing.		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	02/22/2011
Bypass Reason:	Not applicable to this filing.		
Comments:			
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	02/22/2011
Bypass Reason:	Not applicable to this filing.		
Comments:			

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	Item Status:	Status Date:
Satisfied - Item: Important Information Regarding Applications for Insurance	Approved-Closed	02/22/2011

Comments:

This page is submitted for informational purposes, evidencing presentation of the Arkansas fraud notice This page will accompany the submitted form.

Attachment:

Important Info Re Apps for Insurance.pdf

Important Information Regarding Applications for Insurance

The information provided on the [Enrollment and Statement of Health] form will be used in determining the insurability of a person proposed for insurance. Responsible parties completing and submitting a Statement of Health form are required to be made aware of the following statements concerning the consequences of insurance fraud. The lack of an applicable statement shall not constitute a defense against penalties.

ARKANSAS and LOUISIANA — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **COLORADO** — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **FLORIDA** — Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **KENTUCKY** — 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 commits a fraudulent insurance act, which is a crime. **MAINE** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MARYLAND** — Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NEW JERSEY** — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NEW MEXICO** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **NEW YORK (health insurance only)** — 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **OHIO** — 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 a false or deceptive statement is guilty of insurance fraud. **PENNSYLVANIA** — 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 subjects such person to criminal and civil penalties. **RHODE ISLAND** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **TENNESSEE, VIRGINIA, WASHINGTON** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **WASHINGTON, DC** — It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KEEP THIS INFORMATION PAGE FOR YOUR RECORDS.

RELIANCE STANDARD

Home Office: Chicago, Illinois/Administrative Office: Philadelphia, PA