

SERFF Tracking Number:	UCIN-127062610	State:	Arkansas
Filing Company:	United Concordia Insurance Company	State Tracking Number:	48269
Company Tracking Number:	AR/UCIC/001-11		
TOI:	H10I Individual Health - Dental	Sub-TOI:	H10I.000 Health - Dental
Product Name:	Individual		
Project Name/Number:	iDental New Products/AR/UCIC/001-11		

## Filing at a Glance

Company: United Concordia Insurance Company

Product Name: Individual

SERFF Tr Num: UCIN-127062610 State: Arkansas

TOI: H10I Individual Health - Dental

SERFF Status: Closed-Approved-Closed  
State Tr Num: 48269

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: AR/UCIC/001-11 State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Michelle Shutt, Benjamin Schaefer, Krista Maddigan, Kathleen McGonigle, Stacy Bell  
Disposition Date: 03/18/2011

Date Submitted: 03/17/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: iDental New Products

Status of Filing in Domicile: Pending

Project Number: AR/UCIC/001-11

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: AZ is the state of domicile and the filing is pending with AZ for approval.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 03/18/2011

State Status Changed: 03/18/2011

Deemer Date:

Created By: Michelle Shutt

Submitted By: Benjamin Schaefer

Corresponding Filing Tracking Number:

Filing Description:

United Concordia Insurance Company (UCIC), a licensed accident and health insurer, is submitting this filing for approval. The filing contains five (5) new Schedules of Benefits and a revised application for the Individual Dental market.

The application replaces the prior Application for Dental Insurance, ARINAPP-0309, approved on 12/01/2010. The only change to the revised application is under the Plan Selection. The prior application had specific choices for the member

SERFF Tracking Number: UCIN-127062610 State: Arkansas  
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 Product Name: Individual  
 Project Name/Number: iDental New Products/AR/UCIC/001-11

to select and with the addition five (5) new schedules, we replaced the boxes with a fill-in blank line.

## Company and Contact

### Filing Contact Information

Ben Schaefer, Filing Project Manager ucdoicorro@ucci.com  
 4401 Deer Path Road 717-260-6911 [Phone]  
 DPLR4 717-260-7494 [FAX]  
 Harrisburg, PA 17110

### Filing Company Information

United Concordia Insurance Company CoCode: 85766 State of Domicile: Arizona  
 4401 Deer Path Road Group Code: 812 Company Type: LAH  
 Harrisburg, PA 17110 Group Name: Highmark State ID Number:  
 (800) 929-0538 ext. 57225[Phone] FEIN Number: 86-0307623

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$300.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Concordia Insurance Company	\$300.00	03/17/2011	45704336

SERFF Tracking Number: UCIN-127062610 State: Arkansas  
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Product Name: Individual  
Project Name/Number: iDental New Products/AR/UCIC/001-11

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/18/2011	03/18/2011

SERFF Tracking Number: UCIN-127062610 State: Arkansas  
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 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: Individual  
 Project Name/Number: iDental New Products/AR/UCIC/001-11

## Disposition

Disposition Date: 03/18/2011

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
United Concordia Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%
	<b>Percent Change Approved:</b>						
	<b>Minimum:</b>	%	<b>Maximum:</b>	%	<b>Weighted Average:</b>		%

SERFF Tracking Number: UCIN-127062610 State: Arkansas  
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269  
 Company Tracking Number: AR/UCIC/001-11  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: Individual  
 Project Name/Number: iDental New Products/AR/UCIC/001-11

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	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	IND101 Schedule of Benefits	Approved-Closed	Yes
Form	IND201 Schedule of Benefits	Approved-Closed	Yes
Form	IND301 Schedule of Benefits	Approved-Closed	Yes
Form	IND401 Schedule of Benefits	Approved-Closed	Yes
Form	IND501 Schedule of Benefits	Approved-Closed	Yes
Form	Application for Individual Dental Insurance	Approved-Closed	Yes
Rate	AR Rates 01 Region 2 2011	Approved-Closed	Yes

SERFF Tracking Number: UCIN-127062610 State: Arkansas  
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269  
 Company Tracking Number: AR/UCIC/001-11  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: Individual  
 Project Name/Number: iDental New Products/AR/UCIC/001-11

## Form Schedule

### Lead Form Number: INS-1-0311

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/18/2011	INS-1-0311	Schedule Pages	IND101 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND101 0311.pdf
Approved-Closed 03/18/2011	INS-2-0311	Schedule Pages	IND201 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND201 0311.pdf
Approved-Closed 03/18/2011	INS-3-0311	Schedule Pages	IND301 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND301 0311.pdf
Approved-Closed 03/18/2011	INS-4-0311	Schedule Pages	IND401 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND401 0311.pdf
Approved-Closed 03/18/2011	INS-5-0311	Schedule Pages	IND501 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND501 0311.pdf
Approved-Closed 03/18/2011	ARINAPP-0311	Application/ Enrollment Form	Application for Individual Dental Insurance	Revised	Replaced Form #: ARINAPP-0311 Previous Filing #: 45832	0.000	AR individual_enrollment--Revised 2011.pdf

## Schedule of Benefits

<b>Annual Deductible Per Insured Person</b>	<b>\$0 Per Contract Year</b>
<b>Annual Maximum Per Insured Person</b>	<b>Unlimited Per Contract Year</b>
<b>Policy Pays</b>	
<b>Class I / Diagnostic and Preventive Services (No Waiting Period)</b>	
• Exams	<b>100%</b>
• All X-Rays	<b>100%</b>
• Cleanings	<b>100%</b>
• Fluoride Treatments	<b>100%</b>
• Palliative Treatment (Emergency)	<b>100%</b>
<b>Class II / Basic Services (No Waiting Period)</b>	
• Sealants	<b>0%</b>
• Space Maintainers	<b>0%</b>
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	<b>0%</b>
• Basic Restorative (Fillings, etc.)	<b>0%</b>
• Simple Extractions	<b>0%</b>
<b>Class III / Major Services (No Waiting Period)</b>	
• Complex Oral Surgery	<b>0%</b>
• Endodontics (Root canals, etc.)	<b>0%</b>
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	<b>0%</b>
• Non-surgical Periodontics	<b>0%</b>
• Surgical Periodontics	<b>0%</b>
• Crowns, Inlays, Onlays	<b>0%</b>
• Prosthetics (Fixed Partial Dentures, Dentures)	<b>0%</b>

The percentage in the Policy Pays column is the percentage of the Policy's Maximum Allowable Charge that the Policy will pay for Covered Services provided by either a Participating Dentist or a Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

## Schedule of Benefits

<b>Annual Deductible Per Insured Person (Applies to all Covered Services)</b>	<b>\$50 Per Contract Year</b>
<b>Annual Maximum Per Insured Person</b>	<b>\$1,500 Per Contract Year</b>
<b>Policy Pays</b>	
<b>Class I / Diagnostic and Preventive Services (No Waiting Period)</b>	
• Exams	<b>100%</b>
• All X-Rays	<b>100%</b>
• Cleanings	<b>100%</b>
• Fluoride Treatments	<b>100%</b>
• Palliative Treatment (Emergency)	<b>100%</b>
<b>Class II / Basic Services (after a six (6) month Waiting Period)</b>	
• Sealants	<b>80%</b>
• Space Maintainers	<b>80%</b>
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	<b>80%</b>
• Basic Restorative (Fillings, etc.)	<b>80%</b>
• Simple Extractions	<b>80%</b>
<b>Class III / Major Services (No Waiting Period)</b>	
• Complex Oral Surgery	<b>0%</b>
• Endodontics (Root canals, etc.)	<b>0%</b>
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	<b>0%</b>
• Non-surgical Periodontics	<b>0%</b>
• Surgical Periodontics	<b>0%</b>
• Crowns, Inlays, Onlays	<b>0%</b>
• Prosthetics (Fixed Partial Dentures, Dentures)	<b>0%</b>

**The percentage in the Policy Pays column is the percentage of the Policy's Maximum Allowable Charge that the Policy will pay for Covered Services provided by either a Participating Dentist or a Non-Participating Dentist.**

**Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.**

**All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.**

## Schedule of Benefits

<b>Annual Deductible Per Insured Person (Applies to all Covered Services)</b>	<b>\$50 Per Contract Year</b>
<b>Annual Maximum Per Insured Person</b>	<b>\$1,500 Per Contract Year</b>
<b>Policy Pays</b>	
<b>Class I / Diagnostic and Preventive Services (No Waiting Period)</b>	
• Exams	<b>50%</b>
• All X-Rays	<b>50%</b>
• Cleanings	<b>50%</b>
• Fluoride Treatments	<b>50%</b>
• Palliative Treatment (Emergency)	<b>50%</b>
<b>Class II / Basic Services (after a six (6) month Waiting Period)</b>	
• Sealants	<b>50%</b>
• Space Maintainers	<b>50%</b>
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	<b>50%</b>
• Basic Restorative (Fillings, etc.)	<b>50%</b>
• Simple Extractions	<b>50%</b>
<b>Class III / Major Services (No Waiting Period)</b>	
• Complex Oral Surgery	<b>0%</b>
• Endodontics (Root canals, etc.)	<b>0%</b>
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	<b>0%</b>
• Non-surgical Periodontics	<b>0%</b>
• Surgical Periodontics	<b>0%</b>
• Crowns, Inlays, Onlays	<b>0%</b>
• Prosthetics (Fixed Partial Dentures, Dentures)	<b>0%</b>

The percentage in the Policy Pays column is the percentage of the Policy's Maximum Allowable Charge that the Policy will pay for Covered Services provided by either a Participating Dentist or a Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

## Schedule of Benefits

<b>Annual Deductible Per Insured Person (Applies to all Covered Services)</b>	<b>\$50 Per Contract Year</b>
<b>Annual Maximum Per Insured Person</b>	<b>\$1,500 Per Contract Year</b>
<b>Policy Pays</b>	
<b>Class I / Diagnostic and Preventive Services (No Waiting Period)</b>	
• Exams	<b>100%</b>
• All X-Rays	<b>100%</b>
• Cleanings	<b>100%</b>
• Fluoride Treatments	<b>100%</b>
• Palliative Treatment (Emergency)	<b>100%</b>
<b>Class II / Basic Services (after a six (6) month Waiting Period)</b>	
• Sealants	<b>80%</b>
• Space Maintainers	<b>80%</b>
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	<b>80%</b>
• Basic Restorative (Fillings, etc.)	<b>50%</b>
• Simple Extractions	<b>50%</b>
<b>Class III / Major Services (after a twelve (12) month Waiting Period)</b>	
• Complex Oral Surgery	<b>50%</b>
• Endodontics (Root canals, etc.)	<b>50%</b>
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	<b>50%</b>
• Non-surgical Periodontics	<b>50%</b>
• Surgical Periodontics	<b>50%</b>
• Crowns, Inlays, Onlays	<b>50%</b>
• Prosthetics (Fixed Partial Dentures, Dentures)	<b>50%</b>

The percentage in the Policy Pays column is the percentage of the Policy's Maximum Allowable Charge that the Policy will pay for Covered Services provided by either a Participating Dentist or a Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

## Schedule of Benefits

<b>Annual Deductible Per Insured Person (Applies to Class II and Class III Services)</b>	<b>\$50 Per Contract Year</b>
<b>Annual Maximum Per Insured Person</b>	<b>\$1,500 Per Contract Year</b>
<b>Policy Pays</b>	
<b>Class I / Diagnostic and Preventive Services (No Waiting Period)</b>	
• Exams	<b>0%</b>
• All X-Rays	<b>0%</b>
• Cleanings	<b>0%</b>
• Fluoride Treatments	<b>0%</b>
• Palliative Treatment (Emergency)	<b>60%</b>
<b>Class II / Basic Services (after a six (6) month Waiting Period)</b>	
• Sealants	<b>0%</b>
• Space Maintainers	<b>0%</b>
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	<b>0%</b>
• Basic Restorative (Fillings, etc.)	<b>60%</b>
• Simple Extractions	<b>60%</b>
<b>Class III / Major Services (after a six (6) month Waiting Period)</b>	
• Complex Oral Surgery	<b>60%</b>
• Endodontics (Root canals, etc.)	<b>60%</b>
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	<b>60%</b>
• Non-surgical Periodontics	<b>60%</b>
• Surgical Periodontics	<b>60%</b>
• Crowns, Inlays, Onlays	<b>60%</b>
• Prosthetics (Fixed Partial Dentures, Dentures)	<b>60%</b>

**The percentage in the Policy Pays column is the percentage of the Policy's Maximum Allowable Charge that the Policy will pay for Covered Services provided by either a Participating Dentist or a Non-Participating Dentist.**

**Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.**

**All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.**

<b>SECTION A: POLICYHOLDER'S INFORMATION</b>			<b>Requested Effective Date</b>	
<b>Social Security Number</b>		<b>Phone Number</b>		
<b>Policyholder's Name</b> (Last, First, Middle Initial, Suffix)		<b>Date of Birth</b>		<b>Gender</b>
<b>Home Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Email Address</b>				

<b>SECTION B: DEPENDENT INFORMATION</b>						
<b>Social Security Number</b>	<b>Type</b>	<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Gender</b>	<b>Date of Birth</b>
	Spouse/ Domestic Partner					
	Dependent (A)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (B)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (C)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (D)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>

**Replacement of Coverage – Is this insurance intended to replace ANY current dental insurance?**  Yes  No **If yes, complete the following:**

**Insurance Company Name:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

<b>SECTION C: GENERAL INFORMATION</b>		
<b>Premium Payment Frequency:</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	<b>My Individual Dental Insurance will be covering:</b> <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Self and one dependent <hr/> <b>Premium Payment (\$):</b>	<b>Plan Selection:</b> _____

I represent that all information supplied in this application is true and correct. 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.

**Policyholder's Signature**

**Date**

SECTION D: PRODUCER / AGENCY / GENERAL AGENT (IF APPLICABLE)		
Producer Name		Social Security Number
United Concordia Producer ID Number	State	License Number
Signature		Date
Agency Name		Agency Tax ID Number
United Concordia Producer ID Number	State	License Number
General Agent Name		General Agent Tax ID Number
United Concordia Producer ID Number	State	License Number

### APPLICABLE STATE MANDATED PROVISIONS

**AR:** 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.

**LA & RI:** 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.

**CA:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

**FL:** 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.

**KS:** Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

**KY:** 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.

**MD:** Any person who knowingly presents a false or fraudulent claim form 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.

**NJ:** All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NY:** 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.

**OR:** Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

**PA:** 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.

**TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**VA:** Any person who within the 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 may have violated the state law.

**WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

### UNITED CONCORDIA OPERATES AS A WHOLLY OWNED SUBSIDIARY UNDER THE NAME LISTED BELOW IN THE FOLLOWING STATES:

- United Concordia Dental Corporation of Alabama—AL
- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY

**UNITED CONCORDIA**  
Insuring America's Dental Health

SERFF Tracking Number: UCIN-127062610 State: Arkansas  
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269  
 Company Tracking Number: AR/UCIC/001-11  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: Individual  
 Project Name/Number: iDental New Products/AR/UCIC/001-11

**Rate Information**

Rate data applies to filing.

**Filing Method:** 0  
**Rate Change Type:** Neutral  
**Overall Percentage of Last Rate Revision:** 0.000%  
**Effective Date of Last Rate Revision:**  
**Filing Method of Last Filing:** N/A

**Company Rate Information**

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
United Concordia Insurance Company	N/A	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: UCIN-127062610 State: Arkansas  
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 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: Individual  
 Project Name/Number: iDental New Products/AR/UCIC/001-11

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 03/18/2011	AR Rates 01 Region 2 2011	ARIN01-0310UCIC, INS-1-0311, INS-2-0311, INS-3-0311, INS-4-0311, INS-5-0311	New		AR individua_enrollm ent--Revised MARK-UP.pdf

# UNITED CONCORDIA Application for Individual Dental Insurance

<b>SECTION A: POLICYHOLDER'S INFORMATION</b>			<b>Requested Effective Date</b>		
<b>Social Security Number</b>		<b>Phone Number</b>			
<b>Policyholder's Name</b> (Last, First, Middle Initial, Suffix)		<b>Date of Birth</b>		<b>Gender</b>	
<b>Home Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>	
<b>Email Address</b>					

<b>SECTION B: DEPENDENT INFORMATION</b>						
<b>Social Security Number</b>	<b>Type</b>	<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Gender</b>	<b>Date of Birth</b>
	Spouse/ Domestic Partner					
	Dependent (A)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (B)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (C)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (D)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>

Replacement of Coverage – Is this insurance intended to replace ANY current dental insurance?  Yes  No If yes, complete the following:

Insurance Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

<b>SECTION C: GENERAL INFORMATION</b>		
<b>Premium Payment Frequency:</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	<b>My Individual Dental Insurance will be covering:</b> <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Self and one dependent <b>Premium Payment (\$):</b>	<b>Plan Selection:</b> <input type="checkbox"/> IND 100 <input type="checkbox"/> IND 400 <input type="checkbox"/> IND 200 <input type="checkbox"/> IND 500 <input type="checkbox"/> IND 300

I represent that all information supplied in this application is true and correct. 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.

Policyholder's Signature

Date

SECTION D: PRODUCER / AGENCY / GENERAL AGENT (IF APPLICABLE)		
Producer Name		Social Security Number
United Concordia Producer ID Number	State	License Number
Signature		Date
Agency Name		Agency Tax ID Number
United Concordia Producer ID Number	State	License Number
General Agent Name		General Agent Tax ID Number
United Concordia Producer ID Number	State	License Number

**APPLICABLE STATE MANDATED PROVISIONS**

- AR &** Any person who knowingly presents a false or fraudulent claim
- LA:** 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.
- CA:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
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- NJ:** All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- NY:** 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.
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- VA:** Any person who within the 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 may have violated the state law.
- WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**UNITED CONCORDIA OPERATES AS A WHOLLY OWNED SUBSIDIARY UNDER THE NAME LISTED BELOW IN THE FOLLOWING STATES:**

- United Concordia Dental Corporation of Alabama—AL
- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY

SERFF Tracking Number: UCIN-127062610 State: Arkansas  
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269  
 Company Tracking Number: AR/UCIC/001-11  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: Individual  
 Project Name/Number: iDental New Products/AR/UCIC/001-11

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	03/18/2011
<b>Comments:</b>		
<b>Attachment:</b> AR Readability (signed).pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	03/18/2011
<b>Comments:</b> A revised application is attached. A mark-up copy is provided for ease of review.		
<b>Attachments:</b> AR individual_enrollment--Revised 2011.pdf AR individua_enrollment--Revised MARK-UP.pdf		

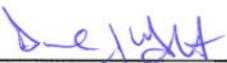
	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	03/18/2011
<b>Bypass Reason:</b> The Outline of Coverage (form number ARIN0C-0309UCIC) filed and approved under SERFF filing number FRCS-126643128/state tracking number 45832 will be used with the filed schedules of benefits.		
<b>Comments:</b>		

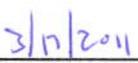
STATE OF ARKANSAS  
READABILITY CERTIFICATION

UNITED CONCORDIA INSURANCE COMPANY

By signature below, it is certified that the forms listed below achieve a Flesch Reading Ease Score above the minimum reading ease score of 40 as required by the Arkansas Code Annotated § 23-80-206(a)(1).

Form Name	Form Number
Individual Application for Dental Insurance	ARINAPP-0311
Schedule of Benefits	INS-1-0311
Schedule of Benefits	INS-2-0311
Schedule of Benefits	INS-3-0311
Schedule of Benefits	INS-4-0311
Schedule of Benefits	INS-5-0311

  
\_\_\_\_\_  
Daniel J. Wright  
Treasurer, Vice-President and Controller

  
\_\_\_\_\_  
Date

<b>SECTION A: POLICYHOLDER'S INFORMATION</b>			<b>Requested Effective Date</b>		
<b>Social Security Number</b>			<b>Phone Number</b>		
<b>Policyholder's Name</b> (Last, First, Middle Initial, Suffix)			<b>Date of Birth</b>		<b>Gender</b>
<b>Home Address</b>			<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Email Address</b>					

<b>SECTION B: DEPENDENT INFORMATION</b>						
Social Security Number	Type	Last Name	First Name	MI	Gender	Date of Birth
	Spouse/ Domestic Partner					
	Dependent (A)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (B)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (C)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (D)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>

**Replacement of Coverage – Is this insurance intended to replace ANY current dental insurance?**  Yes  No **If yes, complete the following:**

**Insurance Company Name:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

<b>SECTION C: GENERAL INFORMATION</b>		
<b>Premium Payment Frequency:</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	<b>My Individual Dental Insurance will be covering:</b> <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Self and one dependent <hr/> <b>Premium Payment (\$):</b>	<b>Plan Selection:</b> <hr/>

I represent that all information supplied in this application is true and correct. 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.

**Policyholder's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

SECTION D: PRODUCER / AGENCY / GENERAL AGENT (IF APPLICABLE)		
Producer Name		Social Security Number
United Concordia Producer ID Number	State	License Number
Signature		Date
Agency Name		Agency Tax ID Number
United Concordia Producer ID Number	State	License Number
General Agent Name		General Agent Tax ID Number
United Concordia Producer ID Number	State	License Number

### APPLICABLE STATE MANDATED PROVISIONS

**AR:** 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.

**LA & RI:** 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.

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### UNITED CONCORDIA OPERATES AS A WHOLLY OWNED SUBSIDIARY UNDER THE NAME LISTED BELOW IN THE FOLLOWING STATES:

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- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY

**UNITED CONCORDIA**  
Insuring America's Dental Health

# UNITED CONCORDIA Application for Individual Dental Insurance

<b>SECTION A: POLICYHOLDER'S INFORMATION</b>			<b>Requested Effective Date</b>		
<b>Social Security Number</b>			<b>Phone Number</b>		
<b>Policyholder's Name</b> (Last, First, Middle Initial, Suffix)			<b>Date of Birth</b>		<b>Gender</b>
<b>Home Address</b>			<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Email Address</b>					

<b>SECTION B: DEPENDENT INFORMATION</b>						
<b>Social Security Number</b>	<b>Type</b>	<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Gender</b>	<b>Date of Birth</b>
	Spouse/ Domestic Partner					
	Dependent (A)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
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	Dependent (C)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (D)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>

Replacement of Coverage – Is this insurance intended to replace ANY current dental insurance?  Yes  No If yes, complete the following:

Insurance Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

<b>SECTION C: GENERAL INFORMATION</b>		
<b>Premium Payment Frequency:</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	<b>My Individual Dental Insurance will be covering:</b> <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Self and one dependent <b>Premium Payment (\$):</b>	<b>Plan Selection:</b> <input type="checkbox"/> IND 100 <input type="checkbox"/> IND 400 <input type="checkbox"/> IND 200 <input type="checkbox"/> IND 500 <input type="checkbox"/> IND 300

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Policyholder's Signature

Date

SECTION D: PRODUCER / AGENCY / GENERAL AGENT (IF APPLICABLE)		
Producer Name		Social Security Number
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