

SERFF Tracking Number: CEUL-127147319 State: Arkansas
Filing Company: Central United Life Insurance Company State Tracking Number: 48663
Company Tracking Number:
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: EAP Application
Project Name/Number: /

Filing at a Glance

Company: Central United Life Insurance Company

Product Name: EAP Application

SERFF Tr Num: CEUL-127147319 State: Arkansas

TOI: H02I Individual Health - Accident Only

SERFF Status: Closed-Approved-
Closed State Tr Num: 48663

Sub-TOI: H02I.000 Health - Accident Only

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Leigh Floyd, Rebecca
Podowski

Disposition Date: 05/04/2011

Date Submitted: 05/03/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/04/2011

State Status Changed: 05/04/2011

Deemer Date:

Created By: Rebecca Podowski

Submitted By: Rebecca Podowski

Corresponding Filing Tracking Number:

Filing Description:

We are filing a new application to correspond with a previous approved accident-only product. The base policy form number is EAP-AR, approved on 3/19/2001. The new application form number is CUL-ESAE-AR-0611 and will be issued on an individual basis.

Central United Life Insurance Company appreciates the Department's time in reviewing our filing.

Company and Contact

Filing Contact Information

SERFF Tracking Number: CEUL-127147319 State: Arkansas
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 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: EAP Application
 Project Name/Number: /

Rebecca Podowski, rpodowsk@manhattanlife.com
 10700 Northwest Freeway 713-529-0045 [Phone]
 Houston, TX 77092

Filing Company Information

Central United Life Insurance Company	CoCode: 61883	State of Domicile: Arkansas
Wortham Tower	Group Code: 117	Company Type:
2727 Allen Parkway	Group Name:	State ID Number:
Suite 500	FEIN Number: 42-0884060	
Houston, TX 77019-2100		
(713) 529-0045 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Central United Life Insurance Company	\$50.00	05/03/2011	47218359

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/04/2011	05/04/2011

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Disposition

Disposition Date: 05/04/2011

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	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
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 05/04/2011	CUL- ESAE-0611	Application/ Enrollment Form	Application/ Enrollment Form	Initial			CUL-ESAE- 0611.pdf

CENTRAL UNITED LIFE INSURANCE COMPANY

[10700 Northwest Freeway, Houston, Texas 77092]

Application for: Enhanced Supplemental Accident Expense Policy

Requested Effective Date: _____

PART 1 - GENERAL INFORMATION

1. PERSONS TO BE COVERED

Name (Please PRINT Full Name)	Relationship	Gender	Date of Birth	Age	Height Ft. In.	Weight Lbs.	Social Security Number
1.	Applicant						- -
2.	Spouse						- -
3.	Child						- -
4.	Child						- -
5.	Child						- -

2. APPLICANT'S HOME ADDRESS

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____
Work Phone: (_____) _____
Email Address: _____

3. PREMIUM PAYOR ADDRESS (if different than Applicant)

Premium Payor Name: _____
Address: [_____]
City: _____ State: _____ Zip: _____
Phone: (_____) _____

4. EMPLOYMENT INFORMATION (All adult applicants)

Employer's Name: _____
Occupation/Duties: _____
Spouse's Employer's Name (if applying): _____
Spouse's Occupation/Duties: _____

5. BENEFIT INFORMATION: Accident Policy

Benefit Amount: Medical Expense Benefit
[.5 Unit 1.0 Unit 1.5 Unit 2.0 Units]
Plan Type: Individual Individual & Spouse
 Single Parent Family Child(ren) Only
Billing Method: Monthly Bank Draft Direct Bill List Bill
Billing Mode: Monthly Quarterly Semi-Annual Annual

6. OPTIONAL RIDER: Accident Disability Rider Yes No

Occupation: Type 1 Type 2
Benefit Amount: Accident Disability Monthly Income Benefit
[.5 Unit 1.0 Unit 1.5 Unit 2.0 Units]
Units elected for Optional Accident Disability Rider may be less than or equal to but cannot exceed the number of units elected for the Accident Policy.

7. BENEFICIARY

Name: _____
Relationship: _____

8. PRIMARY PHYSICIAN

Name: _____
Address: _____
Phone: _____

PART 2 - REPRESENTATION & QUESTIONS OF THE APPLICANT

	YES	NO
1. Are all persons to be insured to the best of your knowledge and belief in good health and free from physical impairment or abnormality?	<input type="checkbox"/>	<input type="checkbox"/>
2a. Is any person to be insured engaged in any hazardous sports or activities including racing, but not limited to parachuting, rodeo riding, mountain climbing, scuba diving or intend to do so?	<input type="checkbox"/>	<input type="checkbox"/>
2b. Is any person to be insured a member/participant in collegiate athletics, a semi-professional or professional sport?	<input type="checkbox"/>	<input type="checkbox"/>
3a. Have you had a driver's license suspended or revoked within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
3b. Have you had a DWI or DUI within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
3c. Is any person to be insured currently under treatment or has any person to be insured been under treatment for drug or alcohol abuse in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are all persons to be insured ages 19 to 25 years old enrolled as a full time student in an accredited school or college?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there any other health, accident or disability insurance in force on the proposed insured?	<input type="checkbox"/>	<input type="checkbox"/>
6. Will the insurance applied for replace or change any existing insurance?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, give name of Company and type of insurance: _____		

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Central United Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original. Requested Draft Date: _____

Date _____ X _____ Signature (as it appears on bank records) _____

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____ Name of Employer

to deduct from my salary and pay to Central United Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____, 20____ \$ _____ each month.

Signature of Employee _____ Date _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

- A. I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Central United Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in the circumstances permitted by state and federal law.
- B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer, the Medical Information Bureau, Inc. ("MIB") or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Central United Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy.
- C. Central United Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply.
- D. This authorization will be valid from the date signed for a period of two and one half years.
- E. I authorize Central United Life Insurance Company to obtain an investigative consumer report on me.

Dated: _____ Dated at: _____

Signed X _____ Signature of Proposed Insured Signed X _____ Signature of Spouse

APPLICANT'S STATEMENT

I hereby apply to Central United Life Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; and (d) no change to the policy will be valid until approved by an officer of the Company which must be noted on or attached to the policy. I have read, or have read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief. I acknowledge I have received an Outline of Coverage for the policy applied for.

WARNING: 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 or material thereto commits a fraudulent insurance act, which may be a crime as determined by a court of law.

I understand that if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income.

Dated at _____ on _____ 20____

Signature of Applicant: _____ Signature of Spouse: _____

AGENT'S STATEMENT

I Certify: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) I have given an outline of coverage for the policy applied for to the Applicant. 3) This does does not replace other insurance.

Dated _____ on _____ 20____

Agent Name (Print) _____ Agent Signature _____ Agent Number _____

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	05/04/2011
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/04/2011
Bypass Reason:	See form schedule		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	05/04/2011
Bypass Reason:	N/A		
Comments:			