

SERFF Tracking Number: SELX-G127160676 State: Arkansas
Filing Company: SENTRY LIFE INSURANCE COMPANY State Tracking Number: 48723
Company Tracking Number: AR018090400003
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Multiple Lines
Project Name/Number: Multiple Lines/AR018090400003

Filing at a Glance

Company: SENTRY LIFE INSURANCE COMPANY

Product Name: Multiple Lines

SERFF Tr Num: SELX-
G127160676

State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-
Closed

State Tr Num: 48723

Sub-TOI: H21.000 Health - Other

Co Tr Num: AR018090400003

State Status: Approved-Closed

Filing Type: Form

Author: SPI SentryInsuranceLH
Date Submitted: 05/09/2011

Reviewer(s): Rosalind Minor

Disposition Date: 05/12/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: 06/01/2011

Implementation Date:

State Filing Description:

General Information

Project Name: Multiple Lines

Project Number: AR018090400003

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 05/12/2011

State Status Changed: 05/12/2011

Created By: SPI SentryInsuranceLH

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

SENTRY LIFE INSURANCE COMPANY

NAIC # 169-68810

FEIN # 39-6040276

FORM FILING - GROUP INSURANCE PRODUCT APPLICATIONS

785-501-102 EMPLOYER APPLICATION

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 05/05/2011

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: SPI SentryInsuranceLH

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The above referenced form is submitted for your review.

This new form will be used with our group life, group dental and group disability income insurance products currently on file with your department, as well as those that may be approved in the future.

This form will replace the employer application form 785-501-42 "Approved" by your department 9-19-2008, with a use date of 1-1-2009; DOI # 40235.

In addition to a couple of cosmetic formatting changes on page 2, the "Child Care and Education Benefit" has been added to the Benefit Selection section on page 2. This new benefit was recently approved by your department as part of our Group Term Life product.

Brian Warner, J.D.
 Compliance/Development

Company and Contact

Filing Contact Information

Brian Warner, Compliance & Development Analyst
 Brian.Warner@sentry.com
 1800 North Point Drive
 Stevens Point, WI 54481
 715-346-7187 [Phone]
 715-346-6044 [FAX]

Filing Company Information

SENTRY LIFE INSURANCE COMPANY
 1800 North Point Drive
 Stevens Point, WI 54481
 (715) 346-6000 ext. [Phone]

CoCode: 68810
 Group Code: 169
 Group Name:
 FEIN Number: 39-6040276

State of Domicile: Wisconsin
 Company Type:
 State ID Number:

Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
SENTRY LIFE INSURANCE COMPANY	\$50.00	05/09/2011	47398824

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/12/2011	05/12/2011

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Disposition

Disposition Date: 05/12/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

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	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	AR - READABILITY CERTIFICATION	Approved-Closed	Yes
Form	Group Employer 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 05/12/2011	785-501- 102	Application/Group Employer Enrollment Application Form	Initial		49.200	ER App 785- 501-102.PDF

Section 3: BENEFIT SELECTION

Options of Dependent Life, Orthodontia, Group Life Child Care and Education Benefits and Salary Definition, when selected, apply to employees in all classes as described below.

*Denotes option availability is limited by group size.

Dependents Life* Spouse: 10% of employee basic amount Child(ren): 5% of employee basic amount

Orthodontia Option* - 50% Coinsurance and \$1,500 Lifetime Maximum per person

Group Life Child Care and Education Benefits

Salary Definition **Standard (with commissions no Overtime or Bonus)** **W-2 Salary**

Class 1

Indicate class description here: _____

Life Flat Benefit (Minimum \$10,000) \$ _____ Reducing Benefit Life \$ _____
 1 times or 2 times Salary to a Maximum Benefit of \$ _____

Short-Term Disability
 50%* or 60% of covered payroll to a Maximum Benefit of \$ _____
Maximum Benefit Period: 13 week* 26 week 52 week*
Elimination Period: 0-day accident/7-day sickness 7-day accident/7-day sickness

Long-Term Disability
 50%* or 60% of covered payroll to a Maximum Monthly Benefit of \$ _____
Maximum Benefit Period _____ Elimination Period _____

Dental
Calendar Year Deductible: \$0* \$50 \$100
Calendar Year Maximum: \$500 \$1000 \$2000
Coinsurance: Option A: 80% preventive/80% Basic/50% Major
 Option B: 100% preventive/80% Basic/50% Major

Class 2

Indicate class description here: _____

Life Flat Benefit (Minimum \$10,000) \$ _____ Reducing Benefit Life \$ _____
 1 times or 2 times Salary to a Maximum Benefit of \$ _____

Short-Term Disability
 50%* or 60% of covered payroll to a Maximum Benefit of \$ _____
Maximum Benefit Period: 13 week* 26 week 52 week*
Elimination Period: 0-day accident/7-day sickness 7-day accident/7-day sickness

Long-Term Disability
 50%* or 60% of covered payroll to a Maximum Monthly Benefit of \$ _____
Maximum Benefit Period _____ Elimination Period _____

Dental
Calendar Year Deductible: \$0* \$50 \$100
Calendar Year Maximum: \$500 \$1000 \$2000
Coinsurance: Option A: 80% preventive/80% Basic/50% Major
 Option B: 100% preventive/80% Basic/50% Major

Class 3

Indicate class description here: _____

Life Flat Benefit (Minimum \$10,000) \$ _____ Reducing Benefit Life \$ _____
 1 times or 2 times Salary to a Maximum Benefit of \$ _____

Short-Term Disability
 50%* or 60% of covered payroll to a Maximum Benefit of \$ _____
Maximum Benefit Period: 13 week* 26 week 52 week*
Elimination Period: 0-day accident/7-day sickness 7-day accident/7-day sickness

Long-Term Disability
 50%* or 60% of covered payroll to a Maximum Monthly Benefit of \$ _____
Maximum Benefit Period _____ Elimination Period _____

Dental
Calendar Year Deductible: \$0* \$50 \$100
Calendar Year Maximum: \$500 \$1000 \$2000
Coinsurance: Option A: 80% preventive/80% Basic/50% Major
 Option B: 100% preventive/80% Basic/50% Major

Section 4: CONTRIBUTIONS & PARTICIPATION

- 12) What percentage of the Employee premium will the Employer pay?
 Life _____ % Short-Term Disability _____ % Dental _____ % Long-Term Disability _____ %
- 13) It is understood that this employer group will not be insured or renewed coverage unless the following requirements are met:
- A. On groups with **3-9** employees:
 Life and Short-Term Disability • Employers must contribute 100% of insurance premium and all eligible employees must participate.
 Dental • Employers must contribute at least 50% of insurance premium and 75% of all eligible employees must participate.
- B. On groups of **10+**, the Employer must contribute at least 25% of insurance premiums for each coverage (i.e. Life, STD, LTD, Dental).
 Participation requirements are:
Life, Short-Term Disability & Long-Term Disability - 75% of all eligible employees must participate.
Dental • on groups of **10-24** employees - 60% of all eligible employees must participate.
 on groups of **25** or more employees - 50% of all eligible employees must participate.
- C. **IF THE EMPLOYER PAYS 100% OF THE PREMIUM FOR ANY BENEFIT, 100% OF ALL ELIGIBLE EMPLOYEES MUST PARTICIPATE FOR THAT BENEFIT.**

Section 5: GENERAL REPRESENTATIONS & AGREEMENTS

IMPORTANT - - READ BEFORE SIGNING

I understand that this insurance is subject to the approval of Sentry Life Insurance Company, and that nothing contained herein shall be binding upon said Company until this insurance is approved and accepted by Sentry. I hereby represent that all the information herein, relative to this application and agreement, is true and complete and that I have read and understand the form.

I understand that Sentry will rely on these statements and this information in approving this application and in determining if the enrolling employees may become insured.

Upon Sentry's approval, insurance will become effective on the date specified by Sentry.

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.

Authorized Signature	Title	Date	Business e-mail address
Salesperson's Signature (Witness)	Salescode	(Area Code)	Telephone Number
Salesperson Address	City	State	Zip

Deposit to be credited toward premium upon Sentry's acceptance of this application: \$ _____
(Make check payable to Sentry Life Insurance Company)

For office use only

Account Mastered Yes No Date Received ____ / ____ / ____

Group # _____ Account # _____

Effective Date _____ Initial _____ Date _____

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/12/2011
Comments:		
Attachment:		
AR - READABILITY CERTIFICATION.PDF		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	05/12/2011
Comments:		
The Application is the form being approved. This form will be attached in the forms section.		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	05/12/2011
Bypass Reason: This is a filing for the application changes only. Policy and rates have already been approved.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	05/12/2011
Bypass Reason: n/a		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	05/12/2011
Bypass Reason: This is not a PPACA product		
Comments:		

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Satisfied - Item: AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT
Item Status: Approved-Closed
Status Date: 05/12/2011

Comments:

Attachments:

AR - NAIC TRANSMITTAL DOCUMENT.PDF
AR - NAIC FORM FILING ATTACHMENT.PDF

Satisfied - Item: AR - READABILITY CERTIFICATION
Item Status: Approved-Closed
Status Date: 05/12/2011

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: SENTRY LIFE INSURANCE COMPANY

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
785-501-102	49.2

Signed: *William O'Reilly*
Name: William O'Reilly
Title: Secretary
Date: 05/09/2011

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
SENTRY LIFE INSURANCE COMPANY 1800 North Point Drive Stevens Point WI 54481	WI		169	68810	39-6040276	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Brian K. Warner 1800 North Point Drive Stevens Point WI 54481	800-533-7827	715-346-6044	Brian.Warner@sentry.com

5. Requested Filing Mode	<input type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	AR018090400003
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8. Market	Group	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise		
		<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____		

9. Type of Insurance	H21 Health - Other
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10. Product Coding Matrix Filing Code	H21.000 Health - Other
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11. Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	05/09/2011
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	05/06/2011
15.	Filing Description:	
<p>SENTRY LIFE INSURANCE COMPANY NAIC # 169-68810 FEIN # 39-6040276 FORM FILING - GROUP INSURANCE PRODUCT APPLICATIONS 785-501-102 EMPLOYER APPLICATION</p> <p>The above referenced form is submitted for your review.</p> <p>This new form will be used with our group life, group dental and group disability income insurance products currently on file with your department, as well as those that may be approved in the future.</p> <p>This form will replace the employer application form 785-501-42 "Approved" by your department 9-19-2008, with a use date of 1-1-2009; DOI # 40235.</p> <p>In addition to a couple of cosmetic formatting changes on page 2, the "Child Care and Education Benefit" has been added to the Benefit Selection section on page 2. This new benefit was recently approved by your department as part of our Group Term Life product.</p> <p>Brian Warner, J.D. Compliance/Development</p>		

16.	Certification (If required)	
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
<p>Print Name <u>Brian K. Warner</u> Title <u>Compliance & Development Analyst</u></p>		
<p>Signature <u></u> Date <u>05/09/2011</u></p>		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	AR018090400003	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Group Employer Application	785-501-102	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: SENTRY LIFE INSURANCE COMPANY

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