

SERFF Tracking Number: UHLC-127155700 State: Arkansas  
 Filing Company: UnitedHealthcare Insurance Company of the River Valley State Tracking Number: 48685  
 Company Tracking Number:  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: AR Enrollment Form  
 Project Name/Number: /

## Filing at a Glance

Company: UnitedHealthcare Insurance Company of the River Valley

Product Name: AR Enrollment Form

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: UHLC-127155700 State: Arkansas

SERFF Status: Closed-Approved- Closed State Tr Num: 48685

Co Tr Num:

Author: Ebony Terry

Date Submitted: 05/05/2011

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 05/05/2011

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type:

Filing Status Changed: 05/05/2011

State Status Changed: 05/05/2011

Created By: Ebony Terry

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

AR Enrollment Form

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Ebony Terry

## Company and Contact

### Filing Contact Information

Ebony Terry, Compliance Analyst

Ebony\_N\_Terry@uhc.com

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800 King Farm Blvd. 240-632-8053 [Phone]  
 Suite 500  
 Rockville, MD 20850

**Filing Company Information**

UnitedHealthcare Insurance Company of the CoCode: 12231 State of Domicile: Illinois  
 River Valley  
 1300 River Drive, Suite 200 Group Code: 707 Company Type: Health  
 Moline, IL 61265 Group Name: State ID Number:  
 (309) 765-1485 ext. [Phone] FEIN Number: 20-1902768

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**Filing Fees**

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company of the River Valley	\$50.00	05/05/2011	47276078

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## Correspondence Summary

### Dispositions

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

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## Disposition

Disposition Date: 05/05/2011

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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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Form</b>	Health Addendum	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 05/05/2011	[100-7381 6/10]	Application/Health Addendum Enrollment Form		Initial			AR health adden 10.pdf

Group Name: \_\_\_\_\_

**Medical Profile (only for groups not requiring individual health statements)**

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**IMPORTANT:** Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have any employees or dependents been diagnosed or treated during the past five years for: <table style="width: 100%; margin-left: 20px;"> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Immune Disorder</td> <td><input type="checkbox"/> Growth Hormones</td> </tr> <tr> <td><input type="checkbox"/> Tumor</td> <td><input type="checkbox"/> AIDS/HIV+</td> <td><input type="checkbox"/> Transplants</td> </tr> <tr> <td><input type="checkbox"/> Heart/Circulatory</td> <td><input type="checkbox"/> Chronic Lung Disorder</td> <td><input type="checkbox"/> Hemophilia/Blood Disorders</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Kidney Disease/Failure</td> <td><input type="checkbox"/> Cerebral Palsy</td> </tr> <tr> <td><input type="checkbox"/> Reproductive Disorder</td> <td><input type="checkbox"/> Liver Disorders (Hepatitis)</td> <td><input type="checkbox"/> Sickle cell anemia</td> </tr> <tr> <td><input type="checkbox"/> Intestinal Disorder</td> <td><input type="checkbox"/> Back Disorder</td> <td><input type="checkbox"/> Immuno deficiency</td> </tr> <tr> <td><input type="checkbox"/> Endocrine Disorder</td> <td><input type="checkbox"/> Rheumatoid Arthritis</td> <td><input type="checkbox"/> Autism</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Connective Tissue Disorder</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Brain/Nervous/Seizures</td> <td><input type="checkbox"/> Lupus</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Multiple Sclerosis</td> <td><input type="checkbox"/> Other Conditions _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Cancer	<input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Growth Hormones	<input type="checkbox"/> Tumor	<input type="checkbox"/> AIDS/HIV+	<input type="checkbox"/> Transplants	<input type="checkbox"/> Heart/Circulatory	<input type="checkbox"/> Chronic Lung Disorder	<input type="checkbox"/> Hemophilia/Blood Disorders	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease/Failure	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Reproductive Disorder	<input type="checkbox"/> Liver Disorders (Hepatitis)	<input type="checkbox"/> Sickle cell anemia	<input type="checkbox"/> Intestinal Disorder	<input type="checkbox"/> Back Disorder	<input type="checkbox"/> Immuno deficiency	<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Autism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Connective Tissue Disorder		<input type="checkbox"/> Brain/Nervous/Seizures	<input type="checkbox"/> Lupus		<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other Conditions _____	
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**If you answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, continue your comments on the back side of this form.**

Question #	Check One Emp	Check One Dep	Age	Nature of Condition/ Diagnosis	Name of Medication	\$ Amount of Claims	Dt Treated/ Recovered	Prognosis Current Treatment

The group policy(s) is deemed executed upon receipt of the signed Employer Application, payment of the required policy charges and acceptance by UnitedHealthcare Insurance Company and its Affiliates ("UnitedHealthcare and Affiliates").

**The Group shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent, including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.**

I represent that, to the best of my knowledge, the information I have provided in this application - including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws - is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy effective date, or other consequences.

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## Supporting Document Schedules

		Item Status:	Status Date:
<b>Bypassed - Item:</b>	Flesch Certification	Approved-Closed	05/05/2011
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
		Item Status:	Status Date:
<b>Bypassed - Item:</b>	Application	Approved-Closed	05/05/2011
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
		Item Status:	Status Date:
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	05/05/2011
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
		Item Status:	Status Date:
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	05/05/2011
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
		Item Status:	Status Date:
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	05/05/2011
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

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	<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b> Cover Letter	Approved-Closed	<b>Date:</b> 05/05/2011
<b>Comments:</b>		
<b>Attachment:</b>		
AR health adden 10.pdf		

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