

SERFF Tracking Number: UHLC-127612806 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 49702
Company Tracking Number: V-APP-PL (09/2011)
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Group Vision
Project Name/Number: Application Form/

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: Group Vision

SERFF Tr Num: UHLC-127612806 State: Arkansas

TOI: H20G Group Health - Vision

SERFF Status: Closed-Approved-
Closed State Tr Num: 49702

Sub-TOI: H20G.000 Health - Vision

Co Tr Num: V-APP-PL (09/2011) State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Jayne Jackowski, Lynn
Powers

Disposition Date: 09/02/2011

Date Submitted: 09/02/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Application Form

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type:

Overall Rate Impact:

Filing Status Changed: 09/02/2011

State Status Changed: 09/02/2011

Deemer Date:

Created By: Jayne Jackowski

Submitted By: Jayne Jackowski

Corresponding Filing Tracking Number:

Filing Description:

We respectfully submit this form for your formal approval. This is a new form and is not intended to replace any forms previously filed with the Department.

The form will be used with previously approved policies to accommodate marketing rebranding for eligible employer groups. Once approved, this form will be used to support the issuance of our portfolio of group vision products offered in your state.

Certain provisions have been [bracketed] to indicate they are variable and other provisions have been {bracketed} to

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indicate they are variable by omission. You have our assurance that only variable areas will be changed and or omitted.

Company and Contact

Filing Contact Information

Jayne Jackowski, Senior Specialty Product Analyst
 Jayne_S_Jackowski@uhc.com
 3100 AMS Blvd. 800-232-5432 [Phone] 14405 [Ext]
 Green Bay, WI 54313 920-661-9861 [FAX]

Filing Company Information

UnitedHealthcare Insurance Company CoCode: 79413 State of Domicile: Connecticut
 185 Asylum Street Group Code: 707 Company Type: Life and Health
 Hartford, CT 06103 Group Name: State ID Number:
 (860) 702-5000 ext. [Phone] FEIN Number: 36-2739571

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$50.00	09/02/2011	51237148

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/02/2011	09/02/2011

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Disposition

Disposition Date: 09/02/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<i>Company Tracking Number:</i>	<i>V-APP-PL (09/2011)</i>		
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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
Form	Group Vision Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: V-APP-PL (09/2011)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 09/02/2011	V-APP-PL (09/2011)	Application/ Enrollment Form	Group Vision Application	Initial			V-APP-PL 09- 12.pdf

Employer Application

Group Vision Care Insurance

[Private Label Brand/Marketing Company]

Requested Policy Effective Date: / /
Requested Policy Anniversary Date: / /

GENERAL INFORMATION

Group's Full Legal Name:
(Include names of subsidiaries
or affiliated companies)

Street Address:

City:

State:

Zip Code:

Contact Person:

Telephone:

Fax Number:

E-Mail Address of Contact:

Billing Address (If Different):

Organization Type: Corporation Partnership Sole Proprietor Political Subdivision Other

Multi Location Group?

Yes No

Number of

Locations:

Locations:

Nature of Business:

Industry Code:

Employer Identification Number
(Tax Id Number)

Subject to ERISA? Yes No

If yes, ERISA plan number:

VISION PLAN PARTICIPATION AND SELECTION

Hours per week
to be eligible:

Benefit Waiting

Period for New Hires:

- Date of event following _____ months of employment
 1st of policy month following _____ months of employment
 Other:

Benefit Waiting Period Waived
for Initial Enrollees: Yes No

Total Number of
Employees on Payroll:

Total Number of full time/
eligible Employees:

Number of COBRA participants in total group:

Number of Retirees in total group:
(applicable to groups of over 50 eligible subscribers)

Will employees retired by the
Employer be eligible for coverage? Yes No

If yes, specify
groups eligibility:

Premiums and Contributions

Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Employee Only				
Employee + One				
Employee + Spouse				
Employee + Children				
Employee + Family				
Composite				
Total Estimated Monthly Premium \$				

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on this Application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this Application is declined, the Company will return the premium deposit submitted with the Application. If my coverage is approved, premium is payable monthly in advance.

Group vision insurance products are underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut.

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 the Company 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, or other consequences as permitted by law.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this Application may be transmitted electronically to me and to the Group's employees.

Company disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. {For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to [<http://www.uhc.com>] and click on the drop down box for employers under "View Our Programs – Producer Payment Programs."} For specific information about the compensation payable with respect to your particular policy, please contact your producer.

FRAUD WARNING NOTICE(S): {(Please review the notice that applies in your state.)}

{For applicants in {Arkansas} {and} {West Virginia} {and} {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.}

{For applicants in 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.}

{For applicants in District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.}

{For applicants in Hawaii:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.}

{For applicants in 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.}

{For applicants in 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.}

{For applicants in 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.}

{For applicants in New Mexico:

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 AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.}

{For applicants in 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.}

{For applicants in Oklahoma:

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.}

{For applicants in Oregon:

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.}

{For applicants in the state of 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.}

{For applicants in all other states:

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.}

{For applicants in 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.}

GROUP SIGNATURE (form must be signed)

Group Authorized Person's Name:	Title:
Group Authorized Person's Signature:	Date:

AGENT/BROKER INFORMATION

Agent/Broker Name:	Agency:	
Agent/Broker Signature:	Date:	
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:
Commissions Payable To:	Agent/Broker Number:	

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	09/02/2011
Bypass Reason:	application only filing		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/02/2011
Bypass Reason:	See Form Schedule		
Comments:			