

State: Arkansas **Filing Company:** Massachusetts Mutual Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: DI MIB Authorization Update
Project Name/Number: DI MIB Authorization Update/DI MIB Authorization Update

Filing at a Glance

Company: Massachusetts Mutual Life Insurance Company
Product Name: DI MIB Authorization Update
State: Arkansas
TOI: H11G Group Health - Disability Income
Sub-TOI: H11G.004 Other
Filing Type: Form
Date Submitted: 11/06/2012
SERFF Tr Num: MASS-128731242
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: DI MIB AUTHORIZATION

Implementation: On Approval
Date Requested:
Author(s): Steven Miller, Robin Perez, Diana Violette, Jennifer Dube, Nick Sheehan
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 11/13/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Massachusetts Mutual Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: DI MIB Authorization Update
Project Name/Number: DI MIB Authorization Update/DI MIB Authorization Update

General Information

Project Name: DI MIB Authorization Update	Status of Filing in Domicile: Pending
Project Number: DI MIB Authorization Update	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: 11/13/2012
	State Status Changed: 11/13/2012
Deemer Date:	Created By: Robin Perez
Submitted By: Jennifer Dube	Corresponding Filing Tracking Number:

Filing Description:

.The attached applications are being submitted in order to comply with the Medical Information Bureau requirement for revised authorization language.

The F100-12(AR) is the Application for Disability Income Benefits Option and it will replace the F100-02(AR) which was approved 03/14/03.

The REIN-12(DI) is a Disability Insurance Reinstatement Application and will replace the REIN-97(DI) which was approved 06/27/97.

The only content that is being changed is the MIB authorization language in each application. Please contact me if you have any questions or concerns. Thank you for your consideration.

Company and Contact

Filing Contact Information

Steve Miller, Compliance Specialist	Stevemiller@Massmutual.com
1295 State Street	860-562-3463 [Phone]
M-381	860-562-6109 [FAX]
Springfield, MA 01111-0001	

Filing Company Information

Massachusetts Mutual Life Insurance Company	CoCode: 65935	State of Domicile: Massachusetts
1295 State Street	Group Code: 435	Company Type:
MIP: M381	Group Name:	State ID Number:
Springfield, MA 01111	FEIN Number: 04-1590850	
(800) 767-1000 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$150.00
Retaliatory?	Yes

State: Arkansas **Filing Company:** Massachusetts Mutual Life Insurance Company
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Fee Explanation: \$75 per form x 2 forms

Per Company: No

Company	Amount	Date Processed	Transaction #
Massachusetts Mutual Life Insurance Company	\$150.00	11/06/2012	64619135

SERFF Tracking #:

MASS-128731242

State Tracking #:

Company Tracking #:

DI MIB AUTHORIZATION

State:

Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.004 Other

Product Name:

DI MIB Authorization Update

Project Name/Number:

DI MIB Authorization Update/DI MIB Authorization Update

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/13/2012	11/13/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/06/2012	11/06/2012

Response Letters

Responded By	Created On	Date Submitted
Jennifer Dube	11/12/2012	11/12/2012

State: Arkansas
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: DI MIB Authorization Update
Project Name/Number: DI MIB Authorization Update/DI MIB Authorization Update

Filing Company: Massachusetts Mutual Life Insurance Company

Disposition

Disposition Date: 11/13/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Application for Disability Income	Approved-Closed	Yes
Form	Disability Income Reinstatement Application	Approved-Closed	Yes

State: Arkansas **Filing Company:** Massachusetts Mutual Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: DI MIB Authorization Update
Project Name/Number: DI MIB Authorization Update/DI MIB Authorization Update

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/06/2012
Submitted Date	11/06/2012
Respond By Date	

Dear Steve Miller,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Disability Income Reinstatement Application, REIN-12(DI) (Form)

Comments:

If this application is a stand alone application, it must contain a Fraud Statement.

Thank you for your cooperation.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State: Arkansas **Filing Company:** Massachusetts Mutual Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: DI MIB Authorization Update
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Response Letter

Response Letter Status Submitted to State
Response Letter Date 11/12/2012
Submitted Date 11/12/2012

Dear Rosalind Minor,

Introduction:

Thank you for your correspondence.

Response 1

Comments:

Please note that this is not a stand alone application, therefore we believe that a Fraud Statement is not necessary.

Related Objection 1

Applies To:

- Disability Income Reinstatement Application, REIN-12(DI) (Form)

Comments:

If this application is a stand alone application, it must contain a Fraud Statement.

Thank you for your cooperation.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you.

Sincerely,

Jennifer Dube

State: Arkansas
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: DI MIB Authorization Update
Project Name/Number: DI MIB Authorization Update/DI MIB Authorization Update

Filing Company: Massachusetts Mutual Life Insurance Company

Form Schedule

Lead Form Number: F100-12(AR)								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/13/2012	Application for Disability Income	F100-12(AR)	AEF	Initial		54.500	F100-12(AR).pdf
2	Approved-Closed 11/13/2012	Disability Income Reinstatement Application	REIN-12(DI)	AEF	Initial		53.000	REIN-12(DI).pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

Massachusetts Mutual Life Insurance Company
Springfield, MA 01111-0001

Application for Disability Income Benefit Options

A Insured Information

- | | |
|---|--|
| <p>1. Name (First, Middle, Last)
_____</p> <p>2. Policy # _____</p> <p>3. DOB ____/____/____ Birth State _____</p> <p>4. Social Security # _____ - _____ - _____</p> <p>5. Residential Address (City, State, Zip)

_____</p> | <p>6. Tel. Home (____) _____ - _____
Bus. (____) _____ - _____
E-mail Address _____</p> <p>7. Business Name & Address (City, State, Zip)

_____</p> |
|---|--|

B Options

- | | |
|--|---|
| <p>1. Option requested</p> <p><input type="checkbox"/> Future Insurability Option Rider (FIO)</p> <p><input type="checkbox"/> Future Insurability Option under Group Supplemental Rider (GSR-FIO)</p> <p><input type="checkbox"/> Renewal of Automatic Increase Benefit Rider (AIB/AABI)</p> <p><input type="checkbox"/> Special 5th Year (AABI subject to contract rules)</p> <p>3. Amount of additional monthly benefit requested \$ _____</p> | <p>2. Option requested</p> <p>Attachment of Rider under Disability Income Purchase Rider (DIPR)</p> <p><input type="checkbox"/> Additional Monthly Income Rider (AMIR)</p> <p><input type="checkbox"/> Annually Renewable Disability Income Rider (ARDI)</p> <p><input type="checkbox"/> Contingent Monthly Income Rider (CMR)</p> <p><input type="checkbox"/> Renewal of Annual Increase Rider (AIR)</p> |
|--|---|

C Occupational Data

- Explain "Yes" answers in Details.**
- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you currently disabled and/or collecting disability benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. For the period of time commencing 90 days prior to, and including, the date of this application: | | |
| a. have you been continuously at work on a full time basis (minimum 30 hours per week) performing all the duties of your occupation without limitation due to injury or sickness? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. have you been homebound or hospitalized due to injury or sickness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. how many days have you missed due to an injury or sickness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Details for 2 (a), (b), and (c) _____ | | |
| 3. Occupational Title and Duties _____ | | |
| 4. Do you plan to change your occupation or hours worked?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Details (Please reference question #) _____ | | |

D Financial Data

1. Employment Status
- Employee (no ownership) Sole Proprietor Partner ____ % ownership
- S-Corporation Shareholder ____ % ownership C-Corporation Shareholder ____ % ownership
2. Earned Income (Business owners include share of business profit/loss in addition to wages)
- Current year \$ _____ Prior year \$ _____
3. Unearned Income (ex: interest, dividends, capital gains, rents)
- Current year \$ _____ Prior year \$ _____
4. Total Net Worth if 3 million dollars or more (assets minus liabilities) \$ _____

D Financial Data (continued)

5. Describe all Disability Income pending or in force coverage (If none, please answer "none".)

Type of Plan: Individual (I), Group (G), Buy-Sell (B), Association (A), Business Overhead (O)

Company	Type (I, G, B, A, O)	Issue Year	Monthly Amount	Benefit Period	Waiting Period	Employer Pay (Yes/No)	Is this being replaced?	Effective replacement date

6. Will the Employer continue Proposed Insured's salary or income if disabled? Yes No

If "Yes," amount per month \$ _____ # of months _____

7. Premium will be paid by Insured Employer Employer paid and included in Employee's W-2

E Agreement and Signature

This application shall be attached to and form a part of any policy of insurance issued. **Company, as used in this Application, refers to Massachusetts Mutual Life Insurance Company.**

Liability of Company – If a premium is accepted with this Application in exchange for a Conditional Receipt signed by the Agent, the Company's liability will be as stated in that Receipt. The Applicant also acknowledges receiving a copy of such Receipt. The new insurance being applied for will not take effect unless each of the applicable conditions is met:

- If this is an application for a Rider being purchased during an Option Period under a **Disability Income Purchase Rider** then that Rider becomes effective as stated on the schedule page of the policy, but no earlier than the date the application for the Rider is signed if:
 - The first premium is paid to the Company on or within 60 days before the end of the Option Period; and
 - The application is approved by the Company at its Home Office.
- If this Application is made in accordance with and subject to the provisions of the **Insurability Rider** contained in the above policy, and the Date of Issue of the coverage applied for is within two years of the Date of Issue of that rider; the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured contained in the Application for that rider were as of its date true and complete to the best knowledge and belief of the undersigned.
- If this is an application for **Future Increases Under AIR/AIB/AABI**, the right to future increases applied for will not become effective until this application is approved by the Company at its Home Office. If approved, the right to future increases will become effective on the Future Increase Date.

Under no circumstances will the coverage being applied for provide coverage for disability beginning prior to the date of this application.

Authority of Agents – No agent can change the terms of this application or any policy issued by the Company. No agent can waive any of the Company's rights or requirements or extend the time for any payment.

Authorization to Obtain and Disclose Information (For the Insured and/or Owner) – I have received the Notice about the Medical Information Bureau, Inc. (MIB). I have also received the Summary of Consumer Rights. I understand and authorize an investigative report be made. This report may include information about my character, general reputation, personal characteristics, and mode of living. I hereby authorize certain parties that have any records or knowledge of me and my health to make such information available to Massachusetts Mutual Life Insurance Company or its reinsurers. These parties include: any licensed physician, medical practitioner, hospital, clinic, other medical or medical related facility, insurance company, the MIB, or other organization. I also authorize MassMutual, or its reinsurers, to disclose information about me to the MIB in the form of a brief coded report for participation in MIB's fraud prevention and detection programs. I agree that a photocopy or facsimile of this authorization may be used to obtain information.

The person(s) signing below agree that, to the best of their knowledge and belief, all statements in this application are complete and true and were correctly recorded. They also adopt all statements made in the application. Under penalty of perjury, the Owner certifies that the Social Security number shown on this application is correct and that he/she is not subject to back up withholding.

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.

X _____
Signature of Proposed Insured

X _____
Signature of Owner (If not the Proposed Insured)

Signed at _____ on _____
City and State Date

X _____
Licensed Agent (Signature required where applicable)

DISABILITY INCOME REINSTATEMENT APPLICATION

Massachusetts Mutual Life Insurance Co.
Springfield, Massachusetts 01111-0001

Reinstatement of policy number(s) _____

Insured's Name

1. Insured's Name

first name	<input type="text"/>	middle name	<input type="text"/>
last name	<input type="text"/>		suffix (e.g., Jr.) <input type="text"/>
		mo. day yr.	

2. Social Security Number

—	—	
---	---	--

3. Date of Birth

—	—	
---	---	--

4. Has the Insured ever:

- a. Been partially or totally disabled? yes no
- b. Been advised of, treated for, or had any known indication of mental/nervous disorder, stroke, pulmonary or lung disorder, blood disorder, cancer, gastrointestinal disorder, tumor, kidney disorder, diabetes, high blood pressure, or heart and circulatory disorder? yes no
- c. Been advised of, treated for, or had any know indication of neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bone including the spine, back or joints? yes no
- d. Had a consultation, surgery, or injury, other than the above, requiring treatment by a physician or other health care provider, hospital, or other treatment facility? yes no
- e. Had any electrocardiogram, x-ray, or other diagnostic test (excluding HIV test)? yes no
- f. Used barbiturates, narcotics, cocaine or other controlled substances not prescribed by a physician? yes no
- g. Received any treatment or advice in relation to alcoholism or the use of alcohol? yes no
- h. Been treated for, or been diagnosed by a member of the medical profession as having a deficiency of the immune system including but not limited to acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? yes no
- i. Within the last 12 months, used tobacco or nicotine in any form? yes no

5. If the answer to any of the above is "yes," state condition, dates of treatment, duration of the condition, result, and the name and address of the physician who treated the condition.

Item	Condition	Date	Duration	Result	Physician's name and address

6. Has the Insured ever applied for life or health insurance and been declined, postponed, rated or restricted in the last ten years?(If "yes," complete the following.) yes no

Name of Carrier	Date	Reason

7. The Insured's present occupation(s), title, exact duties, and the number of hours per week working in the occupation?

Occupation(s)	Title	Exact Duties	Hrs. per week

8. Has the Insured been actively at work on a full-time basis (minimum of 30 hrs. per week) for the past 90 days? (Exclude vacation days, normal non-working days, and absences totalling less than 7 days.) yes no

9. Does the Insured have disability insurance coverage(individual, group or association) in force or an application currently pending? (If "yes," complete the following) yes no

Company Name	Type of Product	Monthly Income	Pending	Year Issued

10. What is the Insured's annual earned income (after business expenses but before taxes) reported for Federal Income Tax purposes?

Actual current as of ___/___/___ \$ _____
Prior tax year _____ \$ _____

11. If reinstating a Business Overhead Expense Policy (BOE or SBOE), what is the Insured's share of current eligible monthly business overhead expenses? \$ _____

To the best of the knowledge and belief of the person(s) signing below, all statements in this application are complete and true and were correctly recorded. Each person signing below adopts all of the statements made in this application and agrees to be bound by them.

Company as used in this Application refers to Massachusetts Mutual Life Insurance Company.

A premium to reinstate may be paid to the agent in exchange for a Conditional Receipt signed by that agent. If this is done, the Company shall be liable only as set forth in that Receipt.

Liability Of The Company - The Insurance applied for will not take effect unless each of the applicable conditions is met:

1. The cost to reinstate the policy(ies) has been paid and the application to reinstate has been approved by the Company at its Home Office.
2. The cost to reinstate the policy(ies) may be paid to the Agent in exchange for a Conditional Receipt signed by the Agent. If this is done the Company shall be liable only as set forth in that Receipt. If not, (i) the application for reinstatement must be approved by the Home Office; and (ii) at the time of payment, all statements that relate to the insurability of the Insured are complete and true as though they were made at that time.

Authority Of The Agent - No agent can change the terms of this application or any policy issued by the Company. No agent can waive any of the Company's rights or requirements or extend the time for payment.

Authorization To Obtain And Disclose Information (For The Insured And/Or Owner) - I have received the Notice about the Medical Information Bureau, Inc.(MIB). I have also received the Notice about the Fair Credit Reporting Act. I understand and authorize an investigative report be made. This report may include information about my character, general reputation, personal characteristics, and mode of living. I hereby authorize certain parties that have any records or knowledge of me and my health to make such information available to Massachusetts Mutual Life Insurance Company or its reinsurers. These parties include: any licensed physician, medical practitioner, hospital, clinic, other medical or medical related facility, insurance company, the MIB, or other organization. I also authorize MassMutual, or its reinsurers, to disclose information about me to the MIB in the form of a brief coded report for participation in MIB's fraud prevention and detection programs. I agree that a photocopy or facsimile of this authorization may be used to obtain information.

ANY POLICY ISSUED AS A RESULT OF A MATERIAL MISSTATEMENT OR OMISSION OF FACTS MAY BE VOID, AND THE COMPANY'S ONLY OBLIGATION SHALL BE TO RETURN PREMIUMS PAID

Insured	Owner (if not insured)	Owner if BOE/SBOE policy
▶ _____	▶ _____	▶ _____

Signed at _____ city _____ state _____ Date _____

Agent's Signature
▶ _____

REIN-12(DI)

Taxpayer Identification - The Owner of the reinstated policy(ies) listed herein certifies, under penalties of perjury, that: (i) the number referred to in item 2 of this application is his/her correct Taxpayer Identification Number(or he/she is waiting for a number to be issued); and (ii) he/she is not subject to backup withholding either because he/she has not been notified by the Internal Revenue Service(IRS) that he/she is subject to backup withholdings as a result of a failure to report all interest or dividends, or the IRS has notified him/her that he/she is no longer subject to backup withholding. **If the IRS has notified the said Owner that he/she is subject to backup withholding and he/she has not received notice from the IRS that backup withholding has terminated, he/she should strike out the language above in (ii) that he/she is not subject to backup withholding due to notified payee underreporting.**

Owner's Signature
▶ _____

SERFF Tracking #:

MASS-128731242

State Tracking #:

Company Tracking #:

DI MIB AUTHORIZATION

State:

Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.004 Other

Product Name:

DI MIB Authorization Update

Project Name/Number:

DI MIB Authorization Update/DI MIB Authorization Update

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/13/2012
Comments:			
Attachment(s):			
AR Certif of Compliance with Rule 19 DI.pdf			
AR DI Readability Cert.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/13/2012
Bypass Reason:	N/A		

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Massachusetts Mutual Life Insurance Company

Form Number(s): F100-12(AR)
REIN-12(DI)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Jo-Anne Rankin

Digitally signed by Jo-Anne Rankin
DN: cn=Jo-Anne Rankin, o=MM USIG, ou=Reinsurance,
Filing, Illustrations, email=jrankin@massmutual.com, c=US
Date: 2012.11.06 12:03:57 -05'00'

Signature of Company Officer

Jo-Anne Rankin

Name

Vice President & Actuary

Title

11/06/2012

Date

READABILITY CERTIFICATION

I hereby certify the accuracy of the Flesch reading ease test score for the following policy forms. These forms are at least 10 (ten) point type, 2 (two) point leaded.

<u>FORM NUMBER AND TITLE</u>	<u>FLESCH SCORE</u>
F100-12(AR) Application for Disability Income	54.5
REIN-12(DI) Disability Income Reinstatement Application	53.0

Signature:

Jo-Anne Rankin
Digitally signed by Jo-Anne Rankin
DN: cn=Jo-Anne Rankin, o=MM USIG,
ou=Reinsurance, Filing, Illustrations,
email=jrankin@massmutual.com, c=US
Date: 2012.11.06 12:04:26 -05'00'

Jo-Anne Rankin
Vice President & Actuary

Date: 11/06/2012