

**State:** Arkansas **Filing Company:** Unimerica Insurance Company  
**TOI/Sub-TOI:** ML02 Multi-Line - Other/ML02.000 Multi-Line - Other  
**Product Name:** MIB Authorization  
**Project Name/Number:** 2012/

## Filing at a Glance

Company: Unimerica Insurance Company  
Product Name: MIB Authorization  
State: Arkansas  
TOI: ML02 Multi-Line - Other  
Sub-TOI: ML02.000 Multi-Line - Other  
Filing Type: Form  
Date Submitted: 10/25/2012  
SERFF Tr Num: UHLC-128743236  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num:  
  
Implementation: On Approval  
Date Requested:  
Author(s): Adamowicz Sue  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 11/01/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

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## General Information

Project Name: 2012 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: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Group Market Type: Employer, Association Overall Rate Impact:  
Filing Status Changed: 11/01/2012  
State Status Changed: 11/01/2012 Deemer Date:  
Created By: Adamowicz Sue Submitted By: Adamowicz Sue  
Corresponding Filing Tracking Number:

### Filing Description:

On behalf of Unimerica Insurance Company, we are submitting the enclosed Authorization and Acknowledgement form to replace current text used with applications for the above Life and Disability Income policies.

As you may know, the Medical Information Bureau advised member companies of their requirement to add a disclosure sentence to authorization forms. Our primary intent was to add the following sentence, "I authorize Unimerica, or its reinsurers, to make a brief report of my personal health information to MIB."

Since we had to update the form for MIB, we took this as an opportunity to make additional improvements. A synopsis of changes follows:

1. We moved the pre-existing disclosure (when applicable) closer to the signature line;
2. We tweaked the description of entities from whom we would obtain information, such as adding "pharmacy benefit manager;"
3. We added text that statements should be true and complete, but are representations and not warranties;
4. We added text about disclosures of the information to others including the MIB;
5. We added that signing is voluntary.

Upon approval, this form will replace the authorization text of the current forms for new groups and for existing business as forms are reprinted and/or reissued. The forms affected are:

- Form ALI-3001-APPI previously approved on March 30, 2005
- Form ADI-4001-APPI previously approved on January 28, 2005

Thank you for your assistance with this submission. Please feel free to call or email me if you have any questions or concerns.

## Company and Contact

### Filing Contact Information

Sue Adamowicz, Compliance Consultant Sue\_Adamowicz@uhc.com  
185 Asylum St 860-702-6003 [Phone]  
Hartford, CT 06103

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**Filing Company Information**

Unimerica Insurance Company	CoCode: 91529	State of Domicile: Wisconsin
PO Box 150450	Group Code: 707	Company Type: Life and Health
Hartford, CT 0606115-0450	Group Name:	State ID Number:
(860) 702-6017 ext. [Phone]	FEIN Number: 52-1996029	

**Filing Fees**

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

Company	Amount	Date Processed	Transaction #
Unimerica Insurance Company	\$50.00	10/25/2012	64253061

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/01/2012	11/01/2012

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## Disposition

Disposition Date: 11/01/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Name Change Endorsement	Approved-Closed	Yes
Supporting Document	Address Change Endorsement	Approved-Closed	Yes
Form	Authorization and Acknowledgement	Approved-Closed	Yes

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## Form Schedule

Lead Form Number: GRP-AUTH-UIC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/01/2012	Authorization and Acknowledgement	GRP-AUTH-UIC	AEF	Initial			MIB Authorization 9-17-Unimerica.pdf

### Form Type Legend:

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

**AUTHORIZATION AND ACKNOWLEDGEMENT**

I declare that all the statements made in this form are, to the best of my knowledge and belief: true and complete; and, that they are the basis on which insurance requested by me may be issued. I understand that: I am completing an insurance application; and, that each response must be: complete; and accurate. I understand all statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me; my personal representative; or, my beneficiary.

I authorize: any licensed physician; medical practitioner; pharmacy benefit manager; hospital; clinic or other medical or medically related facility; other insurer or reinsurer; Medical Information Bureau, Inc. ("MIB"); health care clearinghouse; and, any of their affiliates; representatives; or, business associates; or, other organization; institution or person; that has any records or knowledge of me or my health [or that of my Dependents,] to disclose the information to: the Unimerica Insurance Company; and, its affiliates ("Unimerica"). This information will be used to determine my eligibility for benefits.

I authorize Unimerica to: obtain; use; and disclose; my [and my Dependent's] medical, claim or benefit records. This includes any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers. I authorize Unimerica to disclose the information to the Policy's administrator; or as may be required by law. I authorize Unimerica, or its reinsurers, to make a brief report of my personal health information to MIB.

I understand that information I authorize a person or entity to obtain and use may be: re-disclosed; and no longer protected by federal privacy regulations; except as prohibited by state law. I agree that a photocopy of this form shall be as valid as the original.

I understand that: this authorization is voluntary; and, I may refuse to sign the authorization. My refusal may, however, affect my ability to: enroll in the Policy; or, receive benefits. I understand I may revoke this authorization at any time by notifying Unimerica in writing. Such revocation will not affect any action taken or information released prior to the revocation; and, will not affect any legal right Unimerica has to contest any insurance or claim under the Policy. This authorization, unless revoked earlier, expires [24 months] after the date it is signed. [I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.]

[I request the indicated group coverage for myself and, if applicable, for my dependents.] I have not given the agent; or, any other persons any health information not included on this form. I understand that Unimerica is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on [this] application and any attachments.

I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that: I have read; or have had read to me; [this] completed application; and, that I realize any false statements or misrepresentation in it may result in loss of coverage under the Policy. I understand that [, subject to the Deferred Effective Date provisions,] coverage will not take effect until Unimerica grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with [this] application. [I understand that the Policy does not cover disability that begins during the first insert # of months after the issue date on account of: a disease; or, physical condition; that I now have or have had in the past.]

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date ]

[Return form to:  
Group Medical Underwriting Services  
PO Box 17829  
Portland ME 04112-8829  
Fax: 855-290-5224  
Email: eoi\_underwriting@uhc.com]

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## Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Name Change Endorsement	Approved-Closed	11/01/2012
Bypass Reason:	Not applicable to this filing		

		Item Status:	Status Date:
Bypassed - Item:	Address Change Endorsement	Approved-Closed	11/01/2012
Bypass Reason:	Not applicable to this filing		