

SERFF Tracking Number: SLIA-128090612 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number:
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Variable Vision Addendum
Project Name/Number: /

Filing at a Glance

Company: Security Life Insurance Company of America

Product Name: Variable Vision Addendum SERFF Tr Num: SLIA-128090612 State: Arkansas

TOI: H20G Group Health - Vision SERFF Status: Closed-Approved- State Tr Num:
Closed

Sub-TOI: H20G.000 Health - Vision Co Tr Num: State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Author: Stacy Patacsil Disposition Date: 02/15/2012

Date Submitted: 02/14/2012 Disposition Status: Approved-

Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: 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 Overall Rate Impact:

Filing Status Changed: 02/15/2012

State Status Changed: 02/15/2012

Deemer Date:

Created By: Stacy Patacsil

Submitted By: Stacy Patacsil

Corresponding Filing Tracking Number:

Filing Description:

Attached for your review and approval is a Variable Vision Application, which will be used when Employer Groups apply for Vision Coverage. This is a new form that does not replace any existing form. This Vision Application will be used in conjunction with Group Application, GROUPAPP.2011, which was approved on 2/13/12, SLIA-128088504.

Please note that all bracketed text is intended to be variable and will be customized based on the product being offered. A Statement of Variability has been attached to explain all variable text.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

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Company and Contact

Filing Contact Information

Stacy Patacsil, spatacsil@securitylife.com
1808 Colonial Village Lane 800-233-0307 [Phone] 5718 [Ext]
Suite 102
Lancaster, PA 17601

Filing Company Information

Security Life Insurance Company of America CoCode: 68721 State of Domicile: Minnesota
10901 Red Circle Drive Group Code: 492 Company Type: Life, Accident &
Health
Minnetonka, MN 55343-9137 Group Name: State ID Number:
(952) 544-2121 ext. 3589[Phone] FEIN Number: 41-0808596

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Life Insurance Company of America	\$50.00	02/14/2012	56338520

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/15/2012	02/15/2012

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Disposition

Disposition Date: 02/15/2012

Implementation Date:

Status: Approved-Closed

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	Statement of Variability	Approved-Closed	Yes
Form	Vision Insurance Product 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 02/15/2012	VISIONAD DENDUM.2 011	Application/ Enrollment Form	Vision Insurance Product Addendum	Initial		0.000	VISIONADDE NDUM.2011.p df

**Security Life Insurance Company of America
Vision Insurance Product Addendum – [Product Description]**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Vision Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, attach a copy of the certificate and the latest billing statement.)	Current Carrier:
[Number of COBRA Employees Enrolling: _____] (Each COBRA employee must complete an Employee Enrollment Form and indicate the COBRA start date and qualifying event.)	
[Open Enrollment Date: Annual open enrollment will occur during the month preceding the renewal date.]	
[Does your plan require an Annual Open Enrollment? <input type="checkbox"/> No <input type="checkbox"/> Yes Annual open enrollment will occur during the month preceding the renewal date.]	
Termination of Coverage will occur on: <input type="checkbox"/> the date the employee is no longer actively at work <input type="checkbox"/> the end of the month in which the employee is no longer actively at work	

Coverage Information	
Class Description:	[Weekly Work Hours Required for Eligibility:] [(min. 30 hours)]
<input type="checkbox"/> Employer Funded] <input type="checkbox"/> Voluntary] [Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Amount EMPLOYEE Contributes: _____ % for employee coverage][max. 75% employee contribution)] [Dependent Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No] [If "Yes," Amount EMPLOYEE Contributes: _____ % for dependent coverage] [Eligibility Waiting Period] [(minimum 30 days): <input type="checkbox"/> [_____] [days from date of hire] <input type="checkbox"/> [First of month following [_____] days from date of hire]	

Plan Information		
[(Select One)] <input type="checkbox"/> Plan I] <input type="checkbox"/> Plan II] <input type="checkbox"/> Plan III]		
[Plan #]		
Member Vision Provider Copayment*:		
<input type="checkbox"/> \$5 Exam/\$5 Materials]	<input type="checkbox"/> \$5 Exam/\$10 Materials]	<input type="checkbox"/> \$10 Exam/\$10 Materials]
<input type="checkbox"/> \$10 Exam/\$20 Materials]	<input type="checkbox"/> \$15 Exam/\$25 Materials]	<input type="checkbox"/> \$5 Exam & Materials]
<input type="checkbox"/> \$10 Exam & Materials]	<input type="checkbox"/> Other \$_____ Exam \$_____ Materials]	<input type="checkbox"/> \$_____ Materials]
*Benefit for services rendered by a non-member vision provider is based on a reimbursement schedule		
Frequency ([Exam]/Lenses/Frame):	[Frequency ([Exam]/Lenses/Frame) for covered dependent children, under age 19, if different:]	
<input type="checkbox"/> [[12 Months]/12 Months/12 Months]	<input type="checkbox"/> [[12 Months]/12 Months/12 Months]	
<input type="checkbox"/> [[12 Months]/12 Months/24 Months]	<input type="checkbox"/> [[12 Months]/12 Months/24 Months]	
<input type="checkbox"/> [[12 Months]/24 Months/24 Months]	<input type="checkbox"/> [[12 Months]/24 Months/24 Months]	
<input type="checkbox"/> [[24 Months]/24 Months/24 Months]	<input type="checkbox"/> [[24 Months]/24 Months/24 Months]	

Vision Insurance Product Addendum – [Product Description]

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? Yes No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner

Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	02/15/2012
Bypass Reason:	Not applicable for an application filing.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	02/15/2012
Comments:	The Vision Addendum will be used in conjunction with the attached Group Application.		
Attachment:	GROUPAPP.2011.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	02/15/2012
Comments:			
Attachment:	Vision Addendum SOV.pdf		



SECURITYLIFE

INSURANCE COMPANY OF AMERICA

[Marketing Name] GROUP APPLICATION

PLEASE PRINT CLEARLY

General Information		
Employer's Full Legal Name (exactly as it will appear in the Contract): _____		
Coverages Requested (complete and attach an addendum for each coverage selected): <input type="checkbox"/> Term Life <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Business is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other _____		
State of Incorporation: _____		
Tax ID Number:	Years in Business:	
Nature of Business:	SIC Code:	
[For groups with 2 to 9 eligible employees: Is this a home based business? <input type="checkbox"/> Yes <input type="checkbox"/> No]	[For groups with 2 to 9 eligible employees: Are 90% or more of the employees <input type="checkbox"/> Yes <input type="checkbox"/> No in the same family?]	
Complete Street Address: Street _____ City _____ State _____ Zip _____ County _____		
Complete Mailing Address (if different): Street _____ City _____ State _____ Zip _____ County _____		
Contact Person:	Title:	
Email:	Telephone Number:	Fax Number:
Who should receive the initial Certificates and Administration Materials? <input type="checkbox"/> Employer— <i>Email required:</i> _____ <input type="checkbox"/> Producing Agent		
Type of Bill Requested: <input type="checkbox"/> List Bill <input type="checkbox"/> Self-Administered (Not available to groups <100 lives or groups applying for Dental or Vision)]		
Billing Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly] (Not available for Dental or Vision)]		
Easy-Pay Method (electronic transfer of premium): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, then Form# [EZPAY2008] must be completed.		

Subsidiaries to be Included

Subsidiaries or Other Business Locations to be covered: No Yes; if Yes, complete the following:

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

[FRAUD STATEMENT: 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.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA

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.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA

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

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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 act, which is a crime.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF 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.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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 a crime and may be subject to civil fines and criminal penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO

Any person who, with the 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.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE, VIRGINIA, AND WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VERMONT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.]

Declarations

APPLICANT'S DECLARATION

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of Security Life Insurance Company of America; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

Signature of Officer or Owner

Print Name of Officer or Owner

Date

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.
2. I/we have no knowledge or information about the Applicant, its employees, the dependents of these employees, or any continued persons that is not fully stated in this application.

Signature of Agent

Print Name of Agent

Date

Address:

Telephone #:

License #:

Email:

HOME OFFICE USE:

Vision Addendum – Statement of Variability

Section	Language	Variability
Title	Product Description	Space available to Describe the type of Vision Insurance being offered
Group Information	Number of COBRA Employees Enrolling: _ (Each COBRA employee must complete an Employee Enrollment Form and indicate the COBRA start date and qualifying event.)	Optional to be included or not included
	Open Enrollment Date: Annual open enrollment will occur during the month preceding the renewal date.	Optional to be included or not included
	Does your plan require an Annual Open Enrollment? No Yes Annual open enrollment will occur during the month preceding the renewal date.	Optional to be included or not included
Coverage Information	Weekly Work Hours Required for Eligibility: _	Optional to be included or not included. Hour range will be blank if the Employer has an option, or between 15-40 will be inserted if there is a required amount of hours
	(min. 30 hours)	Included if there is a required minimum of 30 hours
	Employer Funded Voluntary	Optional to be included or not included, based on product being offered
	Does Employee Contribute? Yes No If “Yes,” Amount EMPLOYEE Contributes: _____% for employee coverage	Question included if Employer has the option to choose if an employee contributes % will be a blank space if the Employer has an option to choose how much an employee contributes. Percentage between 1-100% will be inserted if there is a required percentage
	(max. 75% employee contribution)	Included if applicable
	Dependent Vision: Yes No	Optional to be included or not included, depending on if Dependent coverage is offered.
	If “Yes,” Amount EMPLOYEE Contributes: _____% for dependent coverage	Question included if Employer has the option to choose if an employee contributes % will be a blank space if the Employer has an option to choose how much an employee contributes. Percentage between 1-100% will be inserted if there is a required percentage
	Eligibility Waiting Period	Optional to be included or not included

	(minimum 30 days):	Included if there is a required minimum of 30 days
	_____ days from date of hire	Eligibility Waiting Period Option Blank space included if the Employer has an option to choose how many days from date of hire, or a day range of 0-365 days will be automatically included
	First of month following [_____] days from date of hire]	Eligibility Waiting Period Option Blank space included if the Employer has an option to choose how many days, or a day range of 0-365 days will be automatically included.
Plan Information	(Select One) <input type="checkbox"/> Plan I <input type="checkbox"/> Plan II <input type="checkbox"/> Plan III	Included if there are different plan options available
	Plan #	Included if there are different plan options available
	\$5 Exam/\$5 Materials \$5 Exam/\$10 Materials \$10 Exam/\$10 Materials \$10 Exam/\$20 Materials \$15 Exam/\$25 Materials \$5 Exam & Materials \$10 Exam & Materials Other \$_____ Exam \$_____ Materials \$_____ Materials	Different Member Vision Provider Copayment options that can be included or not included
	Exam	Optional to remove Exam from frequency if the plan is Materials only
	<input type="checkbox"/> 12 Months/12 Months/12 Months <input type="checkbox"/> 12 Months/12 Months/24 Months <input type="checkbox"/> 12 Months/24 Months/24 Months <input type="checkbox"/> 24 Months/24 Months/24 Months	Different Frequency options that can be included or not included Exam frequency variable to remove if the plan is Materials only
	Frequency (Exam/Lenses/Frame) for covered dependent children, under age 19, if different:	Optional to be included or not included