

SERFF Tracking Number: HARP-128320372 State: Arkansas
Filing Company: Boston Mutual Life Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: Group Disability Income
Project Name/Number: /BML002

Filing at a Glance

Company: Boston Mutual Life Insurance Company

Product Name: Group Disability Income SERFF Tr Num: HARP-128320372 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num:
Closed

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: State Status: Approved-Closed
Long Term

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Joann Alleano, Michelle Disposition Date: 05/21/2012

Kunzman, Mary Bielucki, Karen

Skinner

Date Submitted: 05/21/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number: BML002

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Our domicile state,
Massachusetts does not require filing.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Association, Trust, Other

Explanation for Other Group Market Type:
Labor Union

Overall Rate Impact:

Filing Status Changed: 05/21/2012

State Status Changed: 05/21/2012

Deemer Date:

Created By: Karen Skinner

Submitted By: Karen Skinner

Corresponding Filing Tracking Number:

Filing Description:

In our capacity as the Reinsurer and designated filing agent, we are submitting the enclosed forms on behalf of Boston Mutual Life Insurance Company ("BML"). We are submitting the attached application for your review and approval for use with the Long Term Disability and Short Term Disability products which were previously approved by your department under SERFF tracking number HARP-127357096 on 10/24/2011.

SERFF Tracking Number: HARP-128320372 State: Arkansas
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State Narrative:

Company and Contact

Filing Contact Information

Karen Skinner, karen.skinner@thehartford.com
 The Hartford 860-843-4565 [Phone]
 200 Hopmeadow Street
 Mail Stop SDC 1-6
 Simsbury, CT 06089

Filing Company Information

(This filing was made by a third party - TheHartford03)

Boston Mutual Life Insurance Company	CoCode: 61476	State of Domicile: Massachusetts
120 Royall Street	Group Code:	Company Type:
Canton, MA 02021	Group Name:	State ID Number:
(800) 669-2668 ext. [Phone]	FEIN Number: 04-1106240	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50 for application filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Boston Mutual Life Insurance Company	\$50.00	05/21/2012	59311411

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/21/2012	05/21/2012

SERFF Tracking Number: *HARP-128320372* *State:* *Arkansas*
Filing Company: *Boston Mutual Life Insurance Company* *State Tracking Number:*
Company Tracking Number:
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.005 Combined Short Term and Long Term*
Product Name: *Group Disability Income*
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Disposition

Disposition Date: 05/21/2012

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	Third Party Filing Authorization	Approved-Closed	Yes
Form	Disability Income Enrollment Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: WS-GI/MI APP - DI 3/12

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 05/21/2012	WS-GI/MI APP - DI 3/12	Application/Disability Income Enrollment Form	Enrollment Form	Initial		47.500	228-074 DI Enroll042012. pdf

BOSTON MUTUAL LIFE INSURANCE COMPANY



120 Royall Street • Canton, MA 02021

NEW CHANGE

GROUP VOLUNTARY DISABILITY INCOME ENROLLMENT FORM

Employee (First, MI, Last)		S.S.N./ITIN	Gender	Date of Birth
Residential Address		City	State	Zip Code
Employer	Date of Hire	I am actively at work at least [20] hours a week. <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Monthly Earnings last 12 Months \$	

Are you currently actively at work and able to perform the duties of your occupation? Yes No

[To the best of your knowledge and belief: have you had a: a) heart attack; b) heart bypass; c) coronary artery disease; d) stroke; e) cancer (other than basal or squamous cell skin cancer); and/or f) positive test result for HIV? Yes No]

[Have you been hospitalized in the last 90 days (for any reason) or been recommended to seek: a) medical advice; b) treatment; care; and/or c) counseling that has not yet been performed? Yes No]

Disability Income Options: 1-3 (select only 1 option)

OPTION 1 - Disability Income	
BENEFIT PERIOD	ELIMINATION PERIOD
[6 Months]	[30 Days]
[Weekly] Income Amount - [\$10.00]	
Total [Weekly] Premium - [\$10.00]	

OPTION 2 - Disability Income	
BENEFIT PERIOD	ELIMINATION PERIOD
[6 Months]	[30 Days]
[Weekly] Income Amount - [\$10.00]	
Total [Weekly] Premium - [\$10.00]	

I elect Option: _____ Total [Weekly] Premium: _____

OPTION 3 I elect to Waive Coverage

Agreement and Declaration – Read Carefully Before Signing: I represent that the statements and answers written in this enrollment form are complete and true to the best of my knowledge and belief, and it is agreed that:

- A. This enrollment form shall form the basis for and become a part of any certificate issued.
- B. The insurance applied for shall be in force as of the effective date of my certificate, provided that the Company approves the coverage applied for without any modification, as to plan, amount of premium, and further, provided that the Company receives the first premium payment within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance shall take effect until the certificate has been delivered to and accepted by me.
- C. I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.
- D. I understand that the beneficiary will be my Estate unless otherwise indicated in Special Request section.
- E. I acknowledge that I have received a copy of Boston Mutual Life Insurance Company’s Notice of Information Privacy Practices and any Outline of Coverage that is required by the State.

Refer to the attached list for the State Fraud Warning.

Special Request: _____

Date _____ State Signed at: _____

Signature of Employee _____

Agent of Record _____ Agent NPN _____

FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

[ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: 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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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 benefits if false information materially related to a claim was provided by the applicant.

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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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.

MAINE: 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.

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.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

see other side

FRAUD WARNING NOTICES . . . *cont.*

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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.

OREGON: 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 may be guilty of insurance fraud.

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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.

TENNESSEE: 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.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: 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.

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.

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.

ALL OTHER STATES: 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.]

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/21/2012
Comments:		
Attachment: CERTIFICATION OF READABILITY.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	05/21/2012
Bypass Reason: We are submitting the attached application for your review and approval for use with the Long Term Disability and Short Term Disability products which were previously approved by your department under SERFF Tracking HARP-127357096, effective date of approval 10/24/2011.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Third Party Filing Authorization	Approved-Closed	05/21/2012
Comments:		
Attachment: Consulting Agreement.pdf		

CERTIFICATION OF READABILITY

Certification of Readability for form WS-GI/MI APP - DI 3/12 et al.

WS-GI/MI APP - DI 3/12 47.5

We hereby certify that the above mentioned forms meet the minimum Flesch Reading Ease Base Score.



May 21, 2012

Michelle L. Kunzman
AVP & Actuary
Hartford Life and Accident Insurance Company

Date

CUSTOMER AGREEMENT

This Customer Agreement is made and entered into effective May 1, 2011 by and between Hartford Life and Accident Insurance Company, a Connecticut corporation ("Contractor") and Boston Mutual Life Insurance Company ("Insurer").

WHEREAS, Contractor and Insurer have entered into a Consulting Services Agreement effective May 1, 2011 ("CSA") under which Contractor shall provide rate and form filing services on behalf of Insurer ("Third Party Filer Services"); and

WHEREAS, Contractor has entered into an agreement with the National Association of Insurance Commissioners (the "NAIC") under which the NAIC granted Contractor access to and use of the NAIC's electronic rate and form filing product, known as the System for Electronic Rate and Form Filing ("SERFF") to assist Contractor in providing Third Party Filer Services ("Third Party Filer License Agreement"); and

WHEREAS, prior to providing information from SERFF, Contractor and Insurer must enter into this Customer Agreement;

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties hereby agree as follows:

1. The above written recitals are true and accurate.
2. Neither Contractor nor the NAIC make any representation or warranty with respect to the SERFF product or the truth, accuracy, currency or completeness of the data in the SERFF product.
3. Neither Contractor nor the NAIC make any representations or warranties regarding the SERFF product which extend beyond the description of the SERFF product, including, without limitation, the implied warranties of merchantability and fitness for a particular purpose.
4. Insurer will not offer, sell or otherwise distribute all or any portion of the information from the SERFF product to any third party (defined as one who is not an officer, director, agent, consultant, contractor, employee, majority-owned subsidiary or affiliate of customer).
5. Insurer may share the information from the SERFF product with any of its subsidiaries or affiliates provided it discloses to Contractor the name and location of said subsidiaries and affiliates.
6. Insurer recognizes the SERFF product is the exclusive property of the NAIC and agrees to take no action adverse to such rights of the NAIC as owner and sole copyright proprietor.
7. Insurer agrees to keep all terms of this Customer Agreement confidential including pricing.

IN WITNESS WHEREOF, the parties have executed this Customer Agreement as of the date first above-written.

Boston Mutual Life Insurance Company

Hartford Life and Accident Insurance Company

By: Walter J. Gorski

By: Michelle L. Kunzman

Name: WALTER J GORSKI

Name: Michelle L. Kunzman

Its: VP, General Counsel, Secy

Its: AVP + Actuary

Date: 4/20/2011

Date: 4/21/2011

MT