

SERFF Tracking Number: INCS-128309958 State: Arkansas  
Filing Company: UnitedHealthcare Insurance Company State Tracking Number:  
Company Tracking Number: WR/RIDER 02/12 D  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: UHC Life/LTD Rider  
Project Name/Number: UHC Life/LTD Rider/WR/RIDER 02/12

## Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: UHC Life/LTD Rider SERFF Tr Num: INCS-128309958 State: Arkansas

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

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: WR/RIDER 02/12 D State Status: Approved-Closed  
Long Term

Filing Type: Form

Reviewer(s): Rosalind Minor  
Author: Renee Weaver Disposition Date: 05/01/2012  
Date Submitted: 04/27/2012 Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: UHC Life/LTD Rider  
Project Number: WR/RIDER 02/12  
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:  
Submission Type: New Submission  
Group Market Type: Employer, Other  
Overall Rate Impact:

Deemer Date:  
Submitted By: Renee Weaver

Filing Description:  
Re: UnitedHealthcare Insurance Company  
NAIC No. 60318

Enclosed Forms:  
Application Form Number: Form AA-2087  
War Exclusion Rider WAREX 02/12

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: Does not require  
prior approval  
Market Type: Group  
Group Market Size: Small and Large  
Explanation for Other Group Market Type:  
Filing Status Changed: 05/01/2012  
State Status Changed: 05/01/2012  
Created By: Renee Weaver  
Corresponding Filing Tracking Number:  
WR/RIDER 02/12

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War Risk Benefit Rider WR/Rider 02/12

This filing is being made by Innovative Compliance Solutions, LLC on behalf of UnitedHealthcare Insurance Company.

The enclosed group forms are being submitted to your Department for review. These are new forms and will not replace any forms previously filed with the Department.

These forms will be used with Group Term Life, AD&D, Short and Long Term Disability Income Policy form UHCLD-POL 2/2008 and Certificate of Coverage form UHCLD-CERT 2/2008 which was approved by your department on 5/22/2008 under SERFF file number UHCLD-125638176.

Application Form AA-2087 will be used when an employee or dependent chooses to purchase an amount of coverage in excess of the guaranteed issue amount or is a late entrant, which will require Medical Underwriting.

Form WAREX 02/12 will be used with the referenced previously approved policy form to amend the form to exclude coverage as defined in the rider.

Form WR/Rider 02/12 is an optional rider that will negate any war risk exclusion for Life/AD&D and may be purchased with or without coverage for a Nuclear or Biological or Chemical Event. Note, a Nuclear or Biological or Chemical Event that is not related to war is not excluded or affected.

The Term Life insurance provisions are being simultaneously submitted separately under SERFF filing No. INCS-128197684

#### Explanation of Variable Text

The form is made up of:

- Nonvariable Text that always appears in an issued document.
- Variable Text that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets]. Whenever text is bracketed, we have included a number that refers to the Explanation of Variables document that explains the logic of the variable. Variable text will appear unbracketed in the final documents issued to the employer and/or member.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

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If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Renee Weaver  
Innovative Compliance Solutions  
Compliance Consultant

Phone: 763-323-8643  
Email: rweaver@innovative-compliance.com  
State Narrative:

## Company and Contact

### Filing Contact Information

Renee Weaver, Consultant rweaver@innovative-compliance.com  
PO Box 773 763-323-8643 [Phone]  
Anoka, MN 55303 763-712-8001 [FAX]

### Filing Company Information

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

UnitedHealthcare Insurance Company CoCode: 79413 State of Domicile: Connecticut  
185 Asylum Street Group Code: Company Type:  
Hartford, CT 06103 Group Name: State ID Number:  
(800) 357-1371 ext. [Phone] FEIN Number: 36-2739571

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$150.00  
Retaliatory? No  
Fee Explanation: 3 forms x \$50=\$150  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$150.00	04/27/2012	58655604

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/01/2012	05/01/2012

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## Disposition

Disposition Date: 05/01/2012

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	authorization letter	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Form	War Benefit Rider	Approved-Closed	Yes
Form	War Exclusion Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: WR/Rider 02/12

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/01/2012	WR/Rider 02/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	War Benefit Rider	Initial		50.700	Revised War Risk Benefit Rider Final for filing 3-27.pdf
Approved-Closed 05/01/2012	WAREX- 02/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	War Exclusion Rider	Initial		55.400	Annotated War Exclusion Rider Final for Filing _2-29-12_.pdf
Approved-Closed 05/01/2012	Form AA- 2087	Application/ Enrollment Form	Application	Initial		0.000	AA-2087 Numbered 8-4 mks.pdf

## War Risk Benefit Rider

**(1)**[Policy/Certificate Amendment No. \_\_\_ Modification(s) to the Policy /Certificate effective \_\_\_\_\_.

**Policyholder:** ABC Company

**Policy Number:** 1234]

This Rider is issued in consideration of the required additional premium.

**(2)** [This Rider provides benefits for Covered Person's who are [Expatriates] [[or] Key Local Nationals] [and to his Dependents]. [An Expatriate is a Covered Person who, on assignment by and at the direction of his Employer, works and resides outside his own country.] [A Key Local National is a Covered Person that works and resides within his country of citizenship and who the Employer has determined is eligible under the Policy as a condition of his employment] [and/or because they are essential to the management of his work country's operation]].

This Rider does not: vary: waive: alter: or, extend any of the terms of the Policy, except as stated herein.

The [(3)Fill-in Product benefits] of the Policy will be provided for war or act of war. **(3.1)**[Any Policy exclusion{s} for loss due to: war or act of war;{(4)or, an accident of war;} {(5)which is stated in [such benefits]} is deleted.]

**(6)** [(3)The Fill-in Product benefits] of the Policy will be provided for loss resulting from an act of war provided the act of war is not the result of a Nuclear, Biological, or Chemical Event.

**(7)** [(3)The Fill-in Product benefits] of the Policy will be provided **(8)**[, not to exceed the reduced amount,] for loss resulting from an act of war provided the act of war is not the result of a Nuclear, Biological, or Chemical Event. The reduced amounts payable {are} stated in the following table:

### [Benefit

- **(3)**Life Insurance Benefit for Covered Person
- Life Insurance Benefit for Dependent
- Accidental Death and Dismemberment Benefit amount of insurance for Loss of Life
- Accidental Death and Dismemberment Benefit amount of insurance for all other losses
- Long Term Disability Maximum Monthly Benefit for all periods of Disability during the Covered Person's lifetime:

### **(9) If the Amount shown in the Schedule is greater than stated below, the amount is reduced to:**

**\$(10)**500,000 to \$10,000,000  
**\$(11)**5,000 to \$100,000  
**\$(12)**500,000 to \$10,000,000

The percentage stated in the Benefit section for the loss based on the reduced AD&D Loss of Life amount shown above

**\$(13)**1,000 to \$10,000

**(14)** [(3)The Fill-in Product benefits] of the Policy will also be provided **(15)**[, not to exceed the reduced amount,] for loss resulting from an act of war involving a Nuclear, Biological, or Chemical Event. The reduced amount{s} for an act of war involving a Nuclear, Biological, or Chemical Event {are} as stated in the following table.

### Benefit

- **(3)**Life Insurance Benefit for Covered Person
- Life Insurance Benefit for Dependent
- Accidental Death and Dismemberment Benefit amount of insurance for Loss of Life
- Accidental Death and Dismemberment Benefit amount of insurance for all other losses
- Long Term Disability Maximum Monthly Benefit for all periods of Disability during the Covered Person's lifetime:

### **(16) [If the Amount shown in the Schedule is greater than stated below, the amount is reduced to:]**

**\$(17)**500,000 to \$10,000,000  
**\$(18)**5,000 to \$100,000  
**\$(19)**500,000 to \$10,000,000

The percentage stated in the Benefit section for the loss based on the reduced AD&D Loss of Life amount shown above]

**\$(20)**1,000 to \$10,000

## War Risk Benefit Rider (continued)

(21) However, [(3) the *Fill-in Product* benefits] of the Policy will (22) [not exceed the reduced amount] for loss resulting from an act of war involving a Nuclear, Biological, or Chemical Event. The reduced amount(s) for an act of war involving a Nuclear, Biological, or Chemical Event {are} stated in the following table.

[Benefit	(23) [If the Amount shown in the Schedule is greater than stated below, the amount is reduced to:]
• (3) Life Insurance Benefit for Covered Person	(24) \$500,000 to \$10,000,000
• Life Insurance Benefit for Dependent	\$(25) 5,000 to \$100,000
• Accidental Death and Dismemberment Benefit amount of insurance for Loss of Life	\$(26) 500,000 to \$10,000,000
• Accidental Death and Dismemberment Benefit amount of insurance for all other losses	The percentage stated in the Benefit section for the loss based on the reduced AD&D Loss of Life amount shown above]
• Long Term Disability Maximum Monthly Benefit for all periods of Disability during the Covered Person's lifetime:	\$(27) 1,000 to 10,000

As used in this Rider:

(28) [Nuclear or Biological or Chemical Event means any event that involves: Nuclear weapon detonations; attacks of nuclear facilities; infectious biological attack; or, chemical dispersal attack.]

(29) [Aggregate Limitation: \$(30) [5,000,000 for: Product(s) Fill-In] for all losses incurred during any continuous (31) [30 day] period (32) {including any Nuclear or Biological or Chemical Event}.

If the total of all benefits payable under the Policy for all losses incurred due to war or act of war during any continuous (33) [30 day] period would, in the absence of the provision, exceed the Aggregate Limitation stated above, then each benefit amount payable for each such loss will be proportionately reduced so that the total will equal the above amount.]

(34) [Conversion Privilege Modification: The Conversion Privilege of the Policy is amended to provide that it will be available only to those Covered Persons {and any Dependents} who are United States citizens (35) {or permanent legal residents (green card holders)} with a United States billing address].

(1) [Dated at Golden Valley, Minnesota on \_\_\_\_\_]

Signed for the Company by:



Thomas J. McGuire, Secretary



Jeffrey D. Alter, President

(1) [UnitedHealthcare Insurance Company  
Hartford, Connecticut]

## WAR EXCLUSION RIDER

(1)[Policy/Certificate Amendment No. \_\_\_Modification(s) to the Policy /Certificate effective \_\_\_\_\_].

**Policyholder:** ABC Company

**Policy Number:** 1234]

This is new going forward so it will be added w/o different effective date. The deleted detail is not included in our current riders that are issued at time of new case.

The following Exclusion is added to the Life Insurance Benefit [and Dependent Life Benefit]:

**Exclusion:** We will not pay for any loss of life caused directly or indirectly by war or any act of war, whether declared or undeclared.

(2)[If there are any conflicts between this Rider and the Entire Group Contract, the provisions of this Rider will prevail.]

(1)[Dated at Golden Valley, Minnesota on January 11, 2012]

Signed for the Company by:



Secretary



President

(1) [UnitedHealthcare Insurance Company  
Hartford, Connecticut]

# UnitedHealthcare Insurance Company

## Personal History Questionnaire / Evidence of Insurability

**Instructions:** As you answer the following questions, please remember that you must disclose, in writing, all material facts. These are facts which an insurer would regard as likely to influence the assessment of an application. If you are in any doubt as to whether any facts are material, you should disclose them to us, as failure to do so may result in the loss of benefits, in the event of a claim, under the policy.

If you choose not to complete this form (2)[or undergo any additional examination and / or tests,] we will be unable to assess the risk and, as a result, your insurance coverage may be restricted.

Due to the nature of the information requested, you may elect to return this form (3 )[and any associated information in a sealed envelope, marked Private and Confidential and addressed directly to: UnitedHealthcare Insurance Company, Medical Underwriting Services, PO Box 17829, Portland, ME 04112, United States of America.]

**PLEASE COMPLETE THIS FORM IN INK USING BLOCK CAPITALS. DO NOT ERASE OR USE CORRECTION FLUID. TO CORRECT, CROSS OUT AND INITIAL/DATE CHANGES. ANSWER ALL QUESTIONS. THEN, SIGN THE AUTHORIZATION AND ACKNOWLEDGEMENT.**

(4)[ Name of Your Employer:	Group Policy No: ]
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### Part A – Personal Details

Last Name :	
First Name	Middle Initial
(5)[Former Name (if changed) :	
Address :	
Phone: (Home) :	E-mail address: *
Phone: (Work) :	If we need to clarify any data / omissions within this form, we may wish to do so by e-mail. Only provide an email address where you are agreeable to our contacting you for this type of information.
Phone: (Cell):	Sex : Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth :	Place of Birth :
Country of Citizenship:	Normal Country of Residence:
Please provide details of countries visited for more than 30 days in the last twelve months:	Do you expect this or your country of residence to change in the next twelve months? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please provide details: ]

**Part A – Personal Details (continued)**

<p><b>(7)</b>Current Occupation / Profession:</p> <p>Describe the duties of your Current Occupation / Profession:</p>	
<p>Does your occupation involve activities or duties involving manual work, heavy machinery or tools, working at heights, underground, underwater, offshore, explosives, security, law enforcement, professional sports, aviation other than as a fare paying passenger on a scheduled flight?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please provide details: ]</p>	
<p>Name and FULL address of your Primary Care Physician:</p> <p>Physician Phone:</p> <p>Physician Fax:</p>	
<p>Have you changed Primary Care Physician in the last <b>(8)</b>[two years?]</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes, Name and FULL address of your Prior Physician:</p> <p>Physician Phone:</p> <p>Physician Fax:</p> <p>Under the care of Prior Physician (From/To):</p>	
<p><b>(9)</b>We may ask you to be examined by an independent examiner appointed by us or our agents. If we do this, in which city would you prefer this to take place?</p>	<p>City :</p> <p>PLEASE CONFIRM PREFERRED SPECIFIC AREA OF THE CITY, IF POSSIBLE (ZIP CODE).</p>
<p>Will you be available to attend an examination within the next 60 days?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> If No, please provide dates when available.</p>	<p>Dates when available:</p> <p style="text-align: right;">]</p>
<p>If you have undergone a <b>(10)</b>[health screening within the last six months or a pre-employment medical] and would like us to consider this information, please provide <b>(11)</b>[or ask your employer to provide, a copy in a sealed envelope marked "Private &amp; Confidential", addressed to: UnitedHealthcare Insurance Company, Medical Underwriting Services, PO Box 17829, Portland, ME 04112, United States of America.]</p> <p>This may avoid the need for us to seek additional medical information. Please check the box if you are forwarding a report. <input type="checkbox"/></p>	

## Part B – Health and Other Information

If you need additional space for any answer, please use Part C.

(13) Height :  (Meters), or:  (Feet/ Inches)  
Weight:  (Kilos), or:  (Lbs) ]

1. During the (14)[past 10 years,] have you:

- consulted a doctor or any other member of the medical profession?  
Yes  No
- been an inpatient or outpatient at a hospital, clinic or nursing home for any condition or illness which required medical, surgical or psychiatric advice, treatment, investigations, tests, x-rays or electrocardiograph?  
Yes  No

There is no need to disclose colds, flu, routine vaccinations, wisdom teeth, employment medicals and (for females only) routine advice about contraception or uncomplicated pregnancy.

(15)[If you have answered Yes to either part of Question 1, complete a) to h) of this section. Answer all the questions, giving as much information as possible about each and every condition, ailment, investigation and visit. (Please use a separate sheet if necessary). If you answered No to both parts, skip to Question 2 below.

- a) Date(s), description and cause (if known) of your symptoms including the part of the body affected.
- b) What was the specific diagnosis made (if known)?
- c) When were your last symptoms?
- d) What treatment have you received for this condition in the past?
- e) What treatment are you now receiving?
- f) Give details and results of any hospital admissions, specialist referrals, investigations, operations, counseling and any follow-up treatment you have received.
- g) Are you fully recovered / discharged from follow-up?  
Yes  No
- h) How much time have you taken off work due to this condition in the last three years?

2. During the past 10 years, have you ever been advised that your blood pressure or cholesterol is too high?

Yes  No

If Yes, provide details.

3. Are you taking any pills, medicine or drugs of any kind, whether prescribed or otherwise or are you receiving any form of treatment (other than as disclosed in Question 1)?

Yes  No

If Yes, state the drug name, strength, condition & dates, or what treatment you are receiving.]

**Part B – Health and Other Information (continued)**

4. **(17)**[During the past 10 years,] have you ever been diagnosed or treated by a member of the medical profession as having **(18)**]:

- a) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  
Yes  No
- b) Hepatitis B or C?  
Yes  No
- c) any sexually transmitted disease?  
Yes  No

5. During the past 10 years, have you ever:

- a) tested positive for HIV/AIDS?  
Yes  No
- b) tested positive for Hepatitis B or C?  
Yes  No
- c) tested positive for, or been treated for, other sexually transmitted disease(s)?  
Yes  No
- b) are you awaiting test results for HIV/AIDS, Hepatitis B or C, or for any sexually transmitted disease or condition?  
Yes  No

If you have answered Yes to any part of Question 4 or Question 5, provide full details including dates: ]

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6. **(19)**[To the best of your knowledge and belief, have any of your natural grandparents, parents, brothers or sisters suffered from or died from heart disease, stroke, high blood pressure, diabetes, kidney disease or cancer before they reached the age of 65, suffered or died from multiple sclerosis, Huntington's disease or from any other hereditary illness?  
Yes  No

If Yes, state relationship, condition (if cancer please specify site), age diagnosed and age at death (if applicable).

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7. Do you consume alcohol? If Yes, please state weekly average.  
Yes  No

Beer \_\_\_\_\_ (litres) or \_\_\_\_\_ (ounces)  
Wine \_\_\_\_\_ (litres) or \_\_\_\_\_ (ounces)  
Spirits \_\_\_\_\_ (millilitres) or \_\_\_\_\_ (ounces)

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8. a) Do you or have you smoked, any cigars, cigarettes, a pipe or used chewing tobacco in the last twelve months?  
Yes  No   
If Yes, please provide details including daily consumption.

b) During the past 10 years, have you ever been advised to give up using tobacco products on medical grounds?  
Yes  No   
If Yes, please provide details including dates and reasons.

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9. In the past 5 years, have you ever participated in any dangerous avocation, sport, pursuit, or pastime (for example, skydiving, ballooning, hang gliding, motor vehicle racing, rock climbing, Russian Roulette, bungee jumping), or engaged in any other dangerous avocation or sport not listed here?  
Yes  No

If you have answered Yes, please provide details

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10. During the past 10 years, have you ever had any life or health insurance application declined, postponed, or modified, or had a waiver or extra premium added, or had an application accepted on any other special terms, or have you withdrawn an application?  
Yes  No

If Yes, please give full details including Company and policy number (if known), type of policy, date of application, reason for decision (if known) ]

**Part B – Health and Other Information (continued)**

11. **(21)**[During the past 10 years, have you ever received benefit from any income protection, disability or critical illness contract, whether sponsored by your employer or yourself?  
 Yes  No

If Yes, please give full details including Company and policy number (if known), type of policy, date of claim and reason.

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12. During the past 10 years, have you ever had any of the following, undergone any investigation in connection with them or are you awaiting any investigations?

a) Palpitations, chest pain, rheumatic, stroke or other condition of your heart or circulatory system?  
 Yes  No

b) Diabetes or any abnormality of your urine, e.g. presence of blood, sugar or albumin?  
 Yes  No

c) Tumor, cancer, growth, lump radiotherapy or chemotherapy?  
 Yes  No

d) Depression, anxiety state or other nervous or mental disorder?  
 Yes  No

e) Muscular disc, bone or joint problem, rheumatic or arthritic complaint?  
 Yes  No

f) Any ailment of the stomach, liver, bowel, kidney or bladder?  
 Yes  No

g) Any gynecological problems?  
 Yes  No

h) Any problems with or disease of your eyes or vision (not wholly corrected by spectacles)?  
 Yes  No

i) Any problems with disease of your ears, hearing or balance?  
 Yes  No

j) Any surgical operation, physical defect, infirmity, illness, ailment or accident not already covered?  
 Yes  No  ]

If you have answered Yes to any of parts **(22)**[12 a) to j),] please give full details indicating the question **(23)**[#(e.g. 12a).] Continue on next page. If you need more space, attach separate sheet with additional information.

**(24)**[Question Number \_\_\_\_\_

State Reason / Condition:	Are you receiving treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosis/Treatment/Results	If Yes, please provide full details including: Name, Address & Phone No. of Physician and/or Hospital
Date of Onset:	
Date of Last Major Attack and Symptoms:	
Date Last taken off from Work	Date Last Seen
Total No. of All Days Lost from Work	Are You Completely Recovered? Yes <input type="checkbox"/> No <input type="checkbox"/>

Question Number \_\_\_\_\_

State Reason / Condition:	Are you receiving treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosis/Treatment/Results	If Yes, please provide full details including: Name, Address & Phone No. of Physician and/or Hospital
Date of Onset:	
Date of Last Major Attack and Symptoms:	
Date Last taken off from Work	Date Last Seen
Total No. of All Days Lost from Work	Are You Completely Recovered? Yes <input type="checkbox"/> No <input type="checkbox"/>

Question Number \_\_\_\_\_

State Reason / Condition:	Are you receiving treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosis/Treatment/Results	If Yes, please provide full details including: Name, Address & Phone No. of Physician and/or Hospital
Date of Onset:	
Date of Last Major Attack and Symptoms:	
Date Last taken off from Work	Date Last Seen
Total No. of All Days Lost from Work	Are You Completely Recovered? Yes <input type="checkbox"/> No <input type="checkbox"/> ]

### Part C – Further Information

Please use this space to tell us anything else we need to know or attach a separate sheet with additional information. **(26)** [If you use it to give more information about any of the questions, please give us the Part and Question number that you are referring to. For example: Part B, Question 5.]

### Part D – Important Notes(27)

1. The full amount of your coverage may not be provided until we have assessed and accepted the application.
2. Coverage may be restricted to the Guaranteed Issue Amount provided under the policy, if any.
3. Coverage may be offered on special terms, but occasionally we may be unable to offer terms.
4. We may ask you to contact your doctor to speed up the completion of reports that we have requested.
5. If we ask you to attend a medical examination it will be necessary to share the application information with an authorized third party who will arrange for the examination to take place.
6. It may be necessary to share medical information obtained from a medical examination report or from a health screening report with your doctor.
7. On occasions the electronic transmission of medical reports may help speed up the assessment of your application. We only accept electronic transmissions directly to a secure location to ensure confidentiality. You should indicate below if you do not agree to this.

Please check this box if you do not consent to the electronic transfer of medical reports.

8. We have a Confidentiality Policy in place to ensure medical information is held securely and access is limited.
9. All answers to questions in this form, and any questions we subsequently ask, must be correct with all relevant information provided. Any failure to do so may result in the wrong terms being quoted or a claim being rejected or reduced.
10. It is important that we are told about anything that might affect our judgment and acceptance of this application. Please disclose such information even if you have doubts about its relevance.
11. It may be necessary to send your application and relevant medical reports to our Reinsurers for their opinion or agreement of the terms offered].

**Part E – Access to Medical Records**

We ask your permission in order that we may approach any doctor for medical information about anything which affects your physical or mental health. This applies both at the initial application and in the event of any claim. If you decide not to allow us to contact your doctor, it may mean that we are unable to proceed with this application.

**Part F – Fraud Warning Notice (29)[(Please review notice that applies in your state)]**

**(30)[For applicants in STATE:]**

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.

**Part G– Authorization and Acknowledgement**

**(31)[I hereby declare that]** all the statements made herein 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.

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 or my beneficiary.

I authorize UnitedHealthcare Insurance Company ("UnitedHealthcare") and its affiliates and authorized representatives to: obtain; use; and disclose; my 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: any health care provider; pharmacy benefit manager; other insurer or reinsurer; Medical Information Bureau; hospital; clinic; or other medical facility; health care clearinghouse; and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information to disclose my information to UnitedHealthcare. I also authorize UnitedHealthcare to disclose information about me to: the Medical Information Bureau; and to any third party administrator of the coverage for which I am applying; or as may be required by 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 UnitedHealthcare in writing, except to the extent that action has already been taken in reliance on this authorization. I also acknowledge the following: 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. This authorization, unless revoked earlier, expires **(32)[24 months]** after the date it is signed. I understand that: I am completing an insurance application; and, that each response must be complete and accurate. I request the indicated group coverage for myself. I have not given the agent, or, any other persons any health information not included on this form. I understand that UnitedHealthcare 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.

**(33)[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 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 certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notice.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**PLEASE PRINT NAME**

Please return this form to: **(34)[UnitedHealthcare Insurance Company, Medical Underwriting Services, PO Box 17829, Portland, ME 04112, USA**

SERFF Tracking Number: INCS-128309958 State: Arkansas  
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number:  
 Company Tracking Number: WR/RIDER 02/12 D  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
 Product Name: UHC Life/LTD Rider  
 Project Name/Number: UHC Life/LTD Rider/WR/RIDER 02/12

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	05/01/2012
<b>Comments:</b>		
<b>Attachment:</b> Readability Cert - War Coverage and War Exclusion Rider Scores.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	05/01/2012
<b>Bypass Reason:</b> NA		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> authorization letter	Approved-Closed	05/01/2012
<b>Comments:</b>		
<b>Attachment:</b> ICS Authorization UHC.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Explanation of Variables	Approved-Closed	05/01/2012
<b>Comments:</b>		
<b>Attachments:</b> SOV for Life-LTD version WRB rider Final 2-28-12.pdf AA-2087 Application Statement of Variables.pdf		

**CERTIFICATION OF COMPLIANCE  
FOR READABILITY**

<u>Form Number(s)</u>	<u>Flesch Readability Score</u>
WR/Rider 02/12	55.4
WAREX-02/12	50.7

I hereby certify on behalf of **UnitedHealthcare Insurance Company** that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores.

As permitted by the NAIC Policy Language Simplification Model Act (575-1) and related state laws and regulations, the company has excluded from scored text: the name and address of the insurance company; captions; tables; and polysyllabic words defined in the policy.



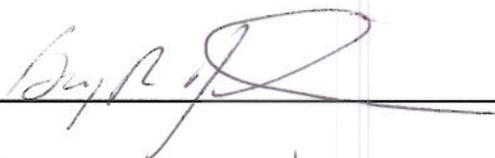
\_\_\_\_\_  
Jennifer Lewis-David, Sr. Assoc. General Counsel

Dated: 3/30/12

January 13, 2011

COMPANY: UnitedHealthcare Insurance Company  
NAIC Number: 79413  
FEIN Number: 36-2739571

Please accept this letter as authorization for Innovative Compliance Solutions, LLC to act as our agent for submission of policy forms and rate information and to perform each and every act necessary in connection with such submission on behalf of UnitedHealthcare Insurance Company.

SIGNATURE:  \_\_\_\_\_

SIGNED BY: Bryan R. Johnson

TITLE: Vice President

UnitedHealthcare Insurance Company

## STATEMENT OF VARIABLES

Form Number	Form Description
WAREX 02/12	War Exclusion Rider
WR/Rider 02/12	War Risk Benefit Rider

### General Variables.

All references to Dependents and coverage applicable to them will be omitted if the dependent class is not included. Variable 2 is used throughout.

Large brackets – any option within may be deleted

### Numbered Variables

#### **War Exclusion Rider (WAREX 02/12):**

1. Text within [ ] will be variable and unique for each Policyholder
2. In / Out

#### **War Risk Benefit Rider (WR/Rider 02/12):**

1. Text within [ ] will be variable and unique for each Policyholder
2. In / out depending on group dynamics (Expatriates, Inpatriates, Third Country Nationals and Key Local Nationals) Optional language may include:
  - [Expatriate [and to his Dependents] [within the Expatriate's home country [or]] within the [country] [geographic region] to which the Expatriate has been sent on assignment.]
  - [for Dependents [of Expatriate] only when the Dependent resides with the Expatriate in the country to which the Expatriate has been sent on assignment].
  - [Key Local Nationals and his Dependents within the Key Local National's home country.]
3. Illustrative. Benefits stated will be those in the policy to which the rider applies.
- 3.1 In / out depending on product/option chosen
4. In / out – reference to “an accident of war” is unnecessary when phrase is not in the policy being amended.
5. In / out – see explanation for item 4.
6. In / out – optional benefit
7. In / out – optional Benefit
8. May be “at reduced amounts”
9. May be “The Amount shown in the Schedule is:”

## STATEMENT OF VARIABLES

10. Range is \$500,000 to \$10,000,000. May state not applicable to particular class
11. Range is \$5,000 to \$100,000. May state not applicable to particular class
12. Range is \$500,000 to \$10,000,000. May state not applicable to particular class
13. Range is \$1,000 to \$10,000. May state not applicable to particular class
14. In / out - optional benefit that is available if the option noted by annotation (6) is selected
15. May be "at reduced amounts"
16. May be "The Amount shown in the Schedule is:"
17. Range is \$500,000 to \$10,000,000. May state not applicable to particular class
18. Range is \$5,000 to \$100,000. May state not applicable to particular class
19. Range is \$500,000 to \$10,000,000. May state not applicable to particular class
20. Range is \$1,000 to \$10,000. May state not applicable to particular class
21. In / out - optional benefit that is available if the option noted by annotation (6) is selected
22. May be "only be provided at reduced amounts."
23. May be "The Amount shown in the Schedule is:"
24. Range is \$500,000 to \$10,000,000. May state not applicable to particular
25. Range is \$5,000 to \$100,000. May state not applicable to particular class
26. Range is \$500,000 to \$10,000,000. May state not applicable to particular
27. Range is \$1,000 to \$10,000. May state not applicable to particular class
28. In / out - definition that is dependent on optional benefit chosen
29. In / out
30. Range is \$5,000,000 to \$50,000,000
31. Range of 15 days to 365 days
32. In / out
33. Range of 15 days to 365 days
34. In / depending on group dynamics (Expatriates, Inpatriates, Third Country Nationals and Key Local Nationals)
35. In / out depending on whether or not legal residents are eligible.

## STATEMENT OF VARIABLES

### DESCRIPTION OF VARIABLES

**POLICY FORM No. UHCLD-POL 2/2008**

**CERTIFICATE FORM NO. UHCLD-CERT 2/2008**

1. The first bullet under Basic Life of the SCHEDULE OF BENEFITS section of the above named Description of Variables is amended to read as follows: The basic Life benefit amounts may be shown as a flat dollar amount [\$1,000 – \$15,000,000], % of salary [1% - 1000%] or multiple of salary [1-50 times]. Each class of employee may have a different benefit amount.
2. The first bullet under Supplemental Life of the SCHEDULE OF BENEFITS section of the above named Description of Variables is amended to read as follows: The Optional Employee Supplemental Life Insurance Benefits may or may not be included. The Optional Employee Supplemental Life Insurance benefit amounts could be a flat dollar amount [\$1000 – 5,000,000], % of salary [1% - 1000%] or multiple of salary [1- 50 times].
3. The first bullet under Basic Accidental Death and Dismemberment Benefit of the SCHEDULE OF BENEFITS section of the above named Description of Variables is amended to read as follows: The basic Accidental Death and Dismemberment benefit amounts may be shown as a flat dollar amount [\$1,000 – \$15,000,000], % of salary [1% - 1000%] or multiple of salary [1-50 times]. Each class of employee may have a different benefit amount.
4. The first bullet under Supplemental Accidental Death and Dismemberment Benefit of the SCHEDULE OF BENEFITS section of the above named Description of Variables is amended to read as follows: The Optional Employee Supplemental Accidental Death and Dismemberment Insurance Benefits may or may not be included. The Optional Employee Supplemental Accidental Death and Dismemberment Insurance benefit amounts could be a flat dollar amount [\$1000 – 5,000,000], % of salary [1% - 1000%] or multiple of salary [1- 50 times].

**UNITEDHEALTHCARE INSURANCE COMPANY**  
**STATEMENT OF VARIABLE LANGUAGE**  
Application Form AA-2087

General Variables applicable to Application: Items may be renumbered if a preceding item is deleted.

Numbered Variables

1. If used for other than the International Market, logo may be changed to the appropriate UnitedHealthcare logo.
2. In / out
3. Text may state only the Address. The address, if changed, will be updated to most current.
4. In / out.
5. Order of items may be adjusted to fit page. Items may be deleted. If, for example, used for employees who are not expatriates, references to country may be omitted.
6. May be the date printed, issued, or other internal coding.
7. In / out. May provide check boxes with specific occupations or occupational classes applicable to group.
8. May be from 6 months – 5 years.
9. In / out.
10. May use other similar terminology such as “physical exam” or delete reference to pre-employment medical.
11. May state Employer, Administrator, Physician, or direct applicant to send themselves. Address will be most current.
12. Same as item 6.
13. In / out. Depending upon the group demographic may not be necessary to use both metrics and may have only one set of boxes as appropriate to the group’s employees.
14. May be less than 10 years, but will not be more.
15. Any question may be in / out. Any question with the 10 year look back, may be less but will not be more.
16. Same as item 6.
17. May be less than 10 years, but will not be more.
18. Any question may be in / out.
19. Any question may be in / out. Any look back period may be less than stated, but will not be more. Additional avocations may be added to item 9 particularly if a dangerous avocation emerges in popularity, but such will be similar and in keeping with those listed.
20. Same as item 6.
21. Any question may be in / out. Any look back period may be less than stated, but will not be more.
22. Items will be numbered to reflect any change in the numbering of the actual questions so that if a question is deleted, for example, the next number will be correctly sequenced.
23. Same as item 22.
24. In / out. Extra boxes of same may be added if there is room, or deleted if more space is needed.
25. Same as item 6.
26. In / out. Directions may be revised for clarity.
27. Any item is in / out.
28. Same as item 6.
29. In / out.
30. If state variation is required, will give applicable state and version.
31. In / out.
32. May be less than 24 months but not more. May have a state variation incorporated such as “24 months, except in XX state the period will not exceed 12 months.”
33. In / out.
34. If address changes, will show most current.
35. Same as item 6.