

SERFF Tracking Number: ONFS-128454751 State: Arkansas
Filing Company: Ohio National Life Assurance Corporation State Tracking Number:
Company Tracking Number: FORM 3197
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.008 Combined Short Term and Long Term -
Unrelated to marketing with employer or
association groups
Product Name: Disability Income Amendment
Project Name/Number: /

Filing at a Glance

Company: Ohio National Life Assurance Corporation

Product Name: Disability Income Amendment SERFF Tr Num: ONFS-128454751 State: Arkansas

TOI: H111 Individual Health - Disability Income SERFF Status: Closed-Approved-
Closed State Tr Num:

Sub-TOI: H111.008 Combined Short Term and Long Term - Unrelated to marketing with
employer or association groups Co Tr Num: FORM 3197 State Status: Approved-Closed

Filing Type: Form

Authors: Doris Jackson, Noreen
Luptowski, ALMI, ACS, Peggy
Johnson, Katherine Skerchock
Date Submitted: 06/12/2012

Reviewer(s): Rosalind Minor
Disposition Date: 06/12/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

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: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/12/2012

State Status Changed: 06/12/2012

Deemer Date:

Created By: Peggy Johnson

Submitted By: Katherine Skerchock

Corresponding Filing Tracking Number:

Filing Description:

Re: Form 3197, Disability Income Amendment

Enclosed for your review and approval is this Amendment, which is for use with policy forms 11DI-1.AR and 11DI-2.AR, which were approved in your state on 06/23/2011, SERFF tracking number ONFS-127188809. There are no rates

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associated with this Amendment. It can only be added to the policy at the time of issue.

The purpose of this Amendment is to prevent the insured from becoming over insured. It will only be added to the policy if the Insured has, or has access to, a voluntary group long term disability program. If the Insured does not elect the group coverage, the monthly benefits provided by the policy will be that which would otherwise have been available. If the Insured chooses to add such coverage, the monthly benefits provided under the policy will be reduced as described in the Amendment.

The application that will be used in applying for this policy with which this form is to be used is Form 6465-AR which was approved for use in your state on 06/23/2011, ONFS- 127140965.

Please feel free to contact me with any additional questions or concerns. I can be reached at 1-800-366-6654, Dept. 7, Option 2 (press 7 after the initial greeting, the system does not prompt this), via fax at 1-513-794-4522, or at the following e-mail address: Doris_Jackson@ohionational.com.

Thank you for your assistance with this filing. I look forward to receiving your approval.

Sincerely,

Doris Jackson, FLMI, AIRC, HIA, CCP
Contract Compliance Regulatory Coordinator
Contract Compliance/Product Development
State Narrative:

Company and Contact

Filing Contact Information

Doris Jackson, Doris_Jackson@ohionational.com
One Financial Way 513-794-6440 [Phone]
Cincinnati, OH 45242 513-794-4522 [FAX]

Filing Company Information

Ohio National Life Assurance Corporation CoCode: 89206 State of Domicile: Ohio
1 Financial Way Group Code: 704 Company Type: Life and Annuity
Cincinnati, OH 45242 Group Name: ONFS State ID Number:

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(513) 794-6100 ext. [Phone]

FEIN Number: 31-0962495

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ohio National Life Assurance Corporation	\$50.00	06/12/2012	60069531

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	06/12/2012	06/12/2012

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Disposition

Disposition Date: 06/12/2012

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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number: Form 3197

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/12/2012	Form 3197	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		Initial		54.000	Form 3197.pdf

Ohio National Life Assurance Corporation
P.O. Box 5409
Cincinnati, OH 45201-5409

AMENDMENT

Insured:

Policy Number:

Date Application Signed:

In your application for Disability Income Insurance coverage, you indicated that you either have existing group long-term disability insurance coverage or are eligible for group long-term disability insurance coverage in the next 12 months.

This policy has been issued on the basis that you, the Undersigned, have agreed not to participate in any group long-term disability insurance plan available to you from your current employer. In the event that you are a current participant in a group long-term disability insurance plan, you represent and warrant that you have, as of the date indicated below, caused your coverage under that group long-term disability insurance plan to terminate. You further agree to decline to participate in any group long-term disability insurance plan that may currently be available or may become available to you in the future through your current employer. You further agree that should you retain coverage in any group long-term disability insurance plan or obtain coverage as a participant in any group long-term disability insurance plan in the future from your current employer, the Monthly Benefit Amount of the above-referenced policy shall be reduced and offset by the monthly benefit amount that is in force with such group long-term disability insurance plan.

Dated at _____ this _____ day of _____, 20____.
(City) (State)

Proposed Insured

Witness

**Sign, Date and Witness both copies.
One copy becomes part of the policy.
Return the second copy to the Underwriting Department.**

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/12/2012
Comments:		
Attachment: Flesch Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	06/12/2012
Comments:		
Attachment: 6465-AR.pdf		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	06/12/2012
Bypass Reason: This is not a rate change.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	06/12/2012
Bypass Reason: This filing does not contain a policy.		
Comments:		

FLESCH CERTIFICATION

STATE OF OHIO)
) SS
COUNTY OF HAMILTON)

The undersigned officer of OHIO NATIONAL LIFE ASSURANCE CORPORATION certifies:

1. The number of words and Flesch reading ease test score in the forms are as follows:

<u>Policy Forms</u>	<u>No. of Words</u>	<u>Flesch</u>
11DI-1	5694	56
 <u>Rider Forms</u>		
11DCL-1	438	50
11DGP-1	844	51
11DSI-1	689	55

The following Endorsements and Application and the base policy forms were scored together because the policy endorsements modify and become a part of the policy. The combined Flesch Reading Ease Test Score exceeds the minimum.

Endorsements and Application
11DMD-2
6465-AR

- 2. Such forms are printed in not less than ten point type, one point leaded.
- 3. No textual language or terminology was excepted in arriving at said Flesch score.
- 4. The entire text of the forms was analyzed.

IN WITNESS WHEREOF, I have signed my name this 26 day of May, 2011.

OHIO NATIONAL LIFE ASSURANCE CORPORATION

BY: 
Elizabeth F. Martini
Vice President and Counsel

Disability Income Insurance Application

1. Proposed Insured Information

a. First Name Middle Name (no initials, please) Last Name

b. Home Address How long at this address?
 City State Zip

c. Mailing Address (if different than home) City State Zip

d. Birth Date **e.** Issue Age (nearest birthday) **f.** Male Female **g.** Social Security Number

h. Driver's License Number **i.** Expiration Date **j.** State Licensed **k.** State of Birth **l.** Country of Birth

m. Are you a U.S. citizen? Yes No
 If "No," currently a citizen of what country?

n. If non-US citizen, do you have a U.S. Green Card? Yes No

o. Home Phone Number **p.** Business Phone Number **q.** Other Phone Number

2. Proposed Insured Employment Information

a. Occupation/Position **b.** Type of Business

c. Present Employer
 Address City County State Zip

d. Length of Current Employment **e.** How many hours per week are you at work in this occupation?

f. Description of Specific Duties (Do not state "usual" or "normal," please be specific.)

g. Additional Occupation(s)/Position(s) and hours worked per week

h. Type of Business

3. Temporary Insurance Coverage - Individual Disability Coverage Only (Check answer to left of question.)

Yes No **a.** Have you been diagnosed as having had, or been treated for, heart attack, stroke or cancer within the last two years or been advised to have any surgery which has not been performed or are you now pregnant?

Yes No **b.** Have you applied for or are you now receiving disability benefits, workers' or unemployment compensation benefits or a pension disability benefit?

Yes No **c.** Have you within the last 5 years been diagnosed as having had, or been treated or advised to seek treatment for: drug abuse or alcoholism; emotional, neurological or mental disorder; or arthritis or any back or neck disorder?

If 3a, 3b or 3c are answered "Yes" or if the total amount applied for exceeds \$5,000 per month, no premium may be accepted, 3d must be answered "No", and you will not obtain coverage except as provided in part c of the Mutual Agreements on page 7.

d. Is premium submitted with this application? Yes No Amount remitted \$

4. Other Coverage/Replacement Information (Check answer to left of question.)

- Yes No **a.** Do you have existing Disability Insurance?
- Yes No **b.** Are you eligible for other Disability Insurance, including Group Disability Insurance, in the next 12 months?
- Yes No **c.** Are you currently applying for other Disability Insurance including, but not limited to, Individual or Group Disability Insurance? If yes, provide details: _____
- Yes No **d.** Do any of your policies contain the Catastrophic Disability Rider? If so, list monthly Catastrophic Cost Benefit Amount. \$ _____
- Yes No **e.** Does the proposed policy replace or cause changes in any existing policy?

If either 4a, 4b, 4c, 4d, or 4e is answered "Yes," list all types of Disability Insurance below, and indicate whether the proposed policy will replace or cause change in any existing policy. If group or association, include the percentage and maximum cap.

Company or Source	Type: DI, Group, BOE, or Buy-Sell	Year Issued	Base Monthly Benefit Amount	Maximum Benefit Period	Check if Employer Paid	Will Coverage Be Changed or Replaced?	Date of Replacement
			\$		<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	
			\$		<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	
			\$		<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	
			\$		<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	

Attach any state replacement and/or transfer form.

5. Nonmedical Information (Check answer to left of question.)

Have you:

- Yes No **a.** ever applied for insurance or policy reinstatement which was declined, postponed, rated, ridered or modified?
- Yes No **b.** within the last five years, been charged with, but not acquitted of, the violation of any criminal law?
- Yes No **c.** any intention of traveling or residing outside the United States or Puerto Rico?
- Yes No **d.** been placed on current active status in the Armed Forces, or expect to have active status in the near future? (If "Yes," complete the appropriate state version of Form 6500.)
- Yes No **e.** within the last five years, engaged in or plan to engage in flying as a pilot or crewmember? (If "Yes," complete appropriate state version of Form 6256A.)
- Yes No **f.** within the last five years, engaged in or plan to engage in motorized racing, hang gliding, ballooning, sky-diving, parachuting, bungee jumping, mountain, rock, or other climbing, scuba diving, or other hazardous avocations?
- Yes No **g.** filed for bankruptcy, either personal or any business you have owned within the last seven years? If "Yes" indicate type and date of discharge.

- Yes No **h.** smoked cigarettes in the last 12 months? If "Yes," indicate date last smoked.

- Yes No **i.** used other forms of tobacco such as cigars, pipe, chewing tobacco or snuff in the last 12 months? If "Yes," indicate date last used.

- Yes No **j.** in the past 5 years, had your professional license revoked, suspended or investigated for any reason or been disbarred?

Details of "Yes" answers. Please identify the question.

6. Financial Information

Fill in all applicable items below to show amounts as required to be reported for **federal income tax purposes**. Show your income only. Do not include the income of your spouse or other family members. Your earned income must be shown as **net earnings after deductions for all business expenses**.

	Current Calendar Year-to-Date	Prior Calendar Year	Second Prior Calendar Year
a. Salary or Wages from Form W2.	\$ _____	\$ _____	\$ _____
b. Sole Proprietor Net Profit from 1040 Schedule C.	\$ _____	\$ _____	\$ _____
c. Share of Partnership or S Corp Non-passive Income from 1040 Schedule E	\$ _____	\$ _____	\$ _____
d. Contributions to Qualified Pension, Profit Sharing or 401(k) plan that would cease if the proposed insured were disabled.	\$ _____	\$ _____	\$ _____
e. Other Earned Income from any other full or part-time work. (Explain in question 2g – pg. 1)	\$ _____	\$ _____	\$ _____
f. Total Earned Income (Must be completed.)	\$ _____	\$ _____	\$ _____
g. Unearned Income including passive income.	\$ _____	\$ _____	\$ _____
h. Net Worth Is your net worth greater than \$5,000,000? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," state amount: \$ _____			

Include LLC in appropriate business category above.

7. Individual DI Coverage

a. Proposed Insured's Occupational Class: Medical 5M 4M 3M
Non-Medical 5A 4A 3A 2A A B

b. Plan Requested:
 Level Premium Step Rate Premium

c. Base Monthly Benefit:

Amount	A,B Occ Only					A,B Occ Only					
	Waiting/ Elimination Period					Benefit Period					
	30	60	90	180	365	1y	2y	5y	A65	A67	A70
1. Base: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Social Insurance Supplement: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d. Additional Benefits/Riders:

- Residual Disability Rider
- Guarantee of Physical Insurability \$ _____
- Cost of Living Increase Rider
- Waiver of Waiting Period (A&B only)
- _____

e. 1. Are you a Business Owner? Yes No

2. If "Yes," indicate type of business: Sole Proprietorship Partnership C-Corporation S-Corporation
(Include LLC in appropriate business category).

f. 1. Will your employer pay any part of premium? Yes No If "Yes," what percentage? _____ %

2. Will the premium paid by your employer be reported to you as W-2 taxable income? Yes No

g. Premium Mode: A S Q M (Bank Draft) List Bill Group No. _____ Other _____

h. Discount Applied for: List Bill: Multi-Life
 Small Group (3-5) Other _____
 Large Group (6+)

Medical Information
Complete whenever applying on a non-medical basis.

12. Proposed Insured

a. Name of your personal physician Phone Number

b. Address of your personal physician City State Zip

c. Date and reason last consulted. d. Height Weight

13.-18. Additional Medical Information (Check answer to left of question.)

As used below, "disorder" includes disease, illness, injury, deformity, condition or impairment of any kind.

- | | |
|---|--|
| <p><input type="checkbox"/> Yes <input type="checkbox"/> No 13. Is anyone proposed for coverage currently taking any prescription medication or under treatment or observation by a medical practitioner?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 14. Has anyone proposed for coverage had a weight change of over 10 pounds in the last year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 15. Has anyone proposed for coverage ever had any of the following:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a) chest pain, high blood pressure, heart murmur, heart attack, stroke or other disorder of the heart or circulatory system?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b) any disorder of the nervous system, paralysis, seizure disorder, dizziness or severe or recurrent headaches?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c) shortness of breath, asthma, bronchitis, emphysema, sleep apnea, or any other respiratory disorder?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No d) hernia, ulcers, hepatitis or any disorder of the stomach, liver, gallbladder, pancreas, intestines or rectum?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No e) sugar, protein or blood in the urine, stone or other disorder of the kidney, bladder, prostate or reproductive organs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No f) cancer, tumor, cyst, goiter or diabetes?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No g) gout, arthritis, rheumatism or disorder of the muscles or bones, including the spine, back or joints?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No h) allergy or any disorder of the skin, eyes, ears, nose, throat, sinuses, larynx, spleen or lymph glands?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No i) Fibromyalgia, chronic fatigue or Chronic Fatigue Syndrome, Epstein Barr virus, or Lyme Disease?</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No 16. Has anyone proposed for coverage ever:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a) been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV (Human Immunodeficiency Virus)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b) received disability benefits or compensation or a disability pension?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c) used barbiturates, tranquilizers, narcotics, cocaine, marijuana, amphetamines, inhalants, anabolic steroids or hallucinogens; except as legally prescribed by a physician (if physician, other than yourself)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No d) been treated or advised to seek treatment for drug abuse or alcoholism?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No e) had any disorder of the breasts, disorder of menstruation, miscarriage or complications of pregnancy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 17. To the best of your knowledge and belief, are you now pregnant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 18. Has anyone proposed for coverage had, within the last five years, other than as noted above:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a) a check-up, consultation, illness, injury or surgery, or been a patient in a hospital, clinic or sanitarium?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b) an EKG, X-ray or other diagnostic test, or advised to have a diagnostic test, or hospitalization or surgery?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c) received marriage counseling or been treated or received counseling for anxiety, depression, stress, mental or nervous disorder or other emotional disorder?</p> |
|---|--|

Details of "Yes" answers in this section. Please identify the question by number and letter. Include all diagnoses, including the names and dosages of all medications, as well as names and addresses of all medical practitioners.
