

State: Arkansas **Filing Company:** Reserve National Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: HHC Applications
Project Name/Number: RESERVE/66/66

Filing at a Glance

Company: Reserve National Insurance Company
Product Name: HHC Applications
State: Arkansas
TOI: H21 Health - Other
Sub-TOI: H21.000 Health - Other
Filing Type: Form
Date Submitted: 07/09/2012
SERFF Tr Num: FRCS-128547421
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 5783

Implementation: On Approval
Date Requested:
Author(s): Marilyn Odell
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 07/13/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: Reserve National Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: HHC Applications
Project Name/Number: RESERVE/66/66

General Information

Project Name: RESERVE/66 Status of Filing in Domicile: Pending
Project Number: 66 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Filing submitted in domicile state (OK) on or about this same date.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type: Individual
Overall Rate Impact: Filing Status Changed: 07/13/2012
State Status Changed: 07/13/2012
Deemer Date: Created By: Marilyn Odell
Submitted By: Exselsa Cartwright Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

We have been retained by Reserve National Insurance Company to file the enclosed forms for approval in your state.

Our fee of \$100 has been sent by EFT on this same date.

The enclosed applications will be used to apply for the Company's previously-approved Home Health Care Indemnity Policy, HHC-95, approved 1/20/95. C-KSB-0812-AR will be used when the applicant is also applying for the Company's Modified Whole Life Policy, MWL-97, approved 5/24/04. Please note that the Home Health Care Indemnity Policy is not long-term care insurance.

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

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

Company and Contact

Filing Contact Information

Marilyn Odell, Compliance Specialist marilyn.odell@firstconsulting.com
1020 Central 800-927-2730 [Phone] 2835 [Ext]
Suite 201 816-391-2755 [FAX]
Kansas City, MO 64105

Filing Company Information

(This filing was made by a third party - FC01)

Reserve National Insurance Company	CoCode: 68462	State of Domicile: Oklahoma
601 East Britton Road	Group Code: 215	Company Type:
Oklahoma City, OK 73114	Group Name: Unitrin, Inc	State ID Number:
(405) 848-7931 ext. [Phone]	FEIN Number: 73-0661453	

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Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: \$50.00 x 2 = \$100.00
Per Company: No

Company	Amount	Date Processed	Transaction #
Reserve National Insurance Company	\$100.00	07/09/2012	60747147

SERFF Tracking #:	FRCS-128547421	State Tracking #:		Company Tracking #:	5783
State:	Arkansas	Filing Company:	Reserve National Insurance Company		
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other				
Product Name:	HHC Applications				
Project Name/Number:	RESERVE/66/66				

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/13/2012	07/13/2012

SERFF Tracking #:	FRCS-128547421	State Tracking #:	Company Tracking #:	5783
State:	Arkansas	Filing Company:	Reserve National Insurance Company	
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other			
Product Name:	HHC Applications			
Project Name/Number:	RESERVE/66/66			

Disposition

Disposition Date: 07/13/2012

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Application for Home Health Care & Modified Whole Life Insurance	Approved-Closed	Yes
Form	Application for Home Health Care Insurance	Approved-Closed	Yes

SERFF Tracking #:	FRCS-128547421	State Tracking #:		Company Tracking #:	5783
State:	Arkansas	Filing Company:	Reserve National Insurance Company		
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other				
Product Name:	HHC Applications				
Project Name/Number:	RESERVE/66/66				

Form Schedule

Lead Form Number: C-KSB-0812-AR							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1	Approved-Closed 07/13/2012	C-KSB-0812-AR	AEF	Application for Home Health Care & Modified Whole Life Insurance	Initial:	54.000	Kemper_Life_Health-Senior_Care_App_AR.pdf
2	Approved-Closed 07/13/2012	H-KSB-0812-AR	AEF	Application for Home Health Care Insurance	Initial:	54.200	Kemper_Health-Senior_Care_App_AR.pdf

Form Type Legend:

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



Application for Life and/or Home Health
Care Indemnity Insurance

**Insurance Benefits Provided by
Reserve National Insurance Company**

APPLICANT	Full Legal Name of Proposed Insured _____
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security No. _____ / _____ / _____ Date of Birth _____ / _____ / _____
	Legal Residence Address _____ Street _____ City _____ State _____ Zip _____
	Mailing Address _____ Street _____ City _____ State _____ Zip _____
	Phone No. _____ / _____ / _____ E-mail _____
	Name of Owner if other than Proposed Insured _____

MODIFIED WHOLE LIFE POLICY	<i>HOME OFFICE USE: Policy Number(s)</i>
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GUARANTEE ISSUE	If you are applying for the Modified Whole Life Policy, please answer the following:	
	Policy Amount: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000	
	1. Do you have existing life insurance or annuity contracts in force?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Will this insurance replace in whole or in part any other insurance?..... <i>(This policy will not be issued to replace other coverages)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Do you elect to pay delinquent premiums pursuant to the Automatic Premium Loan Provision?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you understand that a reduced death benefit amount may be payable during the first two policy years according to the terms of the policy?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Agent Statement:</i> To the best of my knowledge the proposed insured <input type="checkbox"/> does <input type="checkbox"/> does not have any existing life insurance or annuity contracts.		
Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Monthly (Automated Bank Account Withdrawal)		
Initial Premium \$ _____		
Primary Beneficiary	Relationship to Insured	Date of Birth
_____	_____	_____
<i>If more space is needed, list on a separate sheet.</i>		

HOME HEALTH CARE INDEMNITY POLICY	<i>HOME OFFICE USE: Policy Number(s)</i>
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UNDERWRITING	If you are applying for the Home Health Care Indemnity Policy, please answer the following:	
	1. Do you have any health insurance (including home health care, long-term care, or similar coverage) in force at the time of this application?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. If the answer to Question 1 is "Yes," do you intend to replace your current health insurance coverage with the policy applied for? (Complete Replacement Notice if "Yes").....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting or transferring to or from a bed or chair?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you acknowledge receipt of an outline of coverage for this policy?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Monthly (Automated Bank Account Withdrawal)		
Base Policy	Initial Premium \$ _____	
Base Policy + Extra Benefit Rider	Initial Premium \$ _____	

TOTAL INITIAL PREMIUM	\$ _____
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**Insurance Benefits Provided by
Reserve National Insurance Company**

APPLICANT	Full Legal Name of Proposed Insured _____
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security No. _____ / _____ / _____ Date of Birth _____ / _____ / _____
	Legal Residence Address _____ Street _____ City _____ State _____ Zip _____
	Mailing Address _____ Street _____ City _____ State _____ Zip _____
	Phone No. _____ / _____ / _____ E-mail _____
	Name of Owner if other than Proposed Insured _____

HOME HEALTH CARE INDEMNITY POLICY	<i>HOME OFFICE USE: Policy Number(s)</i>
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UNDERWRITING	If you are applying for the Home Health Care Indemnity Policy, please answer the following:	
	1. Do you have any health insurance (including home health care, long-term care, or similar coverage) in force at the time of this application?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. If the answer to Question 1 is "Yes," do you intend to replace your current health insurance coverage with the policy applied for? (Complete Replacement Notice if "Yes").....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting or transferring to or from a bed or chair?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Do you acknowledge receipt of an outline of coverage for this policy?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No

Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Monthly (Automated Bank Account Withdrawal)	
Base Policy	<i>Initial Premium \$</i> _____
Base Policy + Extra Benefit Rider	<i>Initial Premium \$</i> _____

AGREEMENTS & SIGNATURES

IT IS REPRESENTED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto will be the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application will not be considered in force until issued by the Company and the first premium paid during the insured's lifetime. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. For purposes of insurability and underwriting determinations by Reserve National Insurance Company, I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, pharmacy related service organization, or other medical or medically-related facility, insurance company or MIB, Inc. ("MIB"), that has any health or medical records or knowledge concerning me or any members of my family named in this application, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I, or my authorized representative, am/is entitled to receive a copy of this authorization upon request. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114. If this application was taken over the telephone, I state that my answers were correctly recorded and I have signed this application after the telephone call.

SERFF Tracking #:	FRCS-128547421	State Tracking #:		Company Tracking #:	5783
State:	Arkansas	Filing Company:	Reserve National Insurance Company		
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other				
Product Name:	HHC Applications				
Project Name/Number:	RESERVE/66/66				

Supporting Document Schedules

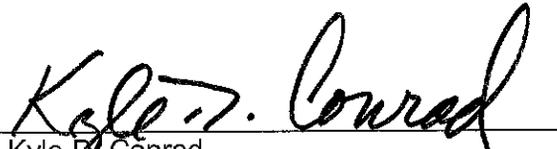
		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/13/2012
Comments:			
Attachment(s):			
AR Readability.pdf			
Authorization_3-29-2012.pdf			
AR CoC.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	07/13/2012
Comments:	Not applicable to this application filing.		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/13/2012
Bypass Reason:	Not applicable to this filing.		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	07/13/2012
Bypass Reason:	Not applicable to this filing.		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/13/2012
Bypass Reason:	Not applicable to this filing.		
Comments:			

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: Reserve National Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
C-KSB-0812-AR	54.0
H-KSB-0812-AR	54.2



Kyle D. Conrad
Sr. Vice President and Associate
Corporate Counsel

June 30, 2012

Date



Reserve National Insurance Company
601 East Britton Road
Oklahoma City, OK 73114-7710
reservenational.com

Date: March 29, 2012

To: The Insurance Commissioner

Authorization

This Authorization, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters related to forms and rates before the Insurance Department.

This Authorization shall be valid for a period of one year and renewable for a like period at the end of each term until terminated by the Company.

Company Name: Reserve National Insurance Company

Signature: 

Name: Kyle D. Conrad

Title: Sr. Vice President and Assoc. Corp. Counsel

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: Reserve National Insurance Company
Form Title(s): Application for Home Health Care & Modified Whole Life Insurance;
Application for Home Health Care Insurance
Form Number(s): C-KSB-0812-AR; H-KSB-0812-AR

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Kyle D. Conrad
Sr. Vice President and Associate
Corporate Counsel

June 30, 2012

Date