

SERFF Tracking Number: AMCM-125838886 State: Arkansas
 Filing Company: American Community Mutual Insurance Company State Tracking Number: 40411
 Company Tracking Number: RA 8/08
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Rewrite Application
 Project Name/Number: /

Filing at a Glance

Company: American Community Mutual Insurance Company

Product Name: Rewrite Application SERFF Tr Num: AMCM-125838886 State: ArkansasLH
 TOI: H16I Individual Health - Major Medical SERFF Status: Closed State Tr Num: 40411
 Sub-TOI: H16I.005A Individual - Preferred Co Tr Num: RA 8/08 State Status: Approved-Closed
 Provider (PPO)
 Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
 Author: Michele Dickelman Disposition Date: 10/02/2008
 Date Submitted: 10/01/2008 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile:
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: Exempt from filing in Michigan.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Group Market Size:
 Overall Rate Impact: Group Market Type:
 Filing Status Changed: 10/02/2008 Deemer Date:
 State Status Changed: 10/02/2008
 Corresponding Filing Tracking Number:
 Filing Description:

Attached is individual insurance application form AR RA 8/08, Arkansas Re-write of Existing American Community Individual Health Insurance. This application will be used in the individual market by people currently insured by us who are seeking to apply for a different product with us. This is a new form, and it does not replace any forms currently in use in your state.

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Any bracketed material represents variable information. No such items will be contradictory to any applicable state or federal law.

Company and Contact

Filing Contact Information

Michele Dickelman, Sr. Compliance Specialist mdickelman@american-community.com
 39201 Seven Mile Road (800) 991-2642 [Phone]
 Livonia, MI 48152 (734) 591-4628[FAX]

Filing Company Information

American Community Mutual Insurance CoCode: 60305 State of Domicile: Michigan
 Company
 39201 Seven Mile Road Group Code: Company Type:
 Livonia, MI 48152 Group Name: State ID Number:
 (800) 991-2642 ext. [Phone] FEIN Number: 38-1290976

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: 1 application form = \$20.00

ACMIC USE ONLY acct #6200030

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Community Mutual Insurance Company	\$20.00	10/01/2008	22856757

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	10/02/2008	10/02/2008

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Disposition

Disposition Date: 10/02/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Arkansas Re-write of Existing American Community Individual Health Insurance	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AR RA 8/08	Application/Enrollment Form	Arkansas Re-write of Initial Existing American Community Individual Health Insurance			40	AR RA 8-08.pdf

Arkansas Re-write of Existing American Community Individual Health Insurance

Agent #: _____



PART I

A. INSTRUCTIONS FOR KEY APPLICANT This application is to be used for rewriting your in force American Community Mutual Insurance Company (herein referred to as “American Community” or “AC”) Individual Health Policy to a new plan of insurance, including plan changes and increasing benefits. This application cannot be used to add a dependent who is not covered by the current policy.

Thank you for applying to American Community. Your health insurance is important protection and the application process is a crucial part of securing coverage for you and your family. Please take the time to carefully complete this application; your answers will become part of the underwriting process and the insurance contract. When completing the application, please follow these procedures:

1. The Application is to be completed by the Key Applicant (Proposed Insured). Children only policies require the parent or guardian who has custody and care of the children to complete and sign the application.
2. Questions apply to each person applying for coverage (all applicants). Provide updated information regarding existing conditions since approval of existing policy as well as new conditions and changes in health status.
3. Please print in black or blue ink only. Signatures are to be written and must be legible (dependents age 18 and over must also sign the application).
4. Corrections to answers can be made by drawing a straight line through the incorrect answer and printing the correct response above the lined-out answer. Applicant must then initial and date the correction.
5. Errors in signature(s) and/or date/time cannot be corrected. A new application is required.
6. Applications should be completed and mailed as soon as possible so they are received by American Community within 30 days of the application date.
7. **Do not cancel your existing American Community insurance coverage** until your new American Community policy has been issued and the policy has been delivered and fully accepted by you. Premiums for the new policy are not required until the new application has been approved by our Underwriting Department and accepted on delivery by the Key Applicant.
8. Your new insurance at American Community will be in force when all of the following events take place:
 - a. The application has been approved for policy issue by American Community’s Underwriting Department.
 - b. Any amendments/exclusion riders to the policy have been signed by the Applicant and received at our Home Office.
9. The effective date of coverage will be the paid-to date of the in force policy.
10. **If Applicant is changing from an American Community Group plan, please use the regular HA-1 Health Application.**
11. If you need to change the address we have on file or if you wish to change the method by which you are currently paying your premium, you need to contact Customer Service at **(800) 991- 2642**.

Arkansas Application for Individual Health Insurance Policies-Rewrite

Please complete application in blue or black ink.



Thank you for rewriting with American Community. Please take the time to carefully complete this application. Your answers will become part of the underwriting process and the insurance contract.

PART II

A. TYPE OF APPLICATION

Rewrite of existing policy with AC. Current Policy # _____

B. PERSONS APPLYING FOR INSURANCE

1. List all Family Members applying for insurance. Children must be at least 15 days old and under 22 years old. Include maiden names of females in parentheses. To qualify as a full time (FT) student (for children between the ages of 18 and 22), a child must be enrolled in a minimum of 12 credit hours at a college, university, or trade school. (If additional space is needed to list your children, please attach an additional page.)

Full Name First-Middle-Last (Include Maiden Name if used within past 5 yrs.)	Relationship to Applicant	Sex M/F	Height FT. IN.	Weight LBS.	✓ if FT Student
	Key Applicant				
	Spouse				
	Child				
	Child				
	Child				

2. If any proposed applicant does not live at the above address, please explain: _____

3. Contact Numbers

Daytime Ph. #
Evening Ph. #
Spouse's Ph. #
E-mail Address

4. Occupation(s) If self-employed, please identify or describe your occupation.

Key Applicant Occupation:
Spouse Occupation:

You may be contacted for a telephone interview.

Please indicate the best time (between 8:00 a.m. and 5:00 p.m. Eastern Standard Time) for an interview: _____

C. BENEFITS REQUESTED

Please complete, sign and attach the Arkansas Product Selection Form identifying the Health Plan selected.

D. QUESTIONS APPLY TO EACH PERSON APPLYING FOR COVERAGE (APPLICANTS)

Please answer all questions.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you, your spouse, significant other, or any dependent or adopted child now pregnant or is there an adoption pending?
If yes, Do Not Submit Application..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has any applicant's driver's license been suspended or revoked since approval of the policy to be replaced?
If yes, please provide their name and driver's license number.....
Name: _____ Driver's license number: _____
If yes, and alcohol or drugs were related to suspension/revocation, please complete Alcohol/Drug Questionnaire. | <input type="checkbox"/> | <input type="checkbox"/> |

Has anyone applying for coverage (Document details of any "Yes" answers on page 3):

- | | Yes | No |
|--|--------------------------|--------------------------|
| 3. Had a change in health status since approval of the policy to be replaced? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Been diagnosed or treated for any medical symptom or condition since approval of the policy to be replaced? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Had any diagnostic testing, treatment, or surgery recommended or scheduled that has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Had any symptoms or conditions for which a prudent person would seek medical advice or treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Taken, or currently take, any medication? | <input type="checkbox"/> | <input type="checkbox"/> |

Note: Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of this policy, if approved, only if such sickness, injury, or condition is fully disclosed on this application and is not excluded from coverage by a rider or policy exclusion.

If any questions or conditions in section D are checked "Yes", please explain below (use additional paper, if necessary). Please indicate all details of the symptoms, injury, ailment or condition. Include items such as specific location of condition, diagnosis, type of treatment, testing, and/or hospitalization.

Question Number	Patient/Applicant	Condition, Injury, Symptom, or Diagnosis			Was recovery complete?	Treatment or advice given, surgery performed, diagnostic test results and medications prescribed	Name, address and phone number of doctors and hospitals
		Condition	Date began	Date last treated			

Additional Information:

E. CONSENT, TERMS AND CONDITIONS

1. I represent that I have read this Application and understand each of the questions, and that the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any misrepresentation on this Application will void my policy at the discretion of American Community. I further agree that if a policy is issued, it will be issued by American Community in full reliance and in consideration of the information, answers and statements contained herein. I understand that this application will be medically underwritten. I agree to provide American Community with any additional information that may be necessary to complete the underwriting process.
2. No contract, waiver, modification or change of contract shall be binding upon American Community unless it is in writing and signed by an authorized officer of American Community.
3. I represent that neither I, nor my spouse, is receiving any form of reimbursement or compensation for this coverage from any employer.
4. I understand and agree that no agent or broker has the authority: (i) to bind American Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information American Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of American Community; or (v) waive or alter any of American Community's other rights or requirements.
5. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics, mode of living or type of risk of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records and criminal history.
6. I consent to any physician, hospital, clinic, pharmacy, or other medical or medically related facility and insurance company, health information repository, its agents, business associates, or legal representatives to give to American Community, its legal representatives or its reinsurers any information or records or knowledge of the health, except for psychotherapy notes, of any persons proposed for insurance to carry out treatment, payment and health care operations.
7. An unaltered copy of this authorization is as valid as the original for 24 months from the date signed. I know that I, or my authorized representative, may request and are entitled to receive a copy of the consent.
8. I am signing this application on my own behalf and on behalf of all listed dependents. I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if my or my dependent's health or any of the answers or statements change prior to the underwriting decision date, I must inform American Community in writing. I understand that failure to do so may result in my application being denied or rescission of my or my dependent's coverage under the policy.
9. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not: a.) provide interim coverage, b.) guarantee coverage, or c.) guarantee issue of a policy.
10. I understand that this application is void if not approved within 90 days after the date the application was signed.
11. I acknowledge receipt of the Outline of Coverage for the health insurance plan selected on the Product Selection Form attached to this application.
12. I understand that the existence of other insurance may reduce the benefits under this plan.

X _____ Signature Key Applicant (or if minor Child, Parent or Guardian)	Date	X _____ Spouse's Signature (or signature of a dependent age 18 or over for child only policies)	Date
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WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Do not cancel your current American Community health insurance coverage until you receive an approval letter and a new insurance policy from American Community. You will be notified of the effective date of your policy.

PROXY	
The undersigned hereby appoints the President of American Community Mutual Insurance Company, with full power of substitution as the undersigned's proxy with full power, to vote and act on their behalf on all issues at all meetings of the members of the Company and any adjournments thereof. If the proxy named herein, or his named substitute, is for any reason unable to act, the Board of Directors of the Company may fill the place of such proxy by appointing another. The proxy named herein shall only vote for those persons to serve as directors who have been nominated by the Board of Directors of the Company. If such persons are unable or unwilling to serve, then the proxies named herein may select other nominees and vote for such other nominees to serve as directors. In addition, all other matters properly brought before the meeting of the members the proxy will vote in accord with the recommendation of the Board of Directors, if any, and, if none, according to his judgment. This proxy will continue in force for the period of time the undersigned is the named insured of a policy issued and in effect by the Company. The proxy may be revoked by the undersigned at any time by filing with the Secretary of the Company a written revocation, a duly executed proxy bearing a later date or by attending and voting in person at any meeting of the members.	
X _____ Signature	_____ Date

AGENT INFORMATION: Name: _____ Number: _____ Phone # _____ Fax # _____ Signature: X _____

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Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 10/02/2008
Comments:
Attachments:
 AR RA 8-08 - Certificate of Unfair Sex Discrimination.pdf
 AR RA 8-08 - Readability.pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 10/02/2008
Bypass Reason: N/A
Comments:

Bypassed -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 10/02/2008
Bypass Reason: N/A
Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 10/02/2008
Bypass Reason: N/A
Comments:

Certificate of Unfair Sex Discrimination

I certify that we, American Community Mutual Insurance Company, are in compliance with Arkansas Rules and Regulation 19 – Unfair Sex Discrimination in the Sale of Insurance.

Francis P. Dempsey
Senior Vice President & General Counsel

October 1, 2008

Date

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road, Livonia, Michigan 48152
734-591-9000 • FAX 734-591-4628
NAIC Company #60305 • NAIC Group #166
Oklahoma Company # 0326

READABILITY CERTIFICATION

TO: THE ARKANSAS DEPARTMENT OF INSURANCE

RE: Form Readability Certification

DATE: October 1, 2008

Form Number

Description

AR RA 8/08

Arkansas Re-write of Existing American Community
Individual Health Insurance

I certify that the above form meets or exceeds a score of forty (40) on the Flesch Readability Test.

Francis P. Dempsey, Senior Vice President
General Counsel & Corporate Secretary

October 1, 2008

DATE