

<i>SERFF Tracking Number:</i>	<i>CAIC-125593721</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Continental American Insurance Company</i>	<i>State Tracking Number:</i>	<i>38609</i>
<i>Company Tracking Number:</i>	<i>6798</i>		
<i>TOI:</i>	<i>L07G Group Life - Whole</i>	<i>Sub-TOI:</i>	<i>L07G.401 Adjustable - Current Assumption - Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Whole Life App</i>		
<i>Project Name/Number:</i>	<i>Whole Life App/</i>		

Filing at a Glance

Company: Continental American Insurance Company

Product Name: Whole Life App	SERFF Tr Num: CAIC-125593721	State: ArkansasLH
TOI: L07G Group Life - Whole	SERFF Status: Closed	State Tr Num: 38609
Sub-TOI: L07G.401 Adjustable - Current Assumption - Indeterminate Premium - Single Life	Co Tr Num: 6798	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Betty Rakes	Disposition Date: 04/14/2008
	Date Submitted: 04/03/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Whole Life App	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Other
Filing Status Changed: 04/14/2008	
State Status Changed: 04/14/2008	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	

The enclosed application form is being sent to your department for your review and approval. This application will be used with our Group Whole Life form, WL9800-MP AR, approved by your department on January 18, 2007.

This life product is marketed to employees on a voluntary group basis. Typically each employee will complete the application on a one to one basis, with an agent present.

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Thank you for your consideration in this matter. Please contact Betty Rakes, Director of Compliance, at (888) 730-2244 extension 4329 or by e-mail at CompanyCompliance@caig-ins.com if you need any additional information.

Company and Contact

Filing Contact Information

Betty Rakes, Senior Compliance Analyst companycompliance@caicworksite.com
 2801 Devine Street (888) 730-2244 [Phone]
 Columbia, SC 29205 (803) 929-4944[FAX]

Filing Company Information

Continental American Insurance Company CoCode: 71730 State of Domicile: South Carolina
 2801 Devine Street Group Code: Company Type: LAH
 Columbia, SC 29205 Group Name: Continental Amer Ins State ID Number:
 Co
 (803) 256-6265 ext. [Phone] FEIN Number: 57-0514130

Filing Fees

Fee Required? Yes
 Fee Amount: \$2.02
 Retaliatory? No
 Fee Explanation: One form - Application
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	\$20.00	04/03/2008	19256522

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/14/2008	04/14/2008

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Disposition

Disposition Date: 04/14/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		No
Supporting Document	Application		No
Form	Application		Yes

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Form Schedule

Lead Form Number: NGP Life App 08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	NGP Life App 08	Application/ Enrollment Form	Application/ Enrollment Form	Initial			NGP Life App 08.pdf



ENROLLMENT FORM

Please Mail: Post Office Box 427
 Columbia, South Carolina 29202
 (800) 433-3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
Life		
Endorsement:		

EFFECTIVE DATE:

Member Name/Owner (First, MI, Last)				S.S.N./ ID Number		Gender	Date of Birth
Street Address			City		State	Zip	
Employer		Job Class		Location		Date of Hire	
Hours Worked	Daytime Phone No.		Beneficiary Name / Relationship				
Spouse's Name (if coverage is requested)		Gender	Spouse Date of Birth	Spouse's Beneficiary/Relationship			
				Employee		Spouse	
Are you actively at work?				<input type="checkbox"/> YES <input type="checkbox"/> NO			
Have you used tobacco products in the last 12 months?				<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Are you now hospitalized or unable to perform your normal duties and activities?						<input type="checkbox"/> YES <input type="checkbox"/> NO	

List all eligible children for whom you are proposing coverage (from Youngest to Oldest):

Name	Gender	Date of Birth	Name	Gender	Date of Birth

LIFE Plan _____

Annual Salary \$ _____

- Coverage:** Employee Face Amount: _____ Premium: _____
 Spouse Face Amount: _____ Premium: _____
 Children Face Amount: _____ Premium: _____
 Children Term Rider Face Amount: _____ Premium: _____

NGP Life 08

This application is not complete unless signed and dated on the back

		Employee	Spouse	Children
1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 90 days, have you been hospitalized in any medical facility or nursing home, as either an in or out patient?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If you answered Yes to any question for Child Coverage, indicate name of Child/Children

If you answered **Yes** to question #2, please explain and list dates of treatment, physician and hospital.

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace or change any existing insurance? YES NO
- If "Yes," provide carrier and policy number: _____

CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved and the necessary premium is paid.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance.

Deduction start date _____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ State of Enrollment _____

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Supporting Document Schedules

Bypassed -Name: Certification/Notice **Review Status:** 04/03/2008
Bypass Reason: Application only filing
Comments:

Bypassed -Name: Application **Review Status:** 04/03/2008
Bypass Reason: This is an application only filing
Comments: