

SERFF Tracking Number: CMNY-125626295 State: Arkansas
Filing Company: Combined Insurance Company of America State Tracking Number: 38802
Company Tracking Number: SL MA69050 0508-AR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Stop Loss
Project Name/Number: Master Application Filing/SL MA69050 0508-MA

Filing at a Glance

Company: Combined Insurance Company of America

Product Name: Stop Loss

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: CMNY-125626295 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 38802

Co Tr Num: SL MA69050 0508-AR

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: Andrew Mead

Disposition Date: 04/30/2008

Date Submitted: 04/29/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Master Application Filing

Project Number: SL MA69050 0508-MA

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Overall Rate Impact:

Filing Status Changed: 04/30/2008

State Status Changed: 04/30/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Employer

Deemer Date:

We enclose, for filing, the group insurance form listed below. This is a new form and is not intended to replace any previously filed form. The variable material in this form has been indicated by brackets.

Form Number Description

SL MA69050 0508-AR Master Application for Stop Loss Coverage

SERFF Tracking Number: CMNY-125626295 State: Arkansas
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This form is intended for use with Stop Loss policy form SL P69050 0201 and related forms, which were approved by the Department on March 27, 2001. This form is submitted in accordance with Department Bulletin Number 6-2008, regarding the addition of a Notice to Applications for Stop Loss Insurance Policies. We certify that the only change made to the enclosed Master Application from the previously approved Master Application is the addition of the Notice requested by the Department.

Company and Contact

Filing Contact Information

Andrew Mead, Director, Compliance andrew.mead@combined.com
 331 Newman Springs Road (732) 945-2320 [Phone]
 Red Bank, NJ 07701 (732) 945-2301[FAX]

Filing Company Information

Combined Insurance Company of America CoCode: 62146 State of Domicile: Illinois
 331 Newman Springs Road Group Code: 317 Company Type:
 Bldg 1, 3rd Floor, Suite 133
 Red Bank, NJ 07701 Group Name: State ID Number:
 (732) 945-2300 ext. [Phone] FEIN Number: 36-2136262

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Our Home State, Illinois, charges a filing of \$50. per form. Therefore, \$50 times one form submitted equals a fee of \$50.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Combined Insurance Company of America	\$50.00	04/29/2008	19959247

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/30/2008	04/30/2008

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Disposition

Disposition Date: 04/30/2008

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	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Filing Cover Letter	Approved-Closed	Yes
Form	Master Application for Stop Loss Coverage	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SL MA69050 0508-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SL MA69050 0508-AR	Application/Enrollment Form	Application/Master Application for Stop Loss Coverage	Initial		49	SL MA69050 0508.pdf

COMBINED INSURANCE COMPANY OF AMERICA
[Home Office: 5050 Broadway, Chicago, Illinois 60640
Administrative Office: 331 Newman Springs Rd., Bldg One, 3rd Floor, Suite 133, Red Bank,
New Jersey 07701]

(hereinafter called the Company)

MASTER APPLICATION FOR INSURANCE COVERAGE

[ABC Company] hereby applies for coverage.
(Name of Employer)

It is understood that this application, if approved, will enable the above named Employer to enroll for Excess Loss Insurance benefits.

General Information

The Employer is applying for the insurance specified below.

[1.] Employer: [ABC Company]

Address: [ABC Company]
[2525 Elm Street]
[Anytown, USA 23456]

Type of Business: [Retail]

Other Locations: Yes No

If "Yes", where: [_____

_____]

If any subsidiary or affiliated companies (under common control through stock ownership, contract etc.) are to be included, list legal name, address and nature of business.

[_____
_____]

[2.] Name of Employee Benefit Plan: [_____]
If applicable provide name of insurance company and group policy number. (A signed copy of the Employee Benefit Plan(s) must be attached.)

[[3.] TPA: [XYZ Company]

Address: [XYZ Company]
[123 Oak Street]
[Anywhere, USA 12345]

[4.] Broker: [Brokers, US]

Address: [Brokers, US]
[789 Birch Street]
[Anywhere, USA 12345]

[5.] Initial Enrollment: Single: [_____] Family: [_____]

Retirees covered under excess loss? Yes (If "Yes", how many?) [_____] No

[6.] Actively-at-Work Provision: Applies Waived (subject to Disclosure Statement)

[7.] **[(A)] [SPECIFIC EXCESS LOSS INSURANCE]**

- (1) Specific Deductible Amount per Covered Participant for the Coverage Period: \$[xx,xxx]
The Specific Deductible amount may not be less than \$10,000
- (2) Specific Lifetime Reimbursement Maximum per Covered Participant: \$[x,xxx,xxx]
- (3) Reimbursement Factor per Covered Participant: [100]%
- (4) Monthly Premium Rates payable per Covered Participant Unit for the Coverage Period: \$[xx.xx] Single
\$[xx.xx] Family
- (5) Type of Specific Contract Applied for:
 - Incurred and Paid
 - Incurred and Paid with Run-In Period of [3] months
 - Incurred and Paid with Run-Out Period of [3] months
 - Include Run-In Limit of: \$[xx,xxx]
 - Paid (renewal Option Only)
- (6) Covered Benefits under Specific:
 - Medical Prescription Drug Card
 - Prescription Drug Other [_____]
- (7) Optional Specific Coverages :
]

[(B)] [AGGREGATE EXCESS LOSS INSURANCE]

- (1) Monthly Deductible Factors: \$[xx.xx] Single
\$[xxx.xx] Family
- (2) Minimum Aggregate Attachment Point: \$[xxx,xxx]
- (3) Maximum Reimbursement per Coverage Period: \$[x,xxx,xxx]
- (4) Reimbursement Factor: [100]%
- (5) Aggregate Premium Rate payable:
 - (a) Per Covered Participant Unit per month: \$[x.xx]
 - (b) Annually: \$[x,xxx]
- [(6) Aggregate Contract Applied for:
 - Incurred and Paid
 - Incurred and Paid with Run-In Period of [3] months
 - Incurred and Paid with Run-Out Period of [3] months

Include Run-In Limit of: \$ [xx,xxx]

Paid (Renewal Option Only)

(7) Covered Benefits under Aggregate:

<input checked="" type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Weekly Indemnity
<input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Vision	
<input type="checkbox"/> Prescription Drug Card	<input type="checkbox"/> Other	[_____]

[(8)] Optional Specific Coverages (as attached Riders):

Family Specific Deductibles: \$[40,000]

[(9)] Optional Aggregate Benefits (as attached Riders):

<input type="checkbox"/> Monthly Aggregate Advance Benefit Rider	
<input type="checkbox"/> Aggregate Terminal Liability Benefit Rider	
Aggregate Terminal Liability Factors:	Single: \$[xx.xx]

[10.] Proposed Effective Date [May 1, 2001] (subject to Company acceptance)

[11.] Deposit of \$[_____] is enclosed to apply to the first payment under the Contract if issued.

It is understood and agreed by the Employer that the Employee Benefit Plan(s) attached (as required in item 2 of this Application) will be the basis of any Excess Loss insurance and that any reimbursement provided by Combined Insurance Company of America will be based on Eligible Expenses paid by the TPA in accordance with the Employee Benefit Plan(s) attached.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dated at [Anytown, USA.] the [fifteenth] day of [April], [2001].

[_____
(Signature of Company Representative)

Applicant: [ABC Company]

By: [A.B. Boss]

Title: [President]

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Supporting Document Schedules

Bypassed -Name:	Certification/Notice	Review Status:	Approved-Closed	04/30/2008
Bypass Reason:	See Filing Cover Letter			
Comments:				
Bypassed -Name:	Application	Review Status:	Approved-Closed	04/30/2008
Bypass Reason:	See Form Schedule tab for application form.			
Comments:				
Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	04/30/2008
Bypass Reason:	Not applicable to this submission.			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	04/30/2008
Bypass Reason:	Not applicable to this submission.			
Comments:				
Satisfied -Name:	Filing Cover Letter	Review Status:	Approved-Closed	04/30/2008
Comments:				
Attachment:				
	Filing Cover Letter.pdf			

April 29, 2008

The Honorable Julie Benafield Bowman
Insurance Commissioner
Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Attention: Life and Health Division

Re: NAIC # 62146
Combined Insurance Company of America
Form #: SL MA69050 0508-AR

Dear Ms. Bowman,

We enclose, for filing, the group insurance form listed below. This is a new form and is not intended to replace any previously filed form. The variable material in this form has been indicated by brackets.

<u>Form Number</u>	<u>Description</u>
SL MA69050 0508-AR	Master Application for Stop Loss Coverage

This form is intended for use with Stop Loss policy form SL P69050 0201 and related forms, which were approved by the Department on March 27, 2001. This form is submitted in accordance with Department Bulletin Number 6-2008, regarding the addition of a Notice to Applications for Stop Loss Insurance Policies. We certify that the only change made to the enclosed Master Application from the previously approved Master Application is the addition of the Notice requested by the Department.

This form has not been submitted to our Home State, Illinois, since Illinois does not require the filing of group insurance forms which are for use solely outside the state of Illinois.

We certify that, in our judgment, the form in this submission complies with the requirements of Ark. Stat. Ann. Sections 23-80-201 through 23-80-208, cited as the Life and Disability

Insurance Policy Language Simplification Act. The form has been scored for the Flesch reading ease test using the computer service to which we subscribe. The test was applied to the entire form and the score for the form is shown below.

Form

Flesch Score

SL MA69050 0508-AR

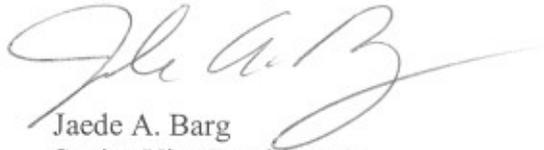
48.9

This form is printed in not less than ten point type, one point leaded.

A check for \$50.00 as payment of the filing fee will follow under separate cover.

If you have any questions, please call Andrew Mead at (732) 945-2320.

Very truly yours,



Jaede A. Barg
Senior Vice President &
Managing Director