

SERFF Tracking Number: CNSC-125548389 State: Arkansas
Filing Company: Conseco Insurance Company State Tracking Number: 38515
Company Tracking Number:
TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
Product Name: Accident Application
Project Name/Number: Accident Application/AP-1022R

Filing at a Glance

Company: Conseco Insurance Company
Product Name: Accident Application SERFF Tr Num: CNSC-125548389 State: ArkansasLH
TOI: H03I Individual Health - Accidental Death & Dismemberment SERFF Status: Closed State Tr Num: 38515
& Dismemberment
Sub-TOI: H03I.000 Health - Accidental Death & Co Tr Num: State Status: Approved-Closed
Dismemberment
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Authors: Beth Blackwell, Stacey Disposition Date: 03/31/2008
Farmer, Michelle Garba
Date Submitted: 03/25/2008 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: Accident Application Status of Filing in Domicile: Pending
Project Number: AP-1022R Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 03/31/2008 Deemer Date:
State Status Changed: 03/31/2008
Corresponding Filing Tracking Number:
Filing Description:
This is a filing for an accidental death and dismemberment application. This application is to be used with a previously approved product 1/19/07.

AP-1022R, is the application that will be used for this product. This application is similar to the previously approved AP-

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1022, the only difference is in question number 3. This is a simplified issue product. The applicant will be asked to provide information on the application for the type of coverage being applied for. Questions 4 through 10 are for the disability benefits and only pertain to the primary applicant if the applicant answers "yes" to any of these questions then disability benefits will not be available. Sections 2 and 5 of the application are being filed as variable. These sections capture the general information and choices of benefits as well as the payment methods. The bar code information at the top of the application is also being filed as variable. The bar code will contain the company information only and is used for internal processing. This application will be used for electronic purposes.

Any filing fees, transmittals or certifications, as required are attached.

Company and Contact

Filing Contact Information

Beth Blackwell, Manager beth_blackwell@conseco.com
 11815 N. Pennsylvania Street (800) 888-4918 [Phone]
 Carmel, IN 46032 (317) 817-2333[FAX]

Filing Company Information

Conseco Insurance Company CoCode: 60682 State of Domicile: Illinois
 11815 N Pennsylvania St Group Code: 233 Company Type:
 Carmel, IN 46032 Group Name: State ID Number:
 (800) 888-4918 ext. [Phone] FEIN Number: 45-0103436

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Conseco Insurance Company	\$50.00	03/25/2008	18940473

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Dismemberment Dismemberment
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/31/2008	03/31/2008

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Disposition

Disposition Date: 03/31/2008

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
Form	Application	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	AP-1022	Application/ Enrollment Form	Initial		0	AP-1022R.pdf



Application to: Conseco Insurance Company

[11825 N. Pennsylvania St., Carmel, Indiana 46032]

SECTION I

Is this a reinstatement? Yes No Is this an upgrade of existing coverage? Yes No

Is this a guaranteed conversion? Yes No

If "Yes" to any of the above, provide existing policy number: _____

Requested Effective Date: _____

SECTION II

Please Print Primary Applicant's Name (First, Middle Initial, Last)	Height	Weight
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(Applicant) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yy)	Age	Social Security Number	(Area Code) Phone Number
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Spouse's Name (If applying for Spouse Insurance) (First, Middle Initial, Last)	(Spouse) <input type="checkbox"/> Male <input type="checkbox"/> Female
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Date of Birth (mm/dd/yy)	Age	Social Security Number	If applying for Child(ren) Insurance, complete Section IV.
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Applicant's Street Address

City	State	Zip Code
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E-mail Address:

Employer's Name:

Occupation: _____	Length of time employed by this employer: _____ Years _____ Months	Job Class (circle one) 1 2	Monthly Gross Income (from all sources):
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Beneficiary's Full Name	Relationship to Primary Applicant:
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SECTION III Do not complete this section if you are applying through a guaranteed conversion.

<p>Please answer the questions below for the type of insurance being applied for: For All Insurance Applied For:</p> <p>1. Will this insurance replace any accident and sickness insurance currently in force with us or another company for any person to be insured? If "Yes," please complete the "Notice to Applicant" form.</p> <p>2. Do you own any other accident, hospital indemnity and/or disability insurance which is not being ended (not including Worker's Compensation)? If "Yes", complete the appropriate information under Section IV on this application.</p> <p>3. Within the past 5 years, have you or any person applying for coverage been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol? If "Yes", the named individual(s) is not eligible for coverage. Please list individual(s) name: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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For Disability Coverage (Only available for Primary Applicant). If the answer to any question 4 through 6 is "Yes", you are not eligible for the disability coverage.		
4.	Are there any material or substantial job duties you are currently unable to perform due to sickness, maternity or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	In the past 12 months have you been off work for 10 or more consecutive workdays due to illness or injury (other than for normal pregnancy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	In the past 6 months, have you taken prescribed medication for the treatment of an injury, disease or disorder of the back, neck or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For Sickness Disability Rider (Only available for Primary Applicant). If the answer to any question 7 through 10 is "Yes", you are not eligible for the Sickness Disability Rider.		
7.	Have you ever been treated for or diagnosed by a physician as having any of the following conditions? Alzheimer's Disease Cardiomyopathy Chronic Fatigue Syndrome Chronic Hepatitis Chronic Liver Disease Chronic Obstructive Pulmonary Disease Crohns Disease Emphysema Fibromyalgia Heart Valve Replacement Insulin Dependent Diabetes Diabetes Diagnosed Prior to age 40 Multiple Sclerosis Muscular Dystrophy Pulmonary Fibrosis Regional Enteritis/Ileitis Rheumatoid Arthritis Psoriatic Arthritis Rheumatic Fever Stroke or TIA Systemic Lupus Cerebrovascular Accident Ulcerative Colitis Schizophrenia Vascular Insufficiency Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	In the past 10 years, have you been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	In the past 5 years, have you been treated for or diagnosed by a physician or had surgery for any of the following conditions: Angina Atrial Fibrillation Carpel Tunnel Syndrome Congestive Heart Failure Coronary Artery Disease Coronary Angioplasty Heart Disorder Coronary Bypass Surgery Drug or Alcohol Abuse Heart Attack Kidney Disease Sciatica Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	In the past 12 months, have you been confined to a hospital or received medical treatment in an emergency room for any of the following: Sickel Cell Anemia Hypertension Chronic Bronchitis Asthma Epilepsy/Seizure Pancreatitis Gastric Bypass Blood Disorder Diverticulitis Joint Replacement Mental or Nervous Disorder Aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION IV Dependent Child Coverage (Please Print and fill out completely) (Each Child to be insured must meet policy eligibility requirements)		
Name	Child(ren) Relationship to Primary Applicant	Date of Birth

Check here if additional space is needed and attach separate sheet.

Other Accident and Sickness Insurance (Please Print and fill out completely.)		
Name of Company	Type of Insurance	Monthly Benefit Amount(s)

Check here if additional space is needed and attach separate sheet.

[SECTION V

Coverage Selection:

Accidental Death and Dismemberment (base coverage only) Level 1 Level 2

Disability Coverage (Available to Primary Applicant only)

Off the Job Disability* 24 hour Accident Short Term Disability* None

Optional Riders:

Sickness Disability* Public Safety* Return of Premium/Cash Value**

Choose One Disability Benefit Amount this amount will be for any disability coverage or disability rider selected (based on income):

Disability Coverage: \$500 \$1,000 \$1,500 \$2,000

Sickness Disability Rider: \$500 \$1,000 \$1,500 \$2,000

*only available for Primary applicant **not available with Section 125

Select Type of Coverage:

Individual Individual plus child(ren) Individual plus spouse Family]

<p>[Payment Mode:</p> <p>Current Direct Bill Options:</p> <p><input type="checkbox"/> Monthly Bank Draft</p> <p><input type="checkbox"/> Semi-Annual</p> <p><input type="checkbox"/> Annual</p> <p>Current Payroll Bill Options:</p> <p><input type="checkbox"/> Payroll deduction</p> <p><input type="checkbox"/> Federal Allotment</p> <p>Frequency:</p> <p><input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 52</p> <p><input type="checkbox"/> Section 125</p> <p>Monthly Bank Draft is the only mode available on the following:</p> <p><input type="checkbox"/> Credit Union Account Number _____</p> <p><input type="checkbox"/> Employee Non-payroll Account Number _____</p> <p>[Other Payment Options:</p> <p><input type="checkbox"/> Credit Card Payment: _____]</p>	<p>Premium Total:</p> <p>Base Coverage \$ _____</p> <p>Sickness Disability Rider \$ _____</p> <p>Public Safety Rider \$ _____</p> <p>[Optional Rider \$ _____]</p> <p>Total \$ _____</p> <p>Amount Collected \$ _____</p> <p><input type="checkbox"/> Draft initial premium payment (an "Authorization to Draft Initial Premium" form must be completed.)</p> <p><input type="checkbox"/> Check remitted with application</p> <p>*All checks should be payable to: Conseco Insurance Company]</p>
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Special Instructions: _____

SECTION VI

Applicant's Statement: I have read or have had read to me, the completed application; all representations are true and complete. I understand that: any false statements or misrepresentations in this application may result in loss of insurance if such false statement materially affected either the acceptance of the risk or the hazard assumed by the Company. The agent has no authority to approve the application, change the policy or waive any policy provisions. For ages 65 and above, I have received the booklet containing insurance advice for people eligible for Medicare. Additionally, I acknowledge that I have received an Outline of Coverage. **No coverage will be effective until all eligibility requirements are met and until the later of: (1) the Effective Date as shown on the Policy Schedule, if issued; or (2) the date the first premium is accepted by Conseco Insurance Company.**

Authorization: I hereby authorize the Medical Information Bureau, or other organization, institution or person, that has any medical or non-medical record or knowledge of me, or any members of my family for whom application has been made, to give the Company any information it may have about me. A photographic copy of this authorization shall be as valid as the original.

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

Date: _____ Signature of Applicant: _____

Where Signed: _____
(City, State)

This Section to be Completed by Agent: I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the insurance applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being solicited by me and signed by the applicant.

[Did you interview each proposed insured in person, ask all questions and witness the signature? Yes No

If "No", please check one of the boxes below:

- Application completed over the phone
- Application completed by the applicant and returned via mail
- Other, provide explanation: _____

_____]

Date: _____ Signature of Agent: _____

Agency: _____ Agent Number: _____

Agent's E-mail address: _____

Agent's Phone Number: _____

Mail to Policyholder

Mail to Agent

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Dismemberment Dismemberment
Product Name: Accident Application
Project Name/Number: Accident Application/AP-1022R

Rate Information

Rate data does NOT apply to filing.

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 Dismemberment Dismemberment
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Supporting Document Schedules

Review Status:
Bypassed -Name: Certification/Notice Approved-Closed 03/31/2008
Bypass Reason: no cert required for the application it is apart of the policy
Comments:

Review Status:
Satisfied -Name: Application Approved-Closed 03/31/2008
Comments:
Attachment:
 AP-1022R.pdf

Review Status:
Bypassed -Name: Health - Actuarial Justification Approved-Closed 03/31/2008
Bypass Reason: Not required for this filing
Comments:

Review Status:
Bypassed -Name: Outline of Coverage Approved-Closed 03/31/2008
Bypass Reason: not required for this filing
Comments:



Application to: Conseco Insurance Company

[11825 N. Pennsylvania St., Carmel, Indiana 46032]

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Is this a guaranteed conversion? Yes No

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Requested Effective Date: _____

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Please Print Primary Applicant's Name (First, Middle Initial, Last)	Height	Weight
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(Applicant) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yy)	Age	Social Security Number	(Area Code) Phone Number
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Spouse's Name (If applying for Spouse Insurance) (First, Middle Initial, Last)	(Spouse) <input type="checkbox"/> Male <input type="checkbox"/> Female
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Date of Birth (mm/dd/yy)	Age	Social Security Number	If applying for Child(ren) Insurance, complete Section IV.
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Applicant's Street Address

City	State	Zip Code
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E-mail Address:

Employer's Name:

Occupation: _____	Length of time employed by this employer: _____ Years _____ Months	Job Class (circle one) 1 2	Monthly Gross Income (from all sources):
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Beneficiary's Full Name	Relationship to Primary Applicant:
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SECTION III Do not complete this section if you are applying through a guaranteed conversion.

Please answer the questions below for the type of insurance being applied for:
For All Insurance Applied For:

1. Will this insurance replace any accident and sickness insurance currently in force with us or another company for any person to be insured? If "Yes," please complete the "Notice to Applicant" form.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you own any other accident, hospital indemnity and/or disability insurance which is not being ended (not including Worker's Compensation)? If "Yes", complete the appropriate information under Section IV on this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the past 5 years, have you or any person applying for coverage been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol? If "Yes", the named individual(s) is not eligible for coverage. Please list individual(s) name: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Disability Coverage (Only available for Primary Applicant). If the answer to any question 4 through 6 is "Yes", you are not eligible for the disability coverage.		
4.	Are there any material or substantial job duties you are currently unable to perform due to sickness, maternity or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	In the past 12 months have you been off work for 10 or more consecutive workdays due to illness or injury (other than for normal pregnancy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	In the past 6 months, have you taken prescribed medication for the treatment of an injury, disease or disorder of the back, neck or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For Sickness Disability Rider (Only available for Primary Applicant). If the answer to any question 7 through 10 is "Yes", you are not eligible for the Sickness Disability Rider.		
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8.	In the past 10 years, have you been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Check here if additional space is needed and attach separate sheet.

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Name of Company	Type of Insurance	Monthly Benefit Amount(s)

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Coverage Selection:

Accidental Death and Dismemberment (base coverage only) Level 1 Level 2

Disability Coverage (Available to Primary Applicant only)

Off the Job Disability* 24 hour Accident Short Term Disability* None

Optional Riders:

Sickness Disability* Public Safety* Return of Premium/Cash Value**

Choose One Disability Benefit Amount this amount will be for any disability coverage or disability rider selected (based on income):

Disability Coverage: \$500 \$1,000 \$1,500 \$2,000

Sickness Disability Rider: \$500 \$1,000 \$1,500 \$2,000

*only available for Primary applicant **not available with Section 125

Select Type of Coverage:

Individual Individual plus child(ren) Individual plus spouse Family]

<p>[Payment Mode:</p> <p>Current Direct Bill Options:</p> <p><input type="checkbox"/> Monthly Bank Draft</p> <p><input type="checkbox"/> Semi-Annual</p> <p><input type="checkbox"/> Annual</p> <p>Current Payroll Bill Options:</p> <p><input type="checkbox"/> Payroll deduction</p> <p><input type="checkbox"/> Federal Allotment</p> <p>Frequency:</p> <p><input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 52</p> <p><input type="checkbox"/> Section 125</p> <p>Monthly Bank Draft is the only mode available on the following:</p> <p><input type="checkbox"/> Credit Union Account Number _____</p> <p><input type="checkbox"/> Employee Non-payroll Account Number _____</p> <p>[Other Payment Options:</p> <p><input type="checkbox"/> Credit Card Payment: _____]</p>	<p>Premium Total:</p> <p>Base Coverage \$ _____</p> <p>Sickness Disability Rider \$ _____</p> <p>Public Safety Rider \$ _____</p> <p>[Optional Rider \$ _____]</p> <p>Total \$ _____</p> <p>Amount Collected \$ _____</p> <p><input type="checkbox"/> Draft initial premium payment (an "Authorization to Draft Initial Premium" form must be completed.)</p> <p><input type="checkbox"/> Check remitted with application</p> <p>*All checks should be payable to: Conseco Insurance Company]</p>
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Authorization: I hereby authorize the Medical Information Bureau, or other organization, institution or person, that has any medical or non-medical record or knowledge of me, or any members of my family for whom application has been made, to give the Company any information it may have about me. A photographic copy of this authorization shall be as valid as the original.

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

Date: _____ Signature of Applicant: _____

Where Signed: _____
(City, State)

This Section to be Completed by Agent: I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the insurance applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being solicited by me and signed by the applicant.

[Did you interview each proposed insured in person, ask all questions and witness the signature? Yes No

If "No", please check one of the boxes below:

- Application completed over the phone
- Application completed by the applicant and returned via mail
- Other, provide explanation: _____

_____]

Date: _____ Signature of Agent: _____

Agency: _____ Agent Number: _____

Agent's E-mail address: _____

Agent's Phone Number: _____

Mail to Policyholder

Mail to Agent