

SERFF Tracking Number: ELCC-125677375 State: Arkansas
Filing Company: Equitable Life & Casualty Insurance Company State Tracking Number: 39213
Company Tracking Number: 3011 AR
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: EquiCash
Project Name/Number: 3011 AR/3011 AR

Filing at a Glance

Company: Equitable Life & Casualty Insurance Company

Product Name: EquiCash SERFF Tr Num: ELCC-125677375 State: ArkansasLH
TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed State Tr Num: 39213
Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: 3011 AR State Status: Approved-Closed
Filing Type: Form/Rate Co Status: Draft-Pending Forms Reviewer(s): Rosalind Minor
Authors: Mark Banks, Jana Disposition Date: 06/11/2008
Peterson, Kathy Foster
Date Submitted: 06/05/2008 Disposition Status: Approved-Closed
Implementation Date Requested: 07/31/2008 Implementation Date:

State Filing Description:

General Information

Project Name: 3011 AR Status of Filing in Domicile: Pending
Project Number: 3011 AR 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: 06/11/2008 Deemer Date:
State Status Changed: 06/11/2008
Corresponding Filing Tracking Number:
Filing Description:
Hospital Indemnity Benefit - (Level 1)10 Day Benefit Period (Daily Benefit amounts between \$100-\$500); (Level 2) -20 Day Benefit Period (Daily Benefit amounts between \$100-\$500); (Level 3) -90 Day Benefit Period (Daily Benefit amounts between \$100-\$500)
Durable Medical Equipment Benefit-(Level 1)-\$200 Per occurrence Per Calendar Year (\$2,500 Lifetime Max); (Level 2) - \$300 Per occurrence Per Calendar Year (\$2,500 Lifetime Max); (Level 3)-\$400 Per occurrence Per Calendar Year (\$2,500 Lifetime Max)

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Ambulance Benefit-(Level 1)-\$100 Per occurrence (\$2,500 Lifetime Max); (Level 2)-\$150 Per occurrence (\$2,500 Lifetime Max); (Level 3) - \$200 Per occurrence (\$2,500 Lifetime Max)
 Emergency Room Benefit-(Level1) - \$150 Per Emergency room visit following an accident or injury; (Level 2)-\$200 Per Emergency room visit following an accident or injury; (Level 3) - \$250 Per Emergency room visit following an accident or injury
 Physician Benefit - (Level 1)-\$25 Per visit, \$75 Calendar Year max; (Level 2)-\$25 Per visit, \$75 Calendar Year max; (Level 3)-\$25 Per visit, \$75 Calendar Year max

The policy is guaranteed renewable and contains a six month pre-existing condition waiting period.

Company and Contact

Filing Contact Information

Jana Peterson, Compliance Specialist Jana.Peterson@Equilife.com
 3 Triad Center (877) 579-3782 [Phone]
 Salt Lake City, UT 84180 (801) 579-3781[FAX]

Filing Company Information

Equitable Life & Casualty Insurance Company CoCode: 62952 State of Domicile: Utah
 3 Triad Center Group Code: -99 Company Type: Life and Health
 Suite 200
 Salt Lake City, UT 84180 Group Name: State ID Number:
 (801) 579-3400 ext. [Phone] FEIN Number: 87-0129771

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Equitable Life & Casualty Insurance Company	\$50.00	06/05/2008	20679429

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/11/2008	06/11/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/10/2008	06/10/2008	Jana Peterson	06/10/2008	06/10/2008

SERFF Tracking Number: ELCC-125677375 *State:* Arkansas
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Disposition

Disposition Date: 06/11/2008

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	Redlined Application	Approved-Closed	Yes
Form	Limited Benefit Health Insurance Policy	Approved-Closed	Yes
Form (revised)	Application - Cash Supplement Insurance	Approved-Closed	Yes
Form	Application - Cash Supplement Insurance Withdrawn		No
Form	Agent Statement	Approved-Closed	Yes
Form	Endorsement to Limited Health Benefit Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Important Notice to Persons on Medicare	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/10/2008
Submitted Date 06/10/2008

Respond By Date

Dear Jana Peterson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application - Cash Supplement Insurance (Form)

Comment:

The application must contain a Fraud Statement as required by ACA 23-66-503 and Bulletin 7-97.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/10/2008
Submitted Date 06/10/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Thank you for your prompt review of Equitable Life and Casualty Insurance Company's recent submission of our new Hospital Indemnity and Related Benefits product Form 3011 AR (SERFF Tracking # ELCC-125677375, Arkansas Tracking # 39213). Your Timely response is very much appreciated. We have received your objection letter, and have made the following change:

A fraud warning has been added to the application form A-3011 AR. Attached please find a clean copy as well as a red-lined copy for your convenience.

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With this revision, we hope that this filing now meets with the approval of the Arkansas Insurance Department. We look forward to hearing from you soon.

Related Objection 1

Applies To:

- Application - Cash Supplement Insurance (Form)

Comment:

The application must contain a Fraud Statement as required by ACA 23-66-503 and Bulletin 7-97.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redlined Application

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application - Cash Supplement Insurance	A-3011 AR		Application/Enrollment Form	Initial		0	A-3011_AR app.pdf
Previous Version							
Application - Cash Supplement Insurance	A-3011		Application/Enrollment Form	Initial		0	A-3011 - Application.pdf

No Rate/Rule Schedule items changed.

Sincerely,

Jana Peterson, Kathy Foster, Mark Banks

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Form Schedule

Lead Form Number: Form 3011

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	Form 3011	Policy/Cont	Limited Benefit ract/Fratern Health Insurance al Policy Certificate	Initial		44	3011 Policy.pdf
Approved-Closed	A-3011 AR	Application/	Application - Cash Enrollment Supplement Form Insurance	Initial		0	A-3011_AR app.pdf
Approved-Closed	AS-3011	Application/	Agent Statement Enrollment Form	Initial		0	AS-3011 - Agent Supplement.p df
Approved-Closed	E-3011	Certificate	Endorsement to Limited Health Benefit Policy	Initial		0	E-3011 - Cancer Endorsement. pdf
Approved-Closed	Form OLC-3011	Outline of Coverage	Outline of Coverage	Initial		0	OLC-3011 - Outline of Coverage.pdf
Approved-Closed	MDN-10	Other	Important Notice to Persons on Medicare	Initial		0	MDN-10 - Medicare Duplication Notice.pdf

**LIMITED BENEFIT HEALTH POLICY
PROVIDING HOSPITAL INDEMNITY AND RELATED BENEFITS**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, please review “Guide to Health Insurance for People with Medicare” that You received from Us.

This Policy is a legal contract between You, named as the Insured in the Policy Schedule, and Us. We promise to pay the benefits provided in this Policy for covered losses that are incurred by You while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached.

THIRTY-DAY RIGHT TO EXAMINE THIS POLICY: If for any reason You are not satisfied with this Policy, return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all Premiums paid and consider the Policy never to have been issued.

PRE-EXISTING CONDITIONS: No benefits are payable for any loss that begins within the first six (6) months after the effective date of Your Policy which is caused by a Pre-Existing Condition. A Pre-Existing Condition is a condition for which medical advice was given or treatment was recommended or provided by a Physician within 6 months before the effective date of Your Policy.

CONSIDERATION: In consideration of Your application and the payment of the initial Premium, this Policy will be in force until the first renewal date shown on Your Policy Schedule. Caution: The issuance of this Policy is based upon Your responses to the questions on Your application. A copy of Your application is attached. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy, subject to the Time Limit on Certain Defenses (see General Provisions). The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at our Home Office: Equitable Life and Casualty, 3 Triad Center, Salt Lake City, UT 84180-1200, or call Us, toll free at 1-800-352-5150.

POLICY RENEWAL CONDITIONS – YOUR POLICY IS GUARANTEED RENEWABLE: This means You have the right to continue Your Policy as long as You pay Your Premium on time. We cannot change any of the terms of Your Policy on Our own, except that in the future We may increase Premiums. Your Premiums are guaranteed for Your first year of coverage. Thereafter, We may change the renewal Premium for Your Policy, but only if We change them for all policies like Yours in Your state on a Premium class basis. A Premium class is determined by such factors as benefits, age, gender, geographic location, tobacco use and the year the Policy is issued. You will be notified at least 31 days before any Premium change. Your Premium will not increase due to a change in Your individual age or Your specific health.

EFFECTIVE DATE: Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown in the Policy Schedule. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal Premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.


Secretary


President

THIS IS A LIMITED POLICY – PLEASE READ IT CAREFULLY.

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Riders, Endorsements, if anyAttached

ApplicationAttached

Policy Schedule

Insured: {Joe Doe} Policy Number: {1234567456}
Initial Premium: \$XXXX.XX
{Alternate Payor: Jake Doe} Policy Anniversary: {April 30}
Effective Date: {03/01/08} First Renewal Date: {5/01/08}

Premium

	Annual	Semi-Annual	Quarterly	Monthly
Policy	\$			
{Cancer Endorsement}	\$			
Total Premium	\$	\$	\$	\$

Benefit Schedule

Hospital Indemnity Benefit Amount{\$100-\$500 per day}
Maximum Benefit Period.....{10-90 Days}

Durable Medical Equipment Benefit Amount{\$200-\$400} per Calendar Year
Lifetime Maximum Benefit Amount\$2,500

Ambulance Service Benefit Amount{\$100-\$200} per occurrence; one occurrence per Period of Care
Lifetime Maximum Benefit Amount\$2,500

Emergency Room Benefit Amount (Injury Only){\$150-\$250} per visit; one visit per Period of Care

Physician Benefit Amount\$25 per visit
Calendar Year Maximum Benefit Amount\$75

{First Occurrence Cancer Benefit Amount{\$1,000-\$10,000}}

DEFINITIONS

In this Policy the words "You", "Your" and "Yourself" refer to the Insured as listed on Your Policy Schedule. The words "We," "Us," and "Our" refer to Equitable Life & Casualty Insurance Company.

CALENDAR YEAR: The period of time beginning on January 1 and ending on December 31 of the same year.

CALENDAR YEAR MAXIMUM BENEFIT AMOUNT: The maximum amount that We will pay for any one benefit in a Calendar Year while Your coverage under this Policy is in force. The Calendar Year Maximum Benefit Amount is shown on the Benefit Schedule.

DURABLE MEDICAL EQUIPMENT: A medical device that is:

- prescribed by a Physician;
- able to withstand repeated use;
- primarily designated for medical purposes and not for convenience, contentment, personal comfort or other non-therapeutic purposes;
- required for activities of daily living; and
- generally not useful in the absence of an illness or Injury.

Durable Medical Equipment does not include any of the following: a) prosthetic devices; b) special appliances and surgical implants that are for cosmetic purposes; c) corrective shoes; d) exercise or sports equipment; and e) improvements or modifications to Your residence, property or vehicles, including but not limited to ramps, elevators, spas, air conditioners and vehicle hand controls.

EMERGENCY: An Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following:

- The patient's life or health would be in serious jeopardy;
- Bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

HOSPITAL: A medical facility which:

- is legally licensed and operated as an acute care Hospital;
- is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- provides inpatient care of injured and sick people;
- is supervised by a Physician;
- provides 24-hour-a-day nursing services supervised by or under a Registered Nurse (RN);
- provides on-site or prearranged use of x-ray equipment, laboratory and surgical facilities; and,
- maintains permanent medical history records.

A Hospital is not a bed, unit, or facility that functions as a/an:

- skilled nursing facility;
- residential assisted living facility;
- nursing home or nursing facility;
- extended care or long term care facility;
- custodial or educational care
- convalescent home;
- rest home, or a home for the aged;
- sanatorium;
- rehabilitation center;
- ambulatory surgical center or other outpatient facility;
- place primarily providing care for alcoholism or substance abuse; or,
- facility for the care and treatment of mental disease or mental disorders.

HOSPITAL STAY: You are admitted as an inpatient in a Hospital for at least 24 consecutive hours by reason of a Sickness or Injury for which a room charge is made. Hospital outpatient, observation or similar status is not considered a Hospital Stay.

HOSPITAL INDEMNITY BENEFIT AMOUNT: The amount We will pay each day of Your Hospital Stay. The Hospital Indemnity Benefit Amount is shown on the Benefit Schedule.

IMMEDIATE FAMILY: A person who is related to You in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild). An Immediate Family member includes an individual who normally lives in Your household.

INJURY: Bodily Injury sustained by You which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, which results in a loss covered by this Policy and which occurs while this Policy is in force.

LIFETIME MAXIMUM BENEFIT AMOUNT: The maximum amount that We will pay for any one benefit while Your coverage under this Policy is in force. The Lifetime Maximum Benefit Amount is shown on the Benefit Schedule.

MAXIMUM BENEFIT PERIOD: The number of days of hospitalization We will pay during any Period of Care. The Maximum Benefit Period is shown on the Benefit Schedule.

MEDICARE: The federal program for health care reimbursement established under Title XVIII of The Social Security Act, as amended.

PERIOD OF CARE: For the purposes of determining a Maximum Benefit Period, Period of Care begins on the first day of a Hospital Stay and ends on the date of discharge. If You are re-admitted within 30 days, then the later period will be considered a continuation of the prior Period of Care. If re-admission occurs more than 30 days after the date of discharge, We will treat the later admission as a new Period of Care.

PHYSICIAN: A person other than You or a member of Your Immediate Family who:

- is a doctor of medicine or osteopathy who is duly licensed by the state to practice medicine or osteopathy;
- provides services within the scope of his or her licenses.

PREMIUM: The amount of money You are required to pay Us in return for the coverage provided by this Policy.

REGISTERED NURSE: A licensed registered nurse (R.N.) who:

- is properly licensed or certified to provide nursing care under the laws of the state where the nurse practices; and
- provides nursing services which are within the scope of the nurse's license or certificate.

SICKNESS: Illness or disease that results in loss covered by this Policy. The loss must begin while Your coverage under this Policy is in force.

BENEFITS

HOSPITAL INDEMNITY BENEFIT: We will pay You the Hospital Indemnity Benefit Amount for each day of Your Hospital Stay. Benefits are not payable beyond the Maximum Benefit Period for any Period of Care. The Hospital Indemnity Benefit Amount and Maximum Benefit Period are shown on the Benefit Schedule.

If Your Policy terminates during a Hospital Stay, We will continue to pay this benefit until the earlier of the initial date of discharge from the Hospital (regardless of any Hospital re-admission) or the date You reach the Maximum Benefit Period.

DURABLE MEDICAL EQUIPMENT BENEFIT: We will pay You the Durable Medical Equipment Benefit Amount for Durable Medical Equipment expenses You incur due to an Injury or Sickness. This benefit is limited to one benefit per Calendar Year, and is subject to the Lifetime Maximum Benefit Amount shown on the Benefit Schedule.

AMBULANCE BENEFIT: We will pay You the Ambulance Service Benefit Amount if a licensed surface or air ambulance service transports You to or from a Hospital where You are confined as an inpatient due to Injury or Sickness. Any ambulance service must be necessary to protect Your health and safety when other reasonable and customary travel methods are not available.

This benefit is limited to one charge per Period of Care and is subject to the Lifetime Maximum Benefit Amount. The Ambulance Service Benefit Amount and the Lifetime Maximum Benefit Amount are shown on the Benefit Schedule.

EMERGENCY ROOM BENEFIT: We will pay You the Emergency Room Benefit Amount for services You receive in a Hospital emergency room or Hospital affiliated emergency care facility due to an Injury, provided the Emergency treatment is followed within 24 hours by a Hospital Stay. The Emergency Room Benefit Amount is shown on the Benefit Schedule and is payable only once for a Period of Care.

PHYSICIAN BENEFIT: We will pay You the Physician Benefit Amount for follow up visits to a Physician when the visit follows a Hospital Stay for which benefits are paid under this Policy. The benefit is limited to three visits per Calendar Year and must be within 6 months of the Hospital Stay. The Physician Benefit Amount and the Calendar Year Maximum Amount are shown on the Benefit Schedule.

LIMITATIONS AND EXCLUSIONS

Notwithstanding anything else herein to the contrary, this Policy excludes benefits for care or expenses:

1. for treatment, services or supplies which:
 - are not prescribed by a Physician as necessary to treat a Sickness or Injury; or
 - are received without charge or legal obligation to pay; or
 - would not routinely be paid in the absence of insurance; or
 - are received from any member of Your Immediate Family; or
 - are received outside the United States; or
 - are incurred while this Policy is not in force.
2. due to mental, nervous, psychotic or psychoneurotic illnesses or disorders.
3. resulting from war or an act of war, whether declared or undeclared, or resulting from service in the armed forces of any country.
4. resulting from committing or attempting to commit an assault or felony or participating in a riot or civil commotion.
5. resulting from an attempted suicide or intentionally self-inflicted Injury while You are sane or insane.
6. for treatment provided in a U.S. government facility, where there is no charge to You.
7. for cosmetic surgery other than:
 - reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
 - reconstructive surgery because of a congenital disease or anomaly.
8. resulting from being legally intoxicated, as defined by the jurisdiction in which the Injury occurs.
9. resulting from Your voluntary use of any drug, narcotic or controlled substance, unless as prescribed by Your Physician.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given to Us within 20 days after a loss begins or as soon as reasonably possible. The notice must be sent to Us at Our Home Office or to an authorized agent. The notice should include Your name and the Policy number.

CLAIM FORMS: When We receive Your Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written Proof of Loss must be given to Us within 90 days after the date of loss. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.

TIMELY PAYMENT OF BENEFITS: Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF BENEFITS: All benefits will be paid to You or Your assignee. Any benefits unpaid at Your death may be paid to Your estate.

ASSIGNMENT: No Assignment of benefits under this Policy shall be binding upon Us unless it is in writing and the original (or a copy of it) is on file with Us. We do not assume any responsibility for the validity of any Assignment. Any payment We make in good faith will end Our liability to the extent of the payment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have You examined as often as reasonably necessary while a claim is pending. We may also require an autopsy where allowed by law. Either will be done at Our expense.

UNPAID PREMIUM: When a claim is paid, any Premium due and unpaid may be deducted from the claim payment.

CLAIM REVIEW: If You believe that Our claim decision is in error, You may appeal Our decision and We will reconsider Your claim. Send Us a written request (no special form is required) explaining why, under the provisions of Your Policy, We should change Our decision. Your written request must be submitted within sixty (60) days of Your receipt of the Explanation of Benefits (EOB) of Your claim. You may authorize someone else to act for You in this process.

Your written request should include Your name, the Covered Person's name, the Policy number, the names, addresses and phone numbers of any persons or organizations You believe We should contact to learn more about the claim under reconsideration, and any supporting documentation or records.

Once We have completed Our review, We will notify You in writing of Our decision. This notification will be sent to You no later than thirty (30) days after receipt of Your written request for appeal. We will pay any benefits that may then be due as a result of Our reconsideration. Should We require longer than thirty (30) days to make Our decision, We will notify You of the reasons for this delay. In any event, the delay will be no longer than an additional forty-five (45) days. Our final decision on Your appeal does not prevent You from taking further legal action.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No statements, except fraudulent misstatements, made by You in the application for this Policy shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. A copy of Your application is attached.

MISSTATEMENT OF AGE: If Your age has been misstated, all amounts payable under the Policy will be such as the Premium paid would have purchased at the correct age. If based on Your correct age We would not have issued this Policy, Our liability will be limited to the refund of any Premium paid, subject to an adjustment for paid claims.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such laws.

PAYMENT OF PREMIUMS: The first Premium is due on the Effective Date of this Policy. Each Premium after the first is due on the last day of the term for which the most recent Premium was paid and must be accepted by Us at Our Home Office.

This Policy will not be in force until the first Premium is accepted by Us. If We accept a Premium, this Policy will continue in force until the end of the term for which that Premium was due.

The amount of the first Premium is shown in the Policy Schedule and is based on Your initial mode of payment. The amount of each Premium after the first is based on Your then current mode of payment and the Premium then being charged for Policies of this form number and Premium classification issued in the same state. If You fail to pay Your Premium by the end of the Grace Period, coverage under this Policy will terminate.

GRACE PERIOD: This Policy has a 31-day Grace Period. This means if a renewal Premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.

CONSERVATION PERIOD: You have an additional 15 days beyond the Grace Period to pay Your Premium. During this 15 day extension, this Policy is not in force unless Your Premium is paid within this period. This Policy will then be renewed with no lapse in coverage.

ALTERNATE PAYOR: An Alternate Payor is a person selected by You to receive a reminder of the renewal Premium due if You have not paid it during the Grace Period. Your Alternate Payor is shown on the Policy Schedule.

REINSTATEMENT: If the Premium is not paid before the Grace Period ends, this Policy will lapse. Later acceptance of Premium by Us (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this Policy. If We or Our agent require an application, You will be given a receipt for the Premium. If the application is approved, this Policy will be reinstated as of the approval date. Lacking such approval, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our decision to decline Your application.

The Reinstated Policy will only cover a loss that results from an Injury sustained after the date of reinstatement, or a Sickness that begins more than ten (10) days after such date. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any Premium accepted with a Reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.

REFUND OF UNEARNED PREMIUM: We will refund that part of any Premium paid which covers a period beyond the end of the Policy month of Your death.

OTHER INSURANCE WITH US: Your insurance under a like Policy or policies with Us is limited to one such Policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all Premiums paid for all such other policies.

LEGAL ACTION: No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years (5 years in Mississippi) after the time written Proof of Loss is required to be given.

Part IV – Premium Payment & Administration

Payor (if not Applicant):

Name

Address

City

State

Zip

INITIAL Premium Paid:

Annual

Semi-Annual

\$, .

Quarterly

2 months (for MBD)

(must include \$25 application fee)

RENEWAL: Direct Bill Bank Draft (Account Type: Checking Savings):

Bank Routing # (9 digits):

Bank Account # [4 or more (do not include check #)]:

Select Bank Draft Day:

Bank Name: _____

I authorize Bank Draft payments.

Name(s) of Depositor(s): _____

Please include a voided check. The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on or shortly following the selected draft day requested above (never before).

Part V – Alternate Payor (Protection Against Unintended Lapse)

I understand that an Alternate Payor is a person other than myself who will receive notice of lapse or termination of my insurance policy for nonpayment of premium. My Alternate Payor will not be notified until thirty (30) days after a premium is due and unpaid.

I elect NOT to designate an Alternate Payor.

I elect to designate an Alternate Payor, named below.

Last Name

First Name

MI

Phone

Address

City

State

Zip

Part VI – Agreement & Acknowledgement

As part of the Application process, Equitable Life & Casualty has certain information that you should review as part of your decision to purchase this policy. Please indicate your receipt of this information:

Outline of Coverage

If over age 65, a Guide to Health Insurance for People on Medicare

Replacement Notice (if applicable)

Notice of Our Information Practices and Privacy Policy

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete. I understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the policy.

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy. Review your policy carefully.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I am currently not covered under the State Medicaid program.

Signed at (City and State): _____

Date: --

Signed Applicant: _____

Witnessed by Agent: _____

Send policy to Applicant Agent

A-3011 AR

Return to Company

Page 2

30110000002

**ENDORSEMENT TO LIMITED BENEFIT HEALTH POLICY
PROVIDING HOSPITAL INDEMNITY AND RELATED BENEFITS**

In consideration of Your application and the payment of additional Premium, this Endorsement is attached to and is made a part of Your Policy. Except as specifically stated otherwise herein, this Endorsement is subject to the definitions, limitations, exclusions and all other provisions of Your Policy.

FIRST OCCURRENCE CANCER BENEFIT

We will pay the benefit amount for this Endorsement shown on the Benefit Schedule (Policy page 3) when You are diagnosed for the first time in Your lifetime as having any internal Cancer after the Effective Date of Your Policy and while this Endorsement is in force. We will pay this benefit even when Cancer is not diagnosed until after death. This benefit is not payable for Skin Cancer.

This benefit is never payable if You have been diagnosed with or treated for any internal Cancer before the Effective Date of coverage under Your Policy.

In addition to the Pathological or Clinical diagnosis required, We may require additional information from the attending Physician and Hospital.

This benefit is payable only once, and will be paid in addition to any other benefit in Your Policy. Payment of the benefit in no way affects any other terms or conditions of Your Policy. Once this benefit is paid, this Endorsement will terminate and no further Premium for this Endorsement will be due. If Your Policy is terminated for any reason, this Endorsement terminates automatically. You may also terminate this Endorsement by written notice to Us.

DEFINITIONS

CANCER: A disease which expresses itself as:

- a malignant tumor characterized by the uncontrolled growth and spread of malignant cells;
- the invasion of body tissue by such malignant cells;
- leukemia; or,
- Hodgkin's disease.

Cancer does not include pre-malignant conditions, conditions with malignant potential, or pre-leukemic conditions. Clinical Diagnosis of Cancer shall be accepted as evidence that Cancer exists when a Pathological Diagnosis cannot be made.

PATHOLOGICAL DIAGNOSIS: A diagnosis of Cancer made from the results of a microscopic study of fixed tissue or blood samples. This type of diagnosis must be made by a Pathologist certified by the American Board of Pathology or the American Osteopathic College of Pathologists. A Pathological Diagnosis of Cancer can be made before or after death.

CLINICAL DIAGNOSIS: A diagnosis of Cancer based on the study of symptoms. We accept a Clinical Diagnosis only when a Pathological Diagnosis is detrimental to Your health, when there is medical evidence to support the diagnosis, and when a Physician is treating You for Cancer.

SKIN CANCER: Basal cell carcinoma, basal cell epithelioma, squamous cell carcinoma, or melanoma of Clark's Level I or II or Breslow level equal to or less than 1.5 mm.


Secretary


President

Equitable Life & Casualty
3 Triad Center
Salt Lake City, Utah 84180-1200
1-800-352-5150

**OUTLINE OF COVERAGE
LIMITED BENEFIT HEALTH COVERAGE
HOSPITAL INDEMNITY AND
RELATED BENEFITS
Policy Form 3011**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

(1) BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

(2) PLEASE READ YOUR POLICY CAREFULLY:

This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(3) LIMITED BENEFIT HEALTH COVERAGE:

Limited Benefit Health Coverage is designed to provide, to persons insured, limited or supplemental coverage. The policy benefits are outlined in Section 4 below; the benefits described in Section 4 may be limited by the limitations contained in Section 5.

(4) BENEFITS PROVIDED UNDER THE POLICY:

Benefit amounts are based on the benefit level you choose. The benefit levels are shown in the table below.

HOSPITAL INDEMNITY BENEFIT:

We will pay you the Hospital Indemnity Benefit amount for each day of your hospital stay due to an injury or sickness. Benefits are not payable beyond the maximum benefit period for any period of care.

If the policy terminates while you are hospitalized, we will continue to pay this benefit until the earlier of the initial date of discharge from the hospital (regardless of any hospital re-admission) or the date you reach the maximum benefit period.

DURABLE MEDICAL EQUIPMENT BENEFIT:

We will pay you the Durable Medical Equipment benefit amount for durable medical equipment expenses you incur due to an injury or sickness. This benefit is limited to one benefit per calendar year, and is subject to the lifetime maximum benefit amount.

AMBULANCE BENEFIT:

We will pay you the Ambulance Service Benefit amount if a licensed surface or air ambulance service transports you to or from a hospital where you are confined as an inpatient due to injury or sickness. Any ambulance service must be necessary to protect your health and safety when other reasonable and customary travel methods are not available. This benefit is limited to one charge per period of care and is subject to the lifetime maximum benefit amount.

EMERGENCY ROOM BENEFIT:

We will pay you the Emergency Room benefit amount for services you receive in a hospital emergency room or hospital affiliated emergency care facility due to an Injury, provided the emergency treatment is followed within 24 hours by a covered hospital stay of at least one day. A day means a continuous 24-hour period. This benefit is payable only once per any period of care.

PHYSICIAN BENEFIT:

We will pay you \$25 per visit for follow up visits to a physician when the visit follows a hospital stay

BENEFIT LEVELS:

Benefit	Level 1	Level 2	Level 3
Hospital Indemnity Benefit	10 Day Benefit Period (Daily Benefit amounts between \$100-\$500)	20 Day Benefit Period (Daily Benefit amounts between \$100-\$500)	90 Day Benefit Period (Daily Benefit amounts between \$100-\$500)
Durable Medical Equipment Benefit	\$200 Per Occurrence Per Calendar Year (\$2,500 Lifetime Max)	\$300 Per Occurrence Per Calendar Year (\$2,500 Lifetime Max)	\$400 Per Occurrence Per Calendar Year (\$2,500 Lifetime Max)
Ambulance Benefit	\$100 Per occurrence (\$2,500 Lifetime Max)	\$150 Per occurrence (\$2,500 Lifetime Max)	\$200 Per occurrence (\$2,500 Lifetime Max)
Emergency Room Benefit	\$150 Per Emergency room visit following an accident or injury	\$200 Per Emergency room visit following an accident or injury	\$250 Per Emergency room visit following an accident or injury
Physician Benefit	\$25 Per visit, \$75 Calendar max	\$25 Per visit, \$75 Calendar max	\$25 Per visit, \$75 Calendar max

for which benefits are paid under the policy. The benefit is limited to three visits per calendar year and must be within 6 months of the hospital stay.

(5) LIMITATIONS AND EXCLUSIONS:

PRE-EXISTING CONDITIONS:

No benefits are payable for any loss that begins within the first six (6) months after the effective date of your policy which is caused by a Pre-Existing Condition. A Pre-Existing Condition is a condition for which medical advice was given or treatment was recommended or provided by a physician within 6 months before the effective date of your policy.

The policy excludes benefits for care or expenses:

1. for treatment, services or supplies which:
 - are not prescribed by a physician as necessary to treat a sickness or injury; or
 - are received without charge or legal obligation to pay; or
 - would not routinely be paid in the absence of insurance; or
 - are received from any member of your immediate family; or
 - are received outside the United States; or
 - are incurred while this policy is not in force.

2. due to mental, nervous, psychotic or psychoneurotic illnesses or disorders.
3. resulting from war or an act of war, whether declared or undeclared, or resulting from service in the armed forces of any country.
4. resulting from committing or attempting to commit an assault or felony or participating in a riot or civil commotion.
5. resulting from an attempted suicide or intentionally self-inflicted Injury while you are sane or insane.
6. for treatment provided in a U. S. government facility, where there is no charge to you.
7. for cosmetic surgery other than:
 - reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
 - reconstructive surgery because of a congenital disease or anomaly.
8. resulting from being legally intoxicated, as defined by the jurisdiction in which the Injury occurs.
9. resulting from your voluntary use of any drug, narcotic or controlled substance, unless as prescribed by your physician.

(6) GUARANTEED RENEWABILITY OF THIS POLICY:

You have the right to continue your policy as long as you pay your premiums when due.

(7) PREMIUM:

Total annual premium for your policy, including additional benefits purchased is _____.

We will not change the premium for your policy during your first year of coverage. Thereafter, we reserve the right to change premium rates for all policies of the same class. We will notify you at least 31 days before any premium change.

(8) OPTIONAL BENEFIT RIDER:

There is an optional First Occurrence Cancer benefit offered with your policy for the payment of an additional premium. If you select this benefit, it will be included in your policy.

FIRST OCCURRENCE CANCER BENEFIT:

We will pay you the First Occurrence Cancer benefit amount when you are diagnosed for the first time as having any internal cancer after the effective date of your policy and while the benefit rider is in force. We will pay this benefit even when cancer is not diagnosed until after death.

This benefit is not payable for skin cancer. This benefit is not available if you have been diagnosed with or treated for internal cancer before the effective date of coverage under your policy.

You may choose a First Occurrence Cancer Benefit Amount from \$1,000 to \$10,000.

THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE BENEFITS PROVIDED.

PLEASE CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS. PLEASE RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.

**EQUITABLE LIFE & CASUALTY
INSURANCE COMPANY
3 Triad Center
Salt Lake City, UT 84180-1200**

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

SERFF Tracking Number: ELCC-125677375 *State:* Arkansas
Filing Company: Equitable Life & Casualty Insurance Company *State Tracking Number:* 39213
Company Tracking Number: 3011 AR
TOI: H141 Individual Health - Hospital Indemnity *Sub-TOI:* H141.000 Health - Hospital Indemnity
Product Name: EquiCash
Project Name/Number: 3011 AR/3011 AR

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: ELCC-125677375 State: Arkansas
 Filing Company: Equitable Life & Casualty Insurance Company State Tracking Number: 39213
 Company Tracking Number: 3011 AR
 TOI: H141 Individual Health - Hospital Indemnity Sub-TOI: H141.000 Health - Hospital Indemnity
 Product Name: EquiCash
 Project Name/Number: 3011 AR/3011 AR

Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	06/11/2008
Comments:		
Attachment: Flesch Certification.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	06/11/2008
Comments: See Form Schedule Tab		
Satisfied -Name: Health - Actuarial Justification	Review Status: Approved-Closed	06/11/2008
Comments: See Actuarial Memorandum on Rate/Rule Schedule Tab		
Satisfied -Name: Outline of Coverage	Review Status: Approved-Closed	06/11/2008
Comments: See Form Schedule Tab		
Satisfied -Name: Redlined Application	Review Status: Approved-Closed	06/11/2008
Comments:		
Attachment: A-3011_AR app redlined.pdf		



3 Triad Center, Suite 200
Salt Lake City, Utah 84110-2460

CERTIFICATION

RE: EquiCash, Limited Health Benefit Insurance Policy, Form 3011

This is to certify that the attached policy Form 3011 has achieved a Flesch Reading Ease Score of 43.7 and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 6-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

Dated this June 5, 2008

EQUITABLE LIFE & CASUALTY INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Kendall R. Surfass". The signature is fluid and cursive.

By
Kendall R. Surfass
Vice President, Secretary and General Counsel

Part IV – Premium Payment & Administration

Payor (if not Applicant):

Name

Address

City

State

Zip

INITIAL Premium Paid:

Annual

Semi-Annual

\$, .

Quarterly

2 months (for MBD)

(must include \$25 application fee)

RENEWAL: Direct Bill Bank Draft (Account Type: Checking Savings):

Bank Routing # (9 digits):

Bank Account # [4 or more (do not include check #)]:

Select Bank Draft Day:

Bank Name: _____

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I elect to designate an Alternate Payor, named below.

Last Name

First Name

MI

Phone

Address

City

State

Zip

Part VI – Agreement & Acknowledgement

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If over age 65, a Guide to Health Insurance for People on Medicare

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Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I am currently not covered under the State Medicaid program.

Signed at (City and State): _____

Date: --

Signed Applicant: _____

Witnessed by Agent: _____

Send policy to Applicant Agent