

SERFF Tracking Number: ICCI-125500744 State: Arkansas
Filing Company: Pan American Life Insurance Company State Tracking Number: 38347
Company Tracking Number: PAN-AM 407
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: Pan-Am LPA-407
Project Name/Number: Pan-Am LPA-407/Pan-AM LPA-407

Filing at a Glance

Company: Pan American Life Insurance Company

Product Name: Pan-Am LPA-407 SERFF Tr Num: ICCI-125500744 State: ArkansasLH
TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed State Tr Num: 38347
Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: PAN-AM 407 State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Author: Brenda Dawson Disposition Date: 04/17/2008
Date Submitted: 02/21/2008 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Pan-Am LPA-407 Status of Filing in Domicile: Authorized
Project Number: Pan-AM LPA-407 Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small
Overall Rate Impact: Group Market Type: Employer
Filing Status Changed: 04/17/2008
State Status Changed: 04/17/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:
See attached cover letter and forms

Company and Contact

Filing Contact Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)
Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com

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519 Colman Center Drive (815) 316-6714 [Phone]
Rockford, IL 61108 (815) 316-6720[FAX]

Filing Company Information

Pan American Life Insurance Company CoCode: 67539 State of Domicile: Louisiana
1300 Godward Street NE Group Code: Company Type:
Suite 6800
Minneapolis, MN 55413 Group Name: State ID Number:
(612) 331-0112 ext. [Phone] FEIN Number: 72-0281240

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Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan American Life Insurance Company	\$50.00	02/21/2008	18083755

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/17/2008	04/17/2008

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	02/25/2008	02/25/2008	Brenda Dawson	04/15/2008	04/15/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Company reviewing the revisions I made	Note To Reviewer	Brenda Dawson	03/24/2008	03/24/2008
Objection Letter of 2/25/08	Note To Filer	Rosalind Minor (FM)	03/21/2008	03/21/2008

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Disposition

Disposition Date: 04/17/2008

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	Cover letter	Approved-Closed	Yes
Supporting Document	Fee Schedule	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form	Prescription Drug Option	Approved-Closed	Yes
Form	Critical Illness Rider	Approved-Closed	Yes
Form (revised)	Employee Application	Approved-Closed	Yes
Form	Employee Application	Withdrawn	No
Form (revised)	Employer Application	Approved-Closed	Yes
Form	Employer Application	Withdrawn	No
Form	Compliance Rider	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 02/25/2008

Submitted Date 02/25/2008

Respond By Date

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Prescription Drug Option (Form)

Comment: Exclusion #4 is an exclusion for contraceptive drugs or devices. ACA 23-79-1103, Parity for contraceptives, states that every health policy that....provides coverage for prescription drugs on an outpatient basis shall provide coverage for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.

Objection 2

- Employee Application (Form)

- Employer Application (Form)

Comment: The applications 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 04/15/2008

Submitted Date 04/15/2008

Dear Rosalind Minor,

Comments:

SERFF Tracking Number: ICCI-125500744 State: Arkansas
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Response 1

Comments: Hi Rosalind - please find attached Arkansas Compliance Rider LPAC-502-AR. This Rider will be attached to all certificates issued in Arkansas and will amend the Prescription Drug Benefit Provision to remove the exclusion for contraceptives.

Also attached are the Employer and Employee applications which were revised for the fraud warning. Your continued review for approval is greatly appreciated. Thank you.

Related Objection 1

Applies To:

- Prescription Drug Option (Form)

Comment:

Exclusion #4 is an exclusion for contraceptive drugs or devices. ACA 23-79-1103, Parity for contraceptives, states that every health policy that....provides coverage for prescription drugs on an outpatient basis shall provide coverage for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.

Related Objection 2

Applies To:

- Employee Application (Form)
- Employer Application (Form)

Comment:

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

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Employee Application	LPAEEAP 6/02-AR		Application/Enrollment Form	Revised		0	AR LPAEEAP 602-AR _EE

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app_.pdf

Previous Version

Employee Application	LPAEEAP 6/02	Application/Enrollment Form	Initial	0	EMPLOY EE APPLICA TION LPAEEAP 602 1-28- 08.pdf
Employer Application	LPAERAP 6/02-AR	Application/Enrollment Form	Revised	0	AR LPAERAP 602-AR _ER app_.pdf

Previous Version

Employer Application	LPAERAP 6/02	Application/Enrollment Form	Initial	0	EMPLOY ER APPLICA TION LPAERAP 602 1-28- 08.pdf
Compliance Rider	LPAC- 502-AR	Certificate Amendment, Insert Page, Endorsement or Rider	Initial	50	AR AEND 4-15- 08.pdf

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No Rate/Rule Schedule items changed.

Sincerely,
Brenda Dawson

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Note To Reviewer

Created By:

Brenda Dawson on 03/24/2008 09:22 AM

Subject:

Company reviewing the revisions I made

Comments:

Hi Rosalind - the company is still reviewing the revisions I made to the prescription drug rider and applications. I hope to have their ok or comments this week. Thank you.

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Note To Filer

Created By:

Rosalind Minor (FM) on 03/21/2008 02:27 PM

Subject:

Objection Letter of 2/25/08

Comments:

Our records indicate that we have not received a response to our Objection Letter of 2/25/08. If a response if not received by April 25, 2008, the filing will be disapproved.

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Form Schedule

Lead Form Number: LPA-CI-407

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	LPAC-407	Certificate	Prescription Drug Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0	Prescription Drug Option filing purposes LPAC-407.pdf
Approved-Closed	LPA-CI--407	Certificate	Critical Illness Rider Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0	Critical Illness Rider LPA-CI-407 1-29-08.pdf
Approved-Closed	LPAEEAP6 /02-AR	Application/ Enrollment Form	Employee Application	Revised	Replaced Form #: Previous Filing #:	0	AR LPAEEAP602-AR _EE app_.pdf
Approved-Closed	LPAERAP6 /02-AR	Application/ Enrollment Form	Employer Application	Revised	Replaced Form #: Previous Filing #:	0	AR LPAERAP602-AR _ER app_.pdf
Approved-Closed	LPAC-502-AR	Certificate	Compliance Rider Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50	AR AEND 4-15-08.pdf

PRESCRIPTION DRUG EXPENSE BENEFIT PROVISIONS

(Applicable only if so indicated on the Certificate Face Page)

PRESCRIPTION DRUG EXPENSE BENEFIT:

Payment will be made for the amount charged that exceeds the co-pay and/or annual deductible amount for prescription drugs dispensed by a participating pharmacy. The co-pay amount is charged for each prescription and each prescription refill.

When a Covered Person utilizes a non-participating pharmacy, such eligible expenses shall be reimbursed at the allowable fee level, less any applicable deductibles and/or co-payments for each prescription refill. In addition to deductible and/or co-payment amounts, the Covered Person will be responsible for any balance in excess of the allowable fee for each prescription. Only those prescriptions eligible for reimbursement at a participating pharmacy will be considered eligible at a non-participating pharmacy. Expenses incurred at a non-participating pharmacy must be submitted with a completed claim form directly to the Company or our authorized agent.

Benefits are payable for necessary Prescription Drugs (see definition) ordered in writing by a Physician for treatment of an Illness or Injury.

NOT COVERED:

No Prescription Drug Expense Benefits will be paid for:

1. drugs dispensed by an individual not licensed to dispense drugs;
2. the administration or injection of any drug;
3. drugs labeled, "Caution — Limited by Federal Law to Investigational Use", or experimental drugs, even though a charge is made to the individual;
4. contraceptives, whether medication or device, regardless of their intended use;
5. drugs administered and consumed at the time and place of the prescription issued;
6. therapeutic devices or appliances, including support garments and other non-medicinal substances; except for disposal insulin needles or syringes;
7. immunization agents, biological sera, blood or blood plasma or oxygen;
8. any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after on 1 year from the Physician's original order;
9. prescriptions for which a Covered Person is entitled to receive without charge from any Worker's Compensation Law, or any municipal, state or federal program;
10. medication which is to be taken by or administered to a Covered Person, in whole or in part, while the Covered Person is a patient in a licensed hospital, rest home, sanitarium, convalescent or extended care facility, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals;
11. expenses incurred by a Covered Person while not covered under the Policy;
12. antineoplastic drugs, except those prescribed in oral dosage form;
13. over the counter (OTC) products, except those specifically included, i.e., insulin;
14. drugs for which the pharmacy's charges are equal to or less than the co-pay stated in the Certificate Schedule;

NOT COVERED - CONTINUED

15. hypodermic needles or syringes; except when prescribed and dispensed at the same time as insulin. Disposable needles or syringes must be dispensed in a days supply corresponding to the amount of insulin dispensed, not to exceed a 90 day supply. Only 1 co-pay shall be charged for the total prescription which shall include the insulin and needles or syringes;
16. drugs furnished, whether on an inpatient or outpatient basis, which are covered under any other carrier providing group coverage for Prescription Drugs through a Coordination of Benefits provision;
17. tretinoin, all dosage forms (e.g., Retin-A), for Covered persons 26 years of age or older;
18. drugs in excess of a 34-day supply or 100 unit doses, whichever is greater, except those specified under the Maintenance Drug Listing;
19. genetically engineered, biotherapeutic drugs or enzyme replacement drugs, growth hormone drugs such as Protropin, or any formula used for growth treatment. This exclusion applies to the purchase of, and administration of such drugs.
20. DESI drugs (determined by FDA to be lacking in substantial evidence of effectiveness);
21. drugs for investigational use or experimental drugs, even if a charge is made. "Experimental" - means any drug or medicine determined experimental by the FDA. It is labeled with "Caution" -- limited by Federal Law to investigational or experimental use;
22. drugs and medicines obtainable without a Prescription, except insulin;
23. Non-legend drugs or injectable drugs, other than insulin;
24. charges which exceed the allowable annual maximum benefit of [\$750.00-1,000.00.]

DEFINITIONS

PRESCRIPTION DRUGS: Prescription Drugs mean:

1. Federal Legend Drugs which are limited to any medicinal substance, where the label is required under the Federal, Food, Drug and Cosmetic Act to bear the legend "Caution: Federal Law prohibits dispensing without prescription";
2. Drugs which require a prescription under State but not under Federal Law;
3. Compound drugs which contain at least one ingredient that constitutes a Federal Legend Drug.
4. Injectable insulin.

PAN AMERICAN LIFE INSURANCE COMPANY

**601 Polydras Street
New Orleans, LA 70130**
(Hereinafter called the Insurer, We, Our, or Us)

**ADMINISTERED BY:
[MID-AMERICA ASSOCIATES, INC.]**

CRITICAL ILLNESS BENEFIT RIDER
(Applicable only if so indicated on the Certificate face page)

By attachment of this Rider, the Policy/Certificate is amended as follows:

CRITICAL ILLNESS BENEFIT: Upon receipt of proof that a Covered Person has received a First Diagnosis of a Critical Illness, the Company will pay the Critical Illness Benefit to the Employee.

BENEFIT AMOUNT: The amount of the Critical Illness Benefit will be:
a. in the case of an Employee, the benefit will be the amount of the Critical Illness Benefit shown on the Certificate Face Page; or
b. in the case of a Dependent spouse, the benefit will be 50% of the Critical Illness Benefit shown on the Certificate Face Page; or
c. in the case of a Dependent child, the benefit will be 25% of the Critical Illness Benefit shown on the Certificate Face Page.

DEFINITIONS: The following definitions are in addition to, or modify, the General Definitions in this Certificate.

CRITICAL ILLNESS: Critical Illness is limited to one of the medical conditions listed below.

a. **Heart Attack** means death of a portion of the heart muscle (myocardium) from a blockage of one or more coronary arteries. The diagnosis of a heart attack requires all of the following:

- i. Clinical picture of myocardial infarction;
- ii. New electrocardiographic (EKG) findings consistent with myocardial infarction; and
- iii. Elevation of cardiac enzymes above standard laboratory levels of normal (in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.

b. **Life-Threatening Cancer** means only those types of cancer shown by the presence of a malignancy identified by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Company will consider Leukemia and Hodgkin's Disease (other than Stage 1 Hodgkin's Disease) as Life-Threatening Cancer. The Company will not consider the following to be Life-Threatening Cancer:

- i. Pre-malignant tumors or polyps;
- ii. Cancer in-situ, non-invasive carcinoma of the breast, carcinoma of the appendix, Stage 1 transitional carcinoma of the urinary bladder;
- iii. Any skin cancers other than invasive malignant melanomas into the dermis or deeper; or
- iv. Stage 1 Hodgkin's Disease.

Diagnosis of Life-Threatening Cancer must be established according to the criteria of malignancy established by the American Board of Pathology after a study of the histological architecture or pattern of the suspect tumor, tissue or specimen.

c. **Stroke** means any acute cerebrovascular accident producing permanent neurological impairment and resulting in at least (30) days of paralysis or other measurable objective neurological deficit. This definition of stroke specifically excludes Transient Ischemic Attacks and Vertebrobasilar Ischemic Attacks. Diagnosis of a stroke must be evidenced by a clinical picture of permanent neurological damage provided from a Computed Axial Tomograph (CAT scan) or a Magnetic Resonance Test (MRI).

- d. **Major Organ Transplant** is the replacement of one or more of the following malfunctioning organ(s) or tissue: liver, kidney, lung, entire heart, or bone marrow. The organ(s) or tissue transplanted must be from a donor suitable.
- e. **Renal Failure** is the chronic irreversible failure of both of the kidneys (end stage renal disease), which requires treatment with regular dialysis. The First Diagnosis of renal failure must be made by a Physician who is a board-certified nephrologist.

FIRST DIAGNOSIS:

First Diagnosis is the definitive validation of a Critical Illness by a Physician through the use of clinical and laboratory investigations from the signs or symptoms. The Physician must be providing services within the scope of his license and must be a board-certified specialist where required under this rider. The First Diagnosis is based on generally accepted standards of care in the medical community relative to the condition being diagnosed. The validation of the First Diagnosis must be completed while coverage is in force under this Critical Illness Benefit.

PRE-EXISTING CONDITION:

Pre-existing Condition is a Critical Illness, including any condition causing or contributing a the Critical Illness, for which, during the twelve months immediately prior to the effective date of this rider, the Covered Person has:

- a. Consulted a Physician or received any medical advice, treatment, care, services, or medical supplies;
- b. Taken prescription medication or had medications prescribed; or
- c. Had symptoms or conditions which would have caused a prudent person to seek diagnosis, care, or treatment.

EXCLUSIONS

In addition to the General Exclusions and Limitations, the following apply:

- a. No Critical Illness Benefit is payable for any conditions other than those listed under the definition of Critical Illness.
- b. No Critical Illness Benefit is payable for a Pre-existing Condition unless coverage under this rider has been in effect for at least twelve months.
- c. The Critical Illness Benefit is payable only once for any Covered Person.

TERMINATION OF COVERAGE

Coverage under the Critical Illness Benefit will terminate as stated in the general termination provisions of the Certificate. In addition, coverage under this Critical Illness rider terminates for the Employee and all Covered Dependents on the date of the employee's First Diagnosis of any Critical Illness. Coverage for any Covered Dependent terminates on the date of the Covered Dependent's First Diagnosis of any Critical Illness. When coverage terminates due to the Employee's First Diagnosis of a Critical Illness, no conversion or premium waiver rights apply.

Only one of the above options may be selected. We, at Our own expense, will have the right to require a medical examination of the person whose illness is the basis for payment when and so often as We may reasonably require while We are paying a benefit under one of the above options.

This Rider does not change, waive or extend any part of the Policy other than as set forth above. All provisions not changed by this Rider shall remain as stated in the Policy/Certificate. This Rider is effective at the same time as the Certificate, unless a later date is shown below.

_____, 20____

Officer

Pan American Life Insurance Company
Employee Application - to be completed by applicant only

New Employee Enrollment Change for Existing Employee GROUP# _____

[Employer		Address		City		State	Zip
Employer Location					Date Employed Full Time		
Occupation		Ave Hrs Per Week	Basic Salary		<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly		
Applicant's Last Name		First		Initial	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other		
Address			City		State	Zip	Phone Number
Birth date: M/D/Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Social Security Number			
Beneficiary's Last Name				First	Initial	Relationship]	

[Dependents First Name	Initial	Last	Relationship	Birth date	M/F	Height	Weight]

[THE FOLLOWING QUESTIONS MUST BE ANSWERED IF APPLYING FOR DEPENDENT COVERAGE

Yes No I acknowledge that all dependent(s) listed above for whom coverage is requested remain principally dependent upon me and are my legal dependent(s) within the meaning of the Internal Revenue Code (IRS).

Yes No Are you or any dependent covered by Medicare, Medicaid or any other State funded medical insurance?
 If yes, list persons covered: _____

Carrier Name: _____ Policy Number: _____

COVERAGE ELECTIONS

<input type="checkbox"/> Medical	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & One Dependent	<input type="checkbox"/> Employee & Family	<input type="checkbox"/> Silver	
				<input type="checkbox"/> Gold	
				<input type="checkbox"/> Platinum	
				<input type="checkbox"/> Comprehensive	
<input type="checkbox"/> Surgical Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Prescription Drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Vision	<input type="checkbox"/>		<input type="checkbox"/>		
<input type="checkbox"/> Dental	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Plan A	
				<input type="checkbox"/> Plan B	
				<input type="checkbox"/> Plan C	

Life Insurance (including AD&D) Amount \$ _____

Dependent Life (not available without dependent coverage) one unit two units

Disability \$ _____ Plan A (26) Plan B (13)

Accelerated Death

Critical Illness]

[Change Request Requested Date of Change _____

Please select appropriate changes and indicate any new information

<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Change of Address	<input type="checkbox"/> Date Married _____
<input type="checkbox"/> Add Dependents	<input type="checkbox"/> Change Life Insurance Amount	<input type="checkbox"/> Date Divorced _____
<input type="checkbox"/> Remove Dependents (list names)	<input type="checkbox"/> Employee Name Change (previous name) _____	<input type="checkbox"/> Other _____]

AGENT NAME	AGENT NUMBER
------------	--------------

MEDICAL QUESTIONNAIRE

IMPORTANT: Provide details to any "Yes" answers in the space below.

(If more space is needed attach additional paper, signed and dated).

- Yes No 1. Have you or any family member applying for coverage had more than \$5,000 in medical expenses within the last 24 months?
- Yes No 2. Have you or any of your dependents, within the last five years, been diagnosed, examined, received medical care, been medically advised or treated in any way for cancer (malignancy), heart problem/condition, any circulatory disorder, stroke, diabetes, high blood pressure, respiratory disorder, kidney/urinary system disorder, digestive/intestinal disorder, blood disorder, multiple sclerosis, cerebral palsy, alcohol or drug abuse, mental illness, or tested positive for HIV (Human Immunodeficiency Virus)?
- Yes No 3. Have you or any of your dependents consulted, been examined or treated in any way for any other condition not listed above during the last five years?
- Yes No 4. Are you or any member of your family, whether or not named on this application, now pregnant or had a Caesarean section, history of premature birth or infertility?

Question Number	Patient Name	Condition/Diagnosis	Treatment, name and dosage of medication, recovery status	Dates Treated	Name, address, and phone number for the treating physician.

LIST NAMES OF PRESCRIBED DRUGS YOU OR YOUR DEPENDENTS ARE TAKING OR HAVE TAKEN WITHIN THE LAST THREE MONTHS.

(If more space is needed attach an additional sheet of paper and sign and date it.)

EMPLOYEE AGREEMENT

I declare that all statements contained in this Medical Questionnaire are true and correct and that no information has been withheld or omitted concerning the past or present state of health about me or my named dependents. I understand that the above answers shall be the basis for the Insurer to issue a certificate of insurance. I understand and agree that the Insurer is not bound by any agreement made by or to any agent unless written herein. I hereby authorize my employer to deduct from my earnings the necessary contribution toward the premium. Initial premium is a refundable deposit - acceptance does not mean coverage approval. I reserve the right to revoke this deduction authorization at any time upon my written notice. Coverage is effective only after approval and satisfaction of the waiting period. If I have waived coverage for myself or my dependents, I understand that if I decide to apply for future coverage, I will be required to provide evidence of insurability satisfactory to the Insurer before coverage is effective. I HEREBY AGREE THAT NO COVERAGE WILL BE EFFECTIVE UNTIL THE DATE SPECIFIED BY THE INSURER IN THE CERTIFICATE OF INSURANCE WHICH IS ONLY ISSUED TO ME AFTER THIS MEDICAL QUESTIONNAIRE IS ACCEPTED BY THE INSURER. I HEREBY CONFIRM AND UNDERSTAND THAT THE UNDERWRITING OF THE INDIVIDUAL APPLICATION TAKEN IN THIS CASE HAS BEEN PREDICATED UPON THE ANSWERS TO THE QUESTIONS IN SAID APPLICATION AND WHERE THERE HAS BEEN A MATERIAL MISREPRESENTATION OF FACTS, COVERAGE CAN BE RESCINDED.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, substance abuse facility, psychiatric facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my dependents' health to give Pan American Life Insurance or its reinsurers any such information. I understand that the information obtained by use of this authorization will be used by Pan American Life Insurance to determine eligibility for insurance benefits. Any information obtained will not be released by the Insurer to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal service in connection with my enrollment for insurance, for any claim, or as may be otherwise lawfully required or as I may further authorize. I understand that I may request a copy of this authorization at any time. I agree that a photographic copy of this authorization shall be valid as the original and that this authorization shall be valid for two and one half years from the date shown below.

The individual applying for coverage has completed this application. Any alterations that may have been made to said applications are confirmed by the applicant's initial.

Fraud Warning: 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.

EMPLOYEE SIGNATURE	DATE
--------------------	------

WAIVER

DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and after careful consideration; I have elected not to take this offer.

EMPLOYEE SIGNATURE	DATE
--------------------	------

**EMPLOYER
PARTICIPATION APPLICATION
FOR**

[

THE *Lifestyles* PLAN™

]

**PAN-AMERICAN
LIFE INSURANCE COMPANY**

EMPLOYER INFORMATION

The Employer hereby requests participation under the Master Group Policy based upon the following statements and representations. The Employer must select the coverage and pay the required premiums. Those eligible will be covered as described in this application.

Group Association (if any)		Member No.:	
FIRM NAME (LEGAL NAME)			TAX NO.
ADDRESS		CITY	STATE ZIP CODE
CONTACT NAME		CONTACT TITLE	PHONE: () FAX: ()
BUSINESS IS A: () SOLE PROPRIETOR () PARTNERSHIP () CORPORATION () L.L.C.		TYPE OF BUSINESS	TOTAL NO. EES NO. FULL-TIME EES
BILLING METHOD: 1) ARE SUBSIDIARIES/AFFILIATES INCLUDED IN THE GROUP? () YES () NO 2) SHOULD BILL BE BROKEN OUT BY LOCATION/SUBSIDIARY? () YES () NO If YES, list locations: _____			
Employee Payroll () Weekly Method: () Bi-Weekly () Monthly		NEXT PAYROLL CYCLE: MO. DAY MO. DAY / TO /	REQUESTED COVERAGE EFFECTIVE DATE:
New Employees are covered following:		WAITING PERIOD () 30 Days () 90 Days () 60 Days () Other	ELIGIBILITY AFTER WAITING PERIOD () 1st of Month - Billed Monthly () 1st Following Pay Period - Billed Every 4 Wks
INDICATE THE PERCENT OF INSURED'S PREMIUM COSTS THE EMPLOYER WILL PAY FOR EMPLOYEES _____% AND DEPENDENTS _____%		WORKERS COMPENSATION CARRIER	
HAS THE EMPLOYER HAD GROUP DENTAL INSURANCE COVERAGE FOR THE LAST 12 MONTHS? () YES () NO ATTACH A COPY OF PREMIUM BILLING		DENTAL CARRIER	POLICY NO.
WHAT PLAN OF BENEFITS WILL BE OFFERED TO YOUR EMPLOYEES? () LIFE and AD&D () DEPENDENT LIFE () DENTAL () VISION () CRITICAL ILLNESS RIDER () SHORT TERM DISABILITY () MEDICAL () PRESCRIPTION DRUG () SURGICAL RIDER () ACCELERATED DEATH RIDER			
CLASS OF EMPLOYEES: EMPLOYEES WORKING (_____) OR MORE HOURS PER WEEK. EMPLOYEES MUST BE ACTIVELY-AT-WORK ON EFFECTIVE DATE OF COVERAGE. IF NOT ACTIVELY-AT-WORK, COVERAGE WILL BE EFFECTIVE ON THE FIRST DAY OF THE MONTH OR ON THE FIRST PAYROLL CYCLE FOLLOWING RETURN TO ACTIVE EMPLOYMENT.			

EMPLOYER UNDERWRITING INFORMATION

- Are any persons applying for coverage currently disabled? () YES () NO
If YES, please provide written details. _____
- Is any employee currently on a leave of absence? () YES () NO
If YES, please provide written details. _____
- Is any person currently receiving or eligible for Continuation of Benefits pursuant to the Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA)? If YES, please provide written details.

- Have any employees or dependents been absent for 7 or more days due to illness, or been confined in a hospital for 7 or more days in the past 12 months? () YES () NO

Pan-American Life Insurance Company

EMPLOYER'S PARTICIPATION AGREEMENT

1. The undersigned Employer hereby applies for coverage under the Lifestyles Master Group Policy of Insurance.
2. Premiums are payable in arrears and due according to the billing method chosen. The undersigned Employer understands and agrees to remit payroll deductions to the Insurer from the coverage effective date for the length of this contract. The Employer understands that coverage and rates may be modified after twelve months.
3. The undersigned Employer understands and agrees that neither the Policy Administrator nor the Insurance Company assume the Employers' responsibilities for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Do not cancel current coverage until after notice of approval has been received from the Policy Administrator.

I hereby certify that the preceding information is complete and accurate. I also understand that the underwriting of these applications has been predicated based upon the answers to the questions contained herein and where there have been material misrepresentations of facts, it may result in the denial of claims payment, coverage can be retroactively rescinded and in such event the sole liability of the Insurer will be a refund of premium paid. **I understand that the Group Policy will not cover anyone currently disabled or not actively at work without specific written approval from the Policy Administrator.**

Fraud Warning: 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.

_____ Dated This _____ Day of _____, 20_____
Applicant's Signature Title

AGENT'S STATEMENT

I hereby confirm and understand that the underwriting of the individual applications taken in this case has been predicated based upon the answers to the questions in said applications and where there has been a material misrepresentation of facts, coverage can be rescinded. There have been no material misrepresentations. I have reviewed the requested coverage for accuracy and it complies with the coverage the employer desires.

_____ Dated This _____ Day of _____, 20_____
Writing Agent's Signature

Please print agent name _____

Print General Agent's name (if applicable) _____

**PAN AMERICAN LIFE INSURANCE COMPANY
601 Polydras Street
New Orleans, LA 70130**

**ADMINISTRATOR's OFFICES
Mid-America Associates, Inc.
30775 Barrington
Madison Heights, MI 48071**

ARKANSAS COMPLIANCE RIDER

With respect to Arkansas Certificateholders only, and in spite of anything in the Policy/Certificate to the contrary, this Rider amends the Policy/Certificate to which is attached as follows:

Under the **PRESCRIPTION DRUG EXPENSE BENEFIT PROVISIONS** (if applicable), Prescription Drugs **Not Covered**, item 4 pertaining to contraceptives is deleted in its entirety.

This Rider does not change, waive or extend any part of the Policy other than as set forth above. All provisions not changed by this Rider shall remain as stated in the Policy/Certificate.

This Rider is effective at the same time as the Policy/Certificate.

President

SERFF Tracking Number: *ICCI-125500744* *State:* *Arkansas*
Filing Company: *Pan American Life Insurance Company* *State Tracking Number:* *38347*
Company Tracking Number: *PAN-AM 407*
TOI: *H14G Group Health - Hospital Indemnity* *Sub-TOI:* *H14G.000 Health - Hospital Indemnity*
Product Name: *Pan-Am LPA-407*
Project Name/Number: *Pan-Am LPA-407/Pan-AM LPA-407*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: ICCI-125500744 State: Arkansas
 Filing Company: Pan American Life Insurance Company State Tracking Number: 38347
 Company Tracking Number: PAN-AM 407
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: Pan-Am LPA-407
 Project Name/Number: Pan-Am LPA-407/Pan-AM LPA-407

Supporting Document Schedules

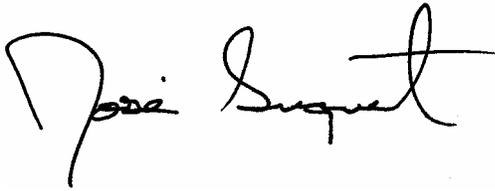
Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	04/17/2008
Comments:				
Attachment:				
	Cert of Comp.pdf			
Bypassed -Name:	Application	Review Status:	Approved-Closed	04/17/2008
Bypass Reason:	Application is part of the forms			
Comments:				
Satisfied -Name:	Cover letter	Review Status:	Approved-Closed	04/17/2008
Comments:				
Attachment:				
	AR Pan Amer 2-20-08 Riders.pdf			
Satisfied -Name:	Fee Schedule	Review Status:	Approved-Closed	04/17/2008
Comments:				
Attachment:				
	AR_Fee_Schedule.pdf			
Satisfied -Name:	Authorization Letter	Review Status:	Approved-Closed	04/17/2008
Comments:				
Attachment:				
	ICC PAN-AMERICAN RSR LETTER OF AUTHORIZATION Group Fixed Indemnity.pdf			

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Pan American Life Insurance Company

Form Number(s): LPA-CI-407, LPAC-407, LPAEEAP6/02, and LPAERAPP6/02

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.

A handwritten signature in black ink, appearing to read "José Suquet". The signature is written in a cursive style with a large initial "J" and a long horizontal stroke at the end.

Signature of Company Officer

José Suquet

Name

President and Chief Executive Officer

Title

February 20, 2008

Date



INSURANCE
COMPLIANCE
CONSULTANTS, INC.

519 Colman Center Drive
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 316-6720

February 8, 2008

Honorable Julie Benafield Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: Pan-American Life Insurance Company – NAIC: 67539
FEIN: 72-0281240
Critical Illness Rider – LPA-CI-407
Group Prescription Drug Benefit Form LPAC-407
Employee Application – LPAEEAP6/02
Employer Application – LPAERAPP6/02
FOR USE WITH: Group Indemnity Policy Form: LPA-502
Previously approved by your Department on October 14, 2002

Dear Commissioner Bowman:

We are hereby submitting the above referenced form for review and approval for use in your state. These forms are new and are not intended to replace any forms previously filed in your state.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Pan-American Life Insurance Company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

The above referenced forms were approved by Delaware on June 21, 2007 the state of issue of the group policy form LPA-502. The forms submitted for review are enhancements to be attached to and made part of the policy. The prescription drug option is added to the Policy. The riders allow the option to cover critical illness for all those covered, and the accelerated benefit under the life insurance is an option for the certificateholder only.

Application, LPAERAPP6/02, is the employer application and application, LPAEEAP6/02, is the employee application.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

The forms were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the contract other than listed or bracketed variables, or to the general print size.

Your prompt review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at (815)316-6714, fax me at (815)316-6720, or e-mail me at Brendadawson@inscompliance.com . Thank you.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.



ARKANSAS INSURANCE DEPARTMENT

1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Pan American Life Insurance Company
Company NAIC Code: 67539
Company Contact Person & Telephone #: Brenda Dawson, Insurance Compliance Consultants, Inc., (815) 316-6714
Form Number(s): LPA-CI-407, LPAC-407, LPAEEAP6/02, and LPAERAPP6/02

* INSURANCE DEPARTMENT USE ONLY *
* ANALYST: AMOUNT: ROUTE SLIP: *

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing *1 x \$50 = \$50
**Retaliatory
Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer. * x \$50 =
**Retaliatory
Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form. * x \$20 =
**Retaliatory
Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms. * x \$20 =
**Retaliatory
Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer. * x \$25 =
**Retaliatory

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to
amend an Insurer's Certificate of Authority.

* _____ x \$400 = _____

Filing to amend Certificate of Authority.

*** _____ x \$100 = _____

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE
AND REGULATION 57.

**THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK.
CODE ANN. 23-63-102, RETALIATORY TAX.

***THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.



January 1, 2008

NAIC Company Code: 67539

Re: Group Fixed Indemnity Policy, LPA5-02

To: All State Insurance Departments

Pan-American Life Insurance Company of New Orleans, LA, hereby authorizes Insurance Compliance Consultants, Inc., to represent us in the submission of the above captioned forms and to negotiate with insurance departments for their approval.

Sincerely,

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink that reads "José Suquet". The signature is written in a cursive style with a long horizontal stroke at the end.

José Suquet, President and Chief Executive Officer

SERFF Tracking Number: ICCI-125500744 State: Arkansas
 Filing Company: Pan American Life Insurance Company State Tracking Number: 38347
 Company Tracking Number: PAN-AM 407
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: Pan-Am LPA-407
 Project Name/Number: Pan-Am LPA-407/Pan-AM LPA-407

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Employee Application	02/21/2008	EMPLOYEE APPLICATION LPAEEAP602 1-28-08.pdf
No original date	Form	Employer Application	02/21/2008	EMPLOYER APPLICATION LPAERAP602 1-28-08.pdf

Pan American Life Insurance Company
Employee Application - to be completed by applicant only

New Employee Enrollment

Change for Existing Employee

GROUP# _____

[Employer		Address		City		State	Zip
Employer Location					Date Employed Full Time		
Occupation		Ave Hrs Per Week	Basic Salary		<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly		
Applicant's Last Name		First		Initial	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other		
Address		City		State	Zip	Phone Number	
Birth date: M/D/Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Social Security Number			
Beneficiary's Last Name			First		Initial	Relationship]	

Dependents	First Name	Initial	Last	Relationship	Birth date	M/F	Height	Weight]

[THE FOLLOWING QUESTIONS MUST BE ANSWERED IF APPLYING FOR DEPENDENT COVERAGE

Yes No I acknowledge that all dependent(s) listed above for whom coverage is requested remain principally dependent upon me and are my legal dependent(s) within the meaning of the Internal Revenue Code (IRS).

Yes No Are you or any dependent covered by Medicare, Medicaid or any other State funded medical insurance?

If yes, list persons covered: _____

Carrier Name: _____ Policy Number: _____

COVERAGE ELECTIONS

	Employee Only	Employee & One Dependent	Employee & Family		
<input type="checkbox"/> Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Silver	
				<input type="checkbox"/> Gold	
				<input type="checkbox"/> Platinum	
				<input type="checkbox"/> Comprehensive	
<input type="checkbox"/> Surgical Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Prescription Drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Vision	<input type="checkbox"/>		<input type="checkbox"/>		
<input type="checkbox"/> Dental	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Plan A	
				<input type="checkbox"/> Plan B	
				<input type="checkbox"/> Plan C	

Life Insurance (including AD&D) Amount \$ _____

Dependent Life (not available without dependent coverage) one unit two units

Disability \$ _____ Plan A (26) Plan B (13)

Accelerated Death

Critical Illness]

[Change Request

Requested Date of Change _____

Please select appropriate changes and indicate any new information

<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Change of Address	<input type="checkbox"/> Date Married _____
<input type="checkbox"/> Add Dependents	<input type="checkbox"/> Change Life Insurance Amount	<input type="checkbox"/> Date Divorced _____
<input type="checkbox"/> Remove Dependents (list names)	<input type="checkbox"/> Employee Name Change (previous name) _____	<input type="checkbox"/> Other _____]

AGENT NAME	AGENT NUMBER
------------	--------------

MEDICAL QUESTIONNAIRE

IMPORTANT: Provide details to any "Yes" answers in the space below.

(If more space is needed attach additional paper, signed and dated).

- Yes No 1. Have you or any family member applying for coverage had more than \$5,000 in medical expenses within the last 24 months?
- Yes No 2. Have you or any of your dependents, within the last five years, been diagnosed, examined, received medical care, been medically advised or treated in any way for cancer (malignancy), heart problem/condition, any circulatory disorder, stroke, diabetes, high blood pressure, respiratory disorder, kidney/urinary system disorder, digestive/intestinal disorder, blood disorder, multiple sclerosis, cerebral palsy, alcohol or drug abuse, mental illness, or tested positive for HIV (Human Immunodeficiency Virus)?
- Yes No 3. Have you or any of your dependents consulted, been examined or treated in any way for any other condition not listed above during the last five years?
- Yes No 4. Are you or any member of your family, whether or not named on this application, now pregnant or had a Caesarean section, history of premature birth or infertility?

Question Number	Patient Name	Condition/Diagnosis	Treatment, name and dosage of medication, recovery status	Treated	Dates	Name, address, and phone number for the treating physician.

LIST NAMES OF PRESCRIBED DRUGS YOU OR YOUR DEPENDENTS ARE TAKING OR HAVE TAKEN WITHIN THE LAST THREE MONTHS.

(If more space is needed attach an additional sheet of paper and sign and date it.)

EMPLOYEE AGREEMENT

I declare that all statements contained in this Medical Questionnaire are true and correct and that no information has been withheld or omitted concerning the past or present state of health about me or my named dependents. I understand that the above answers shall be the basis for the Insurer to issue a certificate of insurance. I understand and agree that the Insurer is not bound by any agreement made by or to any agent unless written herein. I hereby authorize my employer to deduct from my earnings the necessary contribution toward the premium. Initial premium is a refundable deposit - acceptance does not mean coverage approval. I reserve the right to revoke this deduction authorization at any time upon my written notice. Coverage is effective only after approval and satisfaction of the waiting period. If I have waived coverage for myself or my dependents, I understand that if I decide to apply for future coverage, I will be required to provide evidence of insurability satisfactory to the Insurer before coverage is effective. I HEREBY AGREE THAT NO COVERAGE WILL BE EFFECTIVE UNTIL THE DATE SPECIFIED BY THE INSURER IN THE CERTIFICATE OF INSURANCE WHICH IS ONLY ISSUED TO ME AFTER THIS MEDICAL QUESTIONNAIRE IS ACCEPTED BY THE INSURER. I HEREBY CONFIRM AND UNDERSTAND THAT THE UNDERWRITING OF THE INDIVIDUAL APPLICATION TAKEN IN THIS CASE HAS BEEN PREDICATED UPON THE ANSWERS TO THE QUESTIONS IN SAID APPLICATION AND WHERE THERE HAS BEEN A MATERIAL MISREPRESENTATION OF FACTS, COVERAGE CAN BE RESCINDED.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, substance abuse facility, psychiatric facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my dependents' health to give Pan American Life Insurance or its reinsurers any such information. I understand that the information obtained by use of this authorization will be used by Pan American Life Insurance to determine eligibility for insurance benefits. Any information obtained will not be released by the Insurer to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal service in connection with my enrollment for insurance, for any claim, or as may be otherwise lawfully required or as I may further authorize. I understand that I may request a copy of this authorization at any time. I agree that a photographic copy of this authorization shall be valid as the original and that this authorization shall be valid for two and one half years from the date shown below.

The individual applying for coverage has completed this application. Any alterations that may have been made to said applications are confirmed by the applicant's initial.

EMPLOYEE SIGNATURE	DATE
--------------------	------

WAIVER

DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and after careful consideration; I have elected not to take this offer.

EMPLOYEE SIGNATURE	DATE
--------------------	------

EMPLOYER

PARTICIPATION APPLICATION

FOR

[

THE *Lifestyles* **PLAN™**

]

**PAN-AMERICAN
LIFE INSURANCE COMPANY**

EMPLOYER INFORMATION

The Employer hereby requests participation under the Master Group Policy based upon the following statements and representations. The Employer must select the coverage and pay the required premiums. Those eligible will be covered as described in this application.

Group Association (if any)		Member No.:	
FIRM NAME (LEGAL NAME)			TAX NO.
ADDRESS		CITY	STATE ZIP CODE
CONTACT NAME		CONTACT TITLE	PHONE: () FAX: ()
BUSINESS IS A: () SOLE PROPRIETOR () PARTNERSHIP () CORPORATION () L.L.C.		TYPE OF BUSINESS	TOTAL NO. EES NO. FULL-TIME EES
BILLING METHOD: 1) ARE SUBSIDIARIES/AFFILIATES INCLUDED IN THE GROUP? () YES () NO 2) SHOULD BILL BE BROKEN OUT BY LOCATION/SUBSIDIARY? () YES () NO If YES, list locations: _____			
Employee Payroll () Weekly Method: () Bi-Weekly () Monthly		NEXT PAYROLL CYCLE: MO. DAY MO. DAY / TO /	REQUESTED COVERAGE EFFECTIVE DATE:
New Employees are covered following:		WAITING PERIOD () 30 Days () 90 Days () 60 Days () Other	ELIGIBILITY AFTER WAITING PERIOD () 1st of Month - Billed Monthly () 1st Following Pay Period - Billed Every 4 Wks
INDICATE THE PERCENT OF INSURED'S PREMIUM COSTS THE EMPLOYER WILL PAY FOR EMPLOYEES _____% AND DEPENDENTS _____%		WORKERS COMPENSATION CARRIER	
HAS THE EMPLOYER HAD GROUP DENTAL INSURANCE COVERAGE FOR THE LAST 12 MONTHS? () YES () NO ATTACH A COPY OF PREMIUM BILLING		DENTAL CARRIER	POLICY NO.
WHAT PLAN OF BENEFITS WILL BE OFFERED TO YOUR EMPLOYEES? () LIFE and AD&D () DEPENDENT LIFE () DENTAL () VISION () CRITICAL ILLNESS RIDER () SHORT TERM DISABILITY () MEDICAL () PRESCRIPTION DRUG () SURGICAL RIDER () ACCELERATED DEATH RIDER			
CLASS OF EMPLOYEES: EMPLOYEES WORKING (_____) OR MORE HOURS PER WEEK. EMPLOYEES MUST BE ACTIVELY-AT-WORK ON EFFECTIVE DATE OF COVERAGE. IF NOT ACTIVELY-AT-WORK, COVERAGE WILL BE EFFECTIVE ON THE FIRST DAY OF THE MONTH OR ON THE FIRST PAYROLL CYCLE FOLLOWING RETURN TO ACTIVE EMPLOYMENT.			

EMPLOYER UNDERWRITING INFORMATION

- Are any persons applying for coverage currently disabled? () YES () NO
If YES, please provide written details. _____
- Is any employee currently on a leave of absence? () YES () NO
If YES, please provide written details. _____
- Is any person currently receiving or eligible for Continuation of Benefits pursuant to the Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA)? If YES, please provide written details.

- Have any employees or dependents been absent for 7 or more days due to illness, or been confined in a hospital for 7 or more days in the past 12 months? () YES () NO

Pan-American Life Insurance Company

EMPLOYER'S PARTICIPATION AGREEMENT

1. The undersigned Employer hereby applies for coverage under the Lifestyles Master Group Policy of Insurance.
2. Premiums are payable in arrears and due according to the billing method chosen. The undersigned Employer understands and agrees to remit payroll deductions to the Insurer from the coverage effective date for the length of this contract. The Employer understands that coverage and rates may be modified after twelve months.
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Do not cancel current coverage until after notice of approval has been received from the Policy Administrator.

I hereby certify that the preceding information is complete and accurate. I also understand that the underwriting of these applications has been predicated based upon the answers to the questions contained herein and where there have been material misrepresentations of facts, it may result in the denial of claims payment, coverage can be retroactively rescinded and in such event the sole liability of the Insurer will be a refund of premium paid. **I understand that the Group Policy will not cover anyone currently disabled or not actively at work without specific written approval from the Policy Administrator.**

_____ Dated This ____ Day of _____, 20_____
Applicant's Signature Title

AGENT'S STATEMENT

I hereby confirm and understand that the underwriting of the individual applications taken in this case has been predicated based upon the answers to the questions in said applications and where there has been a material misrepresentation of facts, coverage can be rescinded. There have been no material misrepresentations. I have reviewed the requested coverage for accuracy and it complies with the coverage the employer desires.

_____ Dated This ____ Day of _____, 20_____
Writing Agent's Signature

Please print agent name _____

Print General Agent's name (if applicable) _____