

SERFF Tracking Number: LWEL-125731885 State: Arkansas  
Filing Company: AmFirst Insurance Company State Tracking Number: 39607  
Company Tracking Number: AF-HOSPIND-GRP-APP 7-08  
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
Product Name: Application Filing for Group Hospital Indemnity Plan  
Project Name/Number: Application Filing for Group Hospital Indemnity Plan/AF-HOSPIND-GRP-APP 7-08

## Filing at a Glance

Company: AmFirst Insurance Company

Product Name: Application Filing for Group Hospital Indemnity Plan SERFF Tr Num: LWEL-125731885 State: ArkansasLH

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed State Tr Num: 39607

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AF-HOSPIND-GRP-APP 7-08 State Status: FEES PAID

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Rebecca Naderi

Disposition Date: 07/14/2008

Date Submitted: 07/13/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Application Filing for Group Hospital Indemnity Plan

Status of Filing in Domicile: Not Filed

Project Number: AF-HOSPIND-GRP-APP 7-08

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type:

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 07/14/2008

Deemer Date:

State Status Changed: 07/14/2008

Corresponding Filing Tracking Number:

Filing Description:

Application Filing for Group Hospital Indemnity Plan.

## Company and Contact

### Filing Contact Information

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(This filing was made by a third party - lewisandellisincorporated)

Rebecca Naderi, Compliance Consultant rnaderi@lewisellis.com  
2929 N. Central Expy., Ste. 200 (972) 850-3272 [Phone]  
Richardson, TX 75085-1857 (972) 850-3273[FAX]

**Filing Company Information**

AmFirst Insurance Company CoCode: 60250 State of Domicile: Oklahoma  
407 Briarwood Drive, Suite 201 Group Code: -99 Company Type:  
Jackson, MS 39206 Group Name: State ID Number:  
(601) 956-2028 ext. [Phone] FEIN Number: 640902785  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$60.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AmFirst Insurance Company	\$60.00	07/13/2008	21385262

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/14/2008	07/14/2008

*SERFF Tracking Number:*      *LWEL-125731885*                      *State:*                      *Arkansas*  
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## **Disposition**

Disposition Date: 07/14/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Submission Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Authorization Letter	Approved-Closed	Yes
<b>Form</b>	Application for Group Insurance	Approved-Closed	Yes
<b>Form</b>	Group Enrollment Form	Approved-Closed	Yes
<b>Form</b>	Sponsor's Agreement	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** AF-HOSPIND-GRP-APP 7-08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AF-HOSPIND-GRP-APP 7-08	Application/Enrollment Form	Application for Group Insurance	Initial			GroupApplication-AffordableMedicalPlan7-08.pdf
Approved-Closed	AF-Employee Enroll App 7-2008	Application/Group Enrollment Form	Employee Enrollment Form	Initial			EmployeeEnrollApplication-AffordableMedical-7-08.pdf
Approved-Closed	AF-HOSPIND-Sponsor's Agreement 7-08	Application/Enrollment Form	Sponsor's Enrollment Agreement	Initial			AffordableMedicalSponsor'sAgreement7-08.pdf

**Application for Group Insurance to:  
AmFirst Insurance Company**

**Administrative Office**

**P. O. Box 14067 • Jackson, MS 39236-4067**

The Information provided by the Applicant in this Application will be the basis on which any insurance is issued. Incorrect Information could void Insurance.

Applicant		Employer Identification Number	
Name of Business or Organization		SIC Code	
Principal Business or Activity		Billing Address: (If different from Physical Address)	
Physical Address: (Street Number and Name)		Billing Address: (If different from Physical Address)	
City		City	
State	Zip	State	Zip

Executive Contact Person:	Billing Contact Person:
Title:	Title:
Telephone:	Telephone:

**Eligibility**

- [W-2 employees or Contract (1099) employees are eligible. 1099 employees must have employer sponsorship and a common remitter.
- Applicant must be employed and be actively at work with the company for a minimum of 90 days prior to application to be eligible.
- Applicant must work 20 hours or more per week.
- Applicant must be under the age of age 65, benefits reduce to one half at age 65, and policy will terminate at age 70.
- Spouse must be under the age of age 65, benefits reduce to one half at age 65, and policy will terminate at age 70.
- Dependent children\*\* under the age of 19. Full time students are eligible to age 25.
- Mental or physical handicap are eligible (age 19 or more years of age) if primarily supported by the insured and incapable of self-sustaining employment because of the mental or physical handicap.
- Individuals on Medicare are not eligible for this coverage.]

**Insurance Applied For**

[Affordable Medical Plan - Policy Form Series AF-HOSPIND

**Attach copy of proposal or flier describing benefits selected**  
Plan # \_\_\_\_\_

Applicant will pay \_\_\_\_\_% of Employee or Member Costs and \_\_\_\_% of Dependent Costs

Important: The Affordable Medical Plan is NOT basic health insurance. This is limited benefit indemnity insurance. It is not a substitute for basic health coverage, major medical insurance, or any other medical expense reimbursement plan.]

**Policy/ Certificate Delivery**

[Send Policy & Certificate to: \_\_\_\_\_Agent \_\_\_\_\_Employer]

**Payroll and Billing Information**

Billing is alphabetical -12 monthly Premiums  
Effective date: \_\_\_\_\_ (1st of the month)  
  
Make check payable to AmFirst Insurance Company.  
\$ \_\_\_\_\_ (amount of attached check).  
  
**[ALL PREMIUMS ARE PAYABLE IN ADVANCE. THE FIRST PREMIUM MUST BE PAID PRIOR TO THE EFFECTIVE DATE OF INSURANCE. ]**

**Agreements, Representations and Understanding**

**I represent** that all statements made herein are complete and true as of the date I signed this Application, and I understand that AmFirst Insurance Company (AF) will rely on these statements and this information as the basis for approving this Application.

**I understand** that the Insurance Policy for which I have applied is a limited benefit Policy that pays only the benefits selected and set forth in the Policy itself. Our agent has explained the Policy’s limitations and exclusions. For a complete listing of the plan provisions, as well as any limitations and exclusions, please refer to the Group Policy. Any provision of the Group Policy which, on it’s Effective Date, does not agree with the laws of the state in which the Policy is written, will be amended to the minimum requirements of that state.

**I understand** that coverage is effective when: a) the Policy is issued by AmFirst Insurance Company b) the Policy is received and accepted by the Policyholder; c) the full first premium is paid and accepted by AmFirst Insurance Company.

**We agree** to make any necessary payroll deductions for any employee’s share of the cost of this insurance (if any) and to remit the total premium for all insurance as premiums become due.

**I understand** that the Policyholder or AmFirst Insurance Company may terminate the Policy and any Rider(s) on any premium due date by giving at least 90 days written notice to the other party. The Policyholder is responsible for notifying the Insured of the termination or non-renewal of the Policy.

**I understand** that AmFirst Insurance Company and the Policyholder may agree to amend the Policy at any time without the consent of any employee or other person.

**I represent** that I have read and understand this form.]

**“WARNING: Any person who knowingly, and with intent to injure, defraud or deceive AmFirst Insurance Company, makes any claim for the proceeds of an insurance Policy containing any false, incomplete or misleading information is guilty of a felony.”**

On behalf of the Employer, this Application for Group Insurance is signed by

X \_\_\_\_\_ Print Name \_\_\_\_\_

Official Title \_\_\_\_\_

Date \_\_\_\_\_

Agent Name (print) \_\_\_\_\_ Signature \_\_\_\_\_

# AmFirst Insurance Company Enrollment Form

Hand Print – Black Ink Only  
 This is an electronically processed form. Please  
 PRINT in the boxes in capital letters:  
 ABCDEFG...12345 DO NOT TOUCH LINES

Group Name

Requested Effective Date  
 MO / DD / YEAR

Hire Date  
 MO / DD / YEAR

Last Name (Primary Insured)

First Name

MI

M/F

MO / DD / YEAR

AGE

SSN

Last Name (Spouse)

First Name

MI

M/F

MO / DD / YEAR

AGE

SSN

Last Name (Dependents)

First Name

MI

M/F

MO / DD / YEAR

AGE

Student Status  


Please indicate yes in Student Status at left if full time students

Use this form for:

New Application

Additional Insured

Delete Insured

Address

Work Phone

City

State

Zip  
 -

Home Phone

Payment Mode  
 Group Payroll Deduction

[Type of Coverage       Employee       Employee + Spouse       Employee + Children       Employee + Family]

Plan # \_\_\_\_\_

Monthly Premium \_\_\_\_\_

## Authorization, Agreements, Representations and Understanding

[I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. Consumer reporting agencies, or employer having information available as to diagnosis treatment and prognosis with respect to any physical or mental condition and/or treatment of me and other members, to give AmFirst Insurance Company, its reinsurers, or its legal representatives, any and all such information. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application for Insurance.

The agent and I certify that I have read or had read to me the complete application. I realize that any false statement or misrepresentation that is material to the risk or hazard assumed may result in loss of coverage under the coverage applied for, subject to the incontestable period, time limit on certain defenses and legal proceedings.

I understand that no agent can: a) accept risks; b) modify policies; or c) waive any rights or requirements of AmFirst Insurance Company. The acceptance of any certificate or policy issued on this application shall be an acceptance and ratification by me of all corrections, additions or changes made by AmFirst Insurance Company. Any changes are shown in the space labeled "Home Office Use." ; however, any change in the date of birth is subject to my written agreement.

I understand that coverage is effective when: a) the certificate or policy is issued by AmFirst Insurance Company; b) the certificate or policy is received and accepted by me; and c) the first full monthly premium is received and accepted by AmFirst Insurance Company; and d) if there has been no change in my health or occupation since the date below.

I understand that the certificate provides limited benefits, specifically only the benefits which I have selected and are set forth in the certificate itself.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive AmFirst Insurance Company, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

X \_\_\_\_\_  
Signature of Proposed Insured Date

\_\_\_\_\_  
Agent's Printed Name Agent Number

\_\_\_\_\_  
Dated at City State

**MORGAN WHITE ADMINISTRATORS**  
**SPONSOR'S AGREEMENT OF SETTLEMENT DEDUCTION PLAN**  
Morgan White Administrators P.O. Box 14067, Jackson, MS 39236

Until further notice, we will participate in your Settlement Deduction Plan for the benefit of our enrollees. The Settlement Department has been instructed to honor settlement deduction authorizations signed by our enrollees for complete premium or partial premium for insurance coverage by AmFirst Insurance Company.

As a Sponsor, I have agreed to pay the following % of premium for the plan (s) and coverage indicated below: (attach the proposal selected)

Paying Premium for:  Applicant    *OR*     Applicant & Dependents

Plan #	% of Premium	Outline Eligibility	# Eligible

Participation Requirements

Minimum participation requirements are:

Groups of 10 –100 = the greater of 10 enrollees or 20% of the eligible employees

Groups of 100 or more = the greater of 20 or 10% of the eligible

In determining the percentage of participation the total number of eligible employees (as determined by the employer) will be considered. If the group does not meet the participation requirements the group will be returned to the agent. ]

Guaranteed Issue

Guaranteed issue – no health questions subject to minimum participation requirements.]

[I understand that enrollees must be actively at work with the sponsor for a minimum of 3 months to be eligible.]

[In signing this Sponsor's Agreement, it is understood that:

1. Part of the amount paid includes Association dues that are not connected with the insurance company.
2. We may terminate this Sponsor's Agreement as long as 30 days notice is given to Morgan White Administrators and to our insured.
3. Morgan White Administrators may also terminate this Sponsor's Agreement as a whole, when premium participation requirements are not met.
4. Monthly, as we are billed, we will forward to you the amounts deducted from our insured settlement (if any) and any amount I have agreed to contribute (if any).
5. Reasonable access to eligible insured to solicit applications or enrollments and to service certificates issued will be granted.
6. We understand that the Affordable Medical Plan is NOT basic health insurance. This is limited benefit indemnity insurance. It is not a substitute for basic health coverage, major medical insurance, or any other medical expense reimbursement plan.]

Sponsor: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Chief Executive Officer: \_\_\_\_\_, Title: \_\_\_\_\_

Company Contact Person: \_\_\_\_\_, Title: \_\_\_\_\_

Telephone # of Contact Person: \_\_\_\_\_ Fax # of Contact Person: \_\_\_\_\_

Authorized By: \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_ Agent Name: \_\_\_\_\_

(Premium and Applications must be received 5 days prior to the Effective Date)

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## **Rate Information**

Rate data does NOT apply to filing.

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## Supporting Document Schedules

**Review Status:**  
**Bypassed -Name:** Certification/Notice Approved-Closed 07/14/2008  
**Bypass Reason:** These requirements were met with the original policy form filing, AF-HOSPIND-P-25-(10/02) AR, et all previously approved by your Department on January 23, 2008. This filing is for applications only to be used with the previously approved policy form filing.

**Comments:**

**Review Status:**  
**Bypassed -Name:** Application Approved-Closed 07/14/2008  
**Bypass Reason:** Please see Form Schedule Tab for applications.

**Comments:**

**Review Status:**  
**Satisfied -Name:** Submission Letter Approved-Closed 07/14/2008

**Comments:**

**Attachment:**  
 SubLtr-AffMed-Amfirst-AR.pdf

**Review Status:**  
**Satisfied -Name:** Authorization Letter Approved-Closed 07/14/2008

**Comments:**

**Attachment:**  
 Authorization Letter.pdf

**Dallas**

Glenn A. Tobleman, F.S.A., F.C.A.S.  
 S. Scott Gibson, F.S.A.  
 Cabe W. Chadick, F.S.A.  
 Steven D. Bryson, F.S.A.  
 Michael A. Mayberry, F.S.A.  
 Gregory S. Wilson, F.C.A.S.  
 David M. Dillon, F.S.A.  
 Bonnie S. Albritton, F.S.A.  
 Brian D. Rankin, F.S.A.  
 Robert E. Gove, A.S.A.  
 Alexis M. Bash, A.S.A.  
 Sarah A. Hoover, A.S.A.  
 Wes R. Campbell, A.S.A.  
 Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)

**Kansas City**

Gary L. Rose, F.S.A.  
 Terry M. Long, F.S.A.  
 David L. Batchelder, A.S.A.  
 Leon L. Langlitz, F.S.A.  
 Gary R. McElwain, FLMI  
 Christopher H. Davis, F.S.A.  
 Thomas L. Handley, F.S.A.  
 Anthony G. Proulx, F.S.A.  
 Karen E. Elsom, F.S.A.

**London**

Roger K. Annin, F.S.A.  
 Timothy A. DeMars, F.S.A.  
 Scott E. Morrow, F.S.A.

July 13, 2008

Life and Health Division  
 Arkansas Department of Insurance  
 1200 West Third Street  
 Little Rock, Arkansas 72201-1904

Re: AmFirst Insurance Company NAIC #60250

Dear Commissioner:

Please find enclosed a submission of the following forms for your review and approval:

<u>Form #</u>	<u>Description</u>
AF-HOSPIND-GRP-APP 7-08	Application for Group Insurance
AF-Employee Enroll App 7-2008	Group Enrollment Form
AF-HOSPIND-Sponsor's Agreement 7-08	Sponsor's Agreement

These forms are new and do not replace any forms previously filed and approved by your Department. These forms will be used to market Group Hospital Indemnity forms AF-HOSPIND-P-25-(10/02) AR, et al which were previously approved by your Department on January 23, 2008.

The following filing materials are included:

- The above forms
- Filing Authorization Letter

The applicable filing fee in the amount of \$60.00 is being submitted via EFT under SERFF.

Thank you for your review of this filing. If you have any questions or comments, please feel free to call me at (972) 850-3272 or email me at [rnaderi@lewisellis.com](mailto:rnaderi@lewisellis.com).

Sincerely,

A handwritten signature in blue ink that reads 'Rebecca Naderi'.

Rebecca Naderi, FLMI, HIA, ACS, ACP  
 Compliance Consultant  
 Lewis & Ellis, Inc. – Actuaries and Consultants



*AmFirst*  
*Insurance Company*

November 21, 2002

Lewis & Ellis, Inc.  
2929 North Central Expressway, Suite 200  
P. O. Box 85187  
Richardson, Texas 75085

To Whom It May Concern:

This letter or a copy thereof, confirms the authority of Lewis & Ellis Inc. to submit on behalf of AmFirst Insurance Company (the Company), the required forms and rates for any insurance products to the insurance departments of those jurisdictions in which the Company is licensed, and to represent the Company in the negotiation of the approval of said forms and rates, including the provision of necessary assurances and commitments regarding specific conditions of the forms to secure said approvals.

This authorization shall be valid until such time as it is revoked by the Company.

Sincerely

A handwritten signature in black ink, appearing to read 'R. L. Eaton', is written over the printed name.

Richard L. Eaton  
Chief Financial Officer  
AmFirst Insurance Company