

<i>SERFF Tracking Number:</i>	CAIC-125832242	<i>State:</i>	Arkansas
<i>Filing Company:</i>	Continental American Insurance Company	<i>State Tracking Number:</i>	40362
<i>Company Tracking Number:</i>	6965 & 6966		
<i>TOI:</i>	H07G Group Health - Specified Disease - Limited Benefit	<i>Sub-TOI:</i>	H07G.001 Critical Illness
<i>Product Name:</i>	CAIC CI & Combo App		
<i>Project Name/Number:</i>	Arkansas/6965 & 6966		

## Filing at a Glance

Company: Continental American Insurance Company

Product Name: CAIC CI & Combo App      SERFF Tr Num: CAIC-125832242      State: ArkansasLH

TOI: H07G Group Health - Specified Disease - Limited Benefit      SERFF Status: Closed      State Tr Num: 40362

Limited Benefit

Sub-TOI: H07G.001 Critical Illness

Co Tr Num: 6965 & 6966

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Amanda King

Disposition Date: 09/26/2008

Date Submitted: 09/25/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Arkansas

Status of Filing in Domicile: Not Filed

Project Number: 6965 & 6966

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 and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 09/26/2008

State Status Changed: 09/26/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval are the captioned applications. These applications will replace CAI2811 and CA-2006-Combo which were approved on May 13, 2008 and December 2, 2005 respectively.

Thank you for your consideration in this matter. If you have any questions, please contact Amanda King at 888-730-2244, ext 4331 or by e-mail at [CompanyCompliance@caicworksite.com](mailto:CompanyCompliance@caicworksite.com) if you have any questions.

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 Filing Company: Continental American Insurance Company State Tracking Number: 40362  
 Company Tracking Number: 6965 & 6966  
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
 Limited Benefit  
 Product Name: CAIC CI & Combo App  
 Project Name/Number: Arkansas/6965 & 6966

## Company and Contact

### Filing Contact Information

Amanda King, Compliance Analyst  
 2801 Devine Street  
 Columbia, SC 29205

companycompliance@caicworksite.com  
 (888) 730-2244 [Phone]  
 (803) 929-4919[FAX]

### Filing Company Information

Continental American Insurance Company  
 2801 Devine Street  
 Columbia, SC 29205

CoCode: 71730 State of Domicile: South Carolina  
 Group Code: Company Type: LAH  
 Group Name: Continental Amer Ins State ID Number:  
 Co  
 FEIN Number: 57-0514130  
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(803) 256-6265 ext. [Phone]

## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	\$50.00	09/25/2008	22711209

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/26/2008	09/26/2008





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## Form Schedule

Lead Form Number: CAI2811 9/08 & CAI2008C

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CAI2811 9/08	Application/Enrollment Form	Enrollment App	Initial			CAI2811Rev John Doe'd.pdf
Approved-Closed	CAI2008C	Application/Enrollment Form	Combination App	Initial			08 Combo App J Doe'd.pdf



**ENROLLMENT FORM**

Please Mail To: Post Office Box 427  
Columbia, South Carolina 29202  
(800) 433-3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
<b>Critical Illness</b>		
Endorsement:		
EFFECTIVE DATE:		

[Employee] Name/Owner (First, MI, Last) <b>John Q. Doe</b>		S.S.N./ ID Number xxx-xx-xxxx	Gender Male	Date of Birth 9-6-1971
Street Address 123 Any Street		City Columbia	State SC	Zip 29205
Employer ABC Company	Job Class Teacher	Location Columbia, SC	Date of Hire 8-1-2004	
Hours Worked 40	Daytime Phone No. ( 888 ) 555-1234	Beneficiary Name / Relationship (estate unless designated otherwise) Jane Doe - Sibling		
Spouse's Name (if coverage is requested)		Gender	Spouse Date of Birth	
		<b>Employee</b>	<b>Spouse</b>	
Are you actively at work?		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you now hospitalized or unable to perform your normal duties and activities?				<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you used tobacco products in the last 12 months?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

**CRITICAL ILLNESS**       [Employee]       [Employee & Spouse]      [Section 125:  Yes  No]

[Employee] Face Amount: \$ xx.00      [Employee] Cost per pay period: \$ \_\_\_\_\_  ADL Rider  Add-a-buck

Spouse Face Amount: \$ \_\_\_\_\_      Spouse Cost per pay period: \$ \_\_\_\_\_  ADL Rider

		Employee	Spouse
1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever been treated for or diagnosed with a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace or change any existing insurance?  YES  NO
- If "Yes," provide carrier and policy number: \_\_\_\_\_

CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance. Deduction start date November 1, 2008

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

Date 9-18-08 Signature of Applicant John Q. Doe

Date 9-18-08 Signature of Agent Adam Agent State of Enrollment SC



**ENROLLMENT FORM**

Please Mail: Post Office Box 427  
Columbia, South Carolina 29202  
(800) 433-3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
[Critical Illness]		
[Accident]		
[Hospital Indemnity]		
[Cancer]		
[Disability]		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last) <b>John Q. Doe</b>		S.S.N./ ID Number xxx-xx-xxxx	Gender Male	Date of Birth 1-1-70
Street Address <b>123 Any Street</b>		City Columbia	State SC	Zip
Employer ABC Company		Job Class Teacher	Location Columbia	Date of Hire 11-4-04
Hours Worked 40	Daytime Phone No. ( 888 ) 555-1234	Beneficiary Name / Relationship (estate unless designated otherwise) Jane Doe - Sibling		
Spouse's Name (if coverage is requested)		Gender	Spouse Date of Birth	
			<b>Employee</b>	<b>Spouse</b>
Are you actively at work?			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Are you now hospitalized or unable to perform your normal duties and activities?				<input type="checkbox"/> YES <input type="checkbox"/> NO

**List all eligible children for whom you are proposing coverage (from Youngest to Oldest):**

Name	Gender	Date of Birth	Name	Gender	Date of Birth

**Type of Coverage**

1	<b>CRITICAL ILLNESS</b>	<input checked="" type="checkbox"/> Employee <input type="checkbox"/> [Employee & Spouse]	[Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No]
	Employee Face Amount: \$ <u>xx.xx</u>	<b>Employee Cost per pay period:</b> \$ <u>xx.xx</u>	
	Spouse Face Amount: \$ _____	<b>Spouse Cost per pay period:</b> \$ _____	
			<b>Employee</b>
			<b>Spouse</b>
1a	Have you used tobacco products in the last 12 months?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1b	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1c	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1d	Have you ever been treated for or diagnosed with a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	<b>ACCIDENT</b> [ <input checked="" type="checkbox"/> 24 Hour] [ <input type="checkbox"/> Non-Occupational] Plan _____	[Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No]	
	[ <input type="checkbox"/> Wellness] [ <input type="checkbox"/> Hospital Indemnity] [ <input type="checkbox"/> Hospital Admission] [ <input type="checkbox"/> DI Rider] <input type="checkbox"/> _____		
	<input checked="" type="checkbox"/> Employee [ <input type="checkbox"/> Employee & Spouse] [ <input type="checkbox"/> Employee & Children] [ <input type="checkbox"/> Family]	<b>Cost per pay period:</b> \$ <u>xx.xx</u>	
3	<b>HOSPITAL INDEMNITY</b> Plan: _____	[Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No]	
	<input type="checkbox"/> Employee [ <input type="checkbox"/> Employee & Spouse] [ <input type="checkbox"/> Employee & Children] [ <input type="checkbox"/> Family]	<b>Cost per pay period:</b> \$ _____	
<b>If NOT Guaranteed Issue, answer the following questions:</b>			
			<b>Employee</b>
			<b>Spouse</b>
			<b>Children</b>
3a	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
3b	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO

3c	Have you ever been treated for a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3d	Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

3e Employee Height / Weight \_\_\_\_\_ Spouse Height / Weight \_\_\_\_\_

4 **CANCER**  [Basic]  [Enhanced] [Section 125:  Yes  No]  
 [Rider : \_\_\_\_\_ ] **Cost per pay period:** \$ \_\_xx.xx\_\_\_\_\_  
**[Only answer question 4c when applying for the Intensive Care Rider]**

		Employee	Spouse	Children
4a	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4b	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4c	Have you ever been treated for a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

5 **DISABILITY**  [24 Hour]  [Non-Occupational] Class:  [Premier]  [Select]  [Choice]  
Gross Monthly Salary \$ \_\_\_\_\_ [Section 125:  Yes  No]  
Riders: \_\_\_\_\_ Monthly Benefit Amount: \$ \_\_\_\_\_ **Cost per pay period:** \$ \_\_\_\_\_  
Elimination Period: Accident: \_\_\_\_\_ [Sickness: \_\_\_\_\_] Benefit Period: \_\_\_\_\_  
Employee Height / Weight \_\_\_\_\_  
**If NOT Guaranteed Issue, answer the following questions.**

5a	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5b	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input type="checkbox"/> NO
5c	Have you ever been treated for a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5d	In the last twelve (12) months, have you missed more than five (5) consecutive days of work due to illness or injury other than pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5e	Are you taking prescription medications on a regular basis for any back, neck, knee, or shoulder condition, rheumatoid or degenerative arthritis, respiratory disease, urinary or digestive disease, immune system disease or disorder, mental or nervous disorder? (This does not include simple infections/viral infections treated short term with antibiotics)	<input type="checkbox"/> YES <input type="checkbox"/> NO
5f	Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	<input type="checkbox"/> YES <input type="checkbox"/> NO

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace or change any existing insurance?  YES  NO
- If "Yes," provide carrier and policy number: \_\_\_\_\_

CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved and the necessary premium is paid.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance. Deduction start date 11-1-08

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

Date 9-18-08 Signature of Applicant John Q. Doe

Date 9-18-08 Signature of Agent Adam Agent State of Enrollment SC



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Limited Benefit  
Product Name: CAIC CI & Combo App  
Project Name/Number: Arkansas/6965 & 6966

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice **Review Status:** Approved-Closed 09/26/2008  
**Comments:**  
**Attachment:**  
CAICCertComp.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 09/26/2008  
**Bypass Reason:** Please see attached. The filing submitted are applications.  
**Comments:**



**Continental American**  
**INSURANCE COMPANY**

2801 Devine Street, Columbia, South Carolina 29205

**CERTIFICATION OF COMPLIANCE**

I have reviewed or supervised the review of the form contained in the filing and hereby certify that to the best of my knowledge and belief they are in compliance with the applicable statues, regulations and bulletins of the State of Arkansas. I further certify that they will be revised and/or discontinued in the event of future changes in the statues, regulations, or bulletins which would prohibit the use of such forms.

A handwritten signature in black ink, appearing to read "James J. Hennessy".

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James J. Hennessy, AIRC, ACP, CCP  
Vice President, Compliance

September 25, 2008  
Date