

SERFF Tracking Number: AEGX-125995818 State: Arkansas
Filing Company: Monumental Life Insurance Company State Tracking Number: 41360
Company Tracking Number: HS AR0032355F01
TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only
Product Name: Cancer
Project Name/Number: Cancer/HS AR0032355F01

Filing at a Glance

Company: Monumental Life Insurance Company

Product Name: Cancer SERFF Tr Num: AEGX-125995818 State: ArkansasLH

TOI: H07G Group Health - Specified Disease - Limited Benefit SERFF Status: Closed State Tr Num: 41360

Limited Benefit

Sub-TOI: H07G.002A Dread Disease - Cancer Only Co Tr Num: HS AR0032355F01 State Status: Approved-Closed

Only

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI ADMSLH

Disposition Date: 01/20/2009

Date Submitted: 01/19/2009

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Cancer

Project Number: HS AR0032355F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 01/20/2009

State Status Changed: 01/20/2009

Corresponding Filing Tracking Number:

Filing Description:

RE: Monumental Life Insurance Company

NAIC # 0468-66281

FEIN: 52-0419790

"Out of State" Group

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Deemer Date:

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CA4000GAM(Rev. 6/07) - Group Cancer Application

Dear Commissioner:

Attached for your review and approval is a copy of the above captioned form. This form will replace Group Cancer Application CA4000GAM, which was approved by your Department on September 26, 1991. The form has been completed in "John Doe" fashion. Variable information is bracketed. The revisions made are as follows:

1. On page 1 we added a space for the Family Coverage Rate and a space for the administrative fee rate.
2. On page 2 we added a space to provide names of Dependent Children.

These items were omitted in error from the last filing.

Group Cancer Application CA4000GAM(Rev. 6/07) will be used to solicit Group Cancer Indemnity Insurance Policy CA1000GPM, which was approved by your Department on September 26, 1991.

This application is not intended to be filed in our domiciliary state of Iowa.

We request approval of this form in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print.

Completed filing forms are attached. Our filing fee is being sent via EFT.

I respectfully request your favorable review and approval. We appreciate your consideration of this form. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6289 or contact me by e-mail at mfrei@aegonusa.com.

Sincerely,

MONUMENTAL LIFE INSURANCE COMPANY
Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA

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Company and Contact

Filing Contact Information

Margaret Frei, Filing Specialist mfrei@aegonusa.com
 2700 W Plano Parkway (972) 881-6289 [Phone]
 Plano, TX 75075 (972) 881-4097[FAX]

Filing Company Information

Monumental Life Insurance Company CoCode: 66281 State of Domicile: Iowa
 4333 Edgewood Road, N.E. Group Code: 468 Company Type: Life and Health
 Cedar Rapids, IA 52499 Group Name: State ID Number:
 (800) 553-5957 ext. [Phone] FEIN Number: 52-0419790

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monumental Life Insurance Company	\$50.00	01/19/2009	25109946

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/20/2009	01/20/2009

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOC	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Form	Group Cancer Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CA4000GA	Application/Group	Cancer Enrollment Application Form	Initial		43	CA4000GAM Rev-6-07 .PDF

MONUMENTAL LIFE INSURANCE COMPANY
Admin. Office: 520 Park Avenue, Baltimore, MD 21201

ABC LOGO

ABC Cancer [Protection]
[Insurance] Plan

[APPLICATION][Acceptance][Confirmation of] [enrollment] Form][Reservation Form] - **A**

[[You][Sample A. Sample] [and your spouse] [are guaranteed][will be] accept[ance][ed] [in this plan] as long as you have not been diagnosed with cancer in the past [X] years.] [There is no medical exam; you cannot be cancelled as you grow older.] [To confirm your [enrollment][acceptance]: fill in the details below and mail before the [respond by date][date in the box to the right.][You can also enroll your spouse for the same benefits as you.]**A**

[Follow the simple steps below to apply.] [[5] Easy Steps to Apply] **A**

[[•][YES][I would like to review the][Enroll me in the] [ABC] [endorsed] [sponsored] [offered] [recommended] cancer care plan. [This pays me for cancer detection tests and if necessary, for cancer treatment, up to a total of [\$0.00]]] **A**

[Please respond by: XX/XX/XXXX [You will not receive a reminder notice]] [Please mail within XX days of receipt] **A**

[Invitation to apply for:] **A**

[ABC Logo [ABC] Cancer Protection Insurance Plan Identification Card] **A**

[[Member:] Sample A. Sample
[[Member ID][Post #]: XXXXXXXXX]
150 Anystreet Blvd
Anytown, MD 21201] **B**

1. [Select your coverage:][Check one box:] **A**
[(Monthly)[Quarterly][Semi-annual][Annual] [group][rates][premium][cost] [,please check one][premiums billed every [three] months)] **C**

	[Cover] Member [only][Coverage]	[[Cover] Member & Spouse][Coverage]]
[[Member's age is]Under [50]]	[[] \$ 00.00]	[[] \$ 00.00]
[[Member's age is] [50-64]]	[[] \$ 00.00]	[[] \$ 00.00]
[[Member's age is] [65-80]]	[[] \$ 00.00]	[[] \$ 00.00]

[[Cover] Family][Coverage]
[[] \$00.00]

[Rates include a \$X.XX administrative fee] **C**

you are not hospital confined on that date. [I have read the notices on the back of this application.]

[ME, NH and UT Residents: THE CERTIFICATE PROVIDES LIMITED BENEFITS. REVIEW YOUR CERTIFICATE CAREFULLY. It is understood that no person to be covered for [cancer] is also covered by any Title XIX program, designated as Medicaid or any similar name.] **H**

[Are you or any dependents eligible for Medicare? Yes No] **H**

Signature of [Applicant][Member][Employee][Retiree] _____ Date _____

[Signature of Spouse _____ Date _____]

(if applying)

*(Treatment means medical and surgical care by a licensed provider to detect or cure Cancer. This includes examination, diagnostic procedures, surgery (including pre- and post-operative care), prescribed medication, and the application of remedies and therapy. It does not include any diagnostic procedures or examinations performed to monitor a previous removal or remedy of Cancer, provided there is no positive diagnosis of Cancer or of a recurrence of Cancer.)

[4]. [To the best of your knowledge and belief, have you or your dependents (if applying for dependent(s) coverage) **[ever]** received Treatment or been medically advised of Cancer **[excluding Skin Cancer]** Leukemia, Hodgkin's Disease, **[Cystic Fibrosis, Diphtheria, Encephalitis, Heart Attack, Meningitis (Epidemic Cerebrospinal), Multiple Sclerosis, Muscular Dystrophy, Osteomyelitis, Poliomyelitis, Rabies, Scarlet Fever, Sickle Cell Anemia, Small Pox, Stroke, Tetanus, Tuberculosis, Tulermia, and Typhoid Fever during the last [10] years]** (12 months in Texas)(6 months in ME & NH)?

Yes No] [Must be checked in order for the application to be processed]

(Treatment means medical and surgical care by a licensed provider to detect or cure Cancer. This includes examination, diagnostic procedures, surgery (including pre- and post-operative care), prescribed medication, and the application of remedies and therapy. It does not include any diagnostic procedures or examinations performed to monitor a previous removal or remedy of Cancer, provided there is no positive diagnosis of Cancer or of a recurrence of Cancer.)

F

If you have answered "Yes," please indicate name(s) of the person(s) and their corresponding medical condition(s): _____

[It is understood that any person listed above [in item [3] will not be eligible for coverage **[except any person listed with Skin Cancer. Any person listed with Skin Cancer will be eligible for coverage]. [Benefits, however, will not be payable for Skin Cancer.]]**

[5]. Please read, sign and date [at right]:

It is understood that no benefits will be payable for expenses incurred during the first [12 months] [6 months in NH] of coverage for any [cancer] diagnosed or treated within the first [30 days] after the insured person's effective date of coverage(not applicable to residents of AZ, MO, OK, TX, UT, WI and WY).

Your coverage will be effective on the first day of the month following [receipt] [acceptance] of your [application] [confirmation of enrollment form], provided your first premium is paid and you are not hospital confined on that date. [I have read the notices on the back of this application.]

[ME, NH and UT Residents: THE CERTIFICATE PROVIDES LIMITED BENEFITS. REVIEW YOUR CERTIFICATE CAREFULLY. It is understood that no person to be covered for [cancer] is also covered by any Title XIX program, designated as Medicaid or any similar name.] **H**

[Are you or any dependents eligible for Medicare? [] Yes [] No] **H**

Signature of [Applicant][Member][Employee][Retiree] **X** _____ Date _____

[Signature of Spouse **X** _____ Date _____]
(if applying)

I

[AR, CO, DC, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.]

[FL Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.]

[PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceal for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.]

[Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.]

Questions? Call toll-free 1-800-XXX-XXXX (Monday-Friday, X:XX AM to X:XX PM, EST)

[Mail Today!][Complete this form.] [Mail your completed application form][Return] in the[enclosed] [postage-paid] [reply] envelope [to: [Address][City, State Zipcode]**A**

[Send no money!] [Do not send money] **J**

[Underwritten [and administered] by Monumental Life Insurance Company, Baltimore, MD] **K**

[Administered by: [ABC Administrators **C**
123 Anytown PI , Any City, Nowhere, 12345]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

This policy or certificate duplicates some Medicare Benefits
THIS IS NOT A MEDICARE SUPPLEMENT INSURANCE POLICY

H

This policy or certificate provides limited benefits, if you meet the policy conditions, for hospital and medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy or certificate. It does not pay your Medicare deductibles or coinsurance and is not a substitute for a Medicare supplement insurance policy.

This policy or certificate duplicates Medicare benefits when it pays:

hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items and services

Before You Buy This Policy:

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

For help in understanding your insurance, contact your state insurance department or state senior insurance counseling program.

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Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 01/20/2009
Comments:
Attachment:
 AR - READABILITY CERTIFICATION.PDF

Satisfied -Name: Application **Review Status:** Approved-Closed 01/20/2009
Comments:
 The Application filed for your review and approval is attached to the Forms Schedule.

Satisfied -Name: AR - NAIC TRANSMITTAL DOC **Review Status:** Approved-Closed 01/20/2009
Comments:
Attachment:
 AR - NAIC TRANSMITTAL DOC.PDF

Satisfied -Name: AR - NAIC FORM FILING ATTACHMENT **Review Status:** Approved-Closed 01/20/2009
Comments:
Attachment:
 AR - NAIC FORM FILING ATTACHMENT.PDF

Satisfied -Name: Explanation of Variables **Review Status:** Approved-Closed 01/20/2009
Comments:
Attachment:
 Explanation of Variables.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Monumental Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
CA4000GAM Rev-6-07	43.3

Signed: 
Name: Edward G. Weigand
Title: Assistant Secretary
Date: January 19, 2009

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Monumental Life Insurance Company 4333 Edgewood Road, N.E. Cedar Rapids IA 52499	IA	Life Accident & Health	468	66281	52-0419790	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Margaret A. Frei, AIRC, ACS, ACP 2700 W Plano Parkway Plano TX 75075	877-527-6444 Ext. 6289	972-881-4097	mfrei@aegonusa.com

5. Requested Filing Mode	<input type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	CA4000GAM(Rev. 6/07)
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8. Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9. Type of Insurance	H07G Group Health - Specified Disease - Limited Benefit
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10. Product Coding Matrix Filing Code	H07G.002A Dread Disease - Cancer Only
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11. Submitted Documents	<input type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____
	<input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate
	<input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____
	SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input checked="" type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____

12.	Filing Submission Date	January 19, 2009
13.	Filing Fee (If required)	Amount <u>\$50.00</u> Check Date <u>N/A</u> Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u>N/A</u>
14.	Date of Domiciliary Approval	N/A
15.	Filing Description:	
	<p>RE: Monumental Life Insurance Company NAIC # 0468-66281 FEIN: 52-0419790 "Out of State" Group CA4000GAM(Rev. 6/07) - Group Cancer Application</p> <p>Dear Commissioner:</p> <p>Attached for your review and approval is a copy of the above captioned form. This form will replace Group Cancer Application CA4000GAM, which was approved by your Department on September 26, 1991. The form has been completed in "John Doe" fashion. Variable information is bracketed. The revisions made are as follows:</p> <ol style="list-style-type: none"> 1. On page 1 we added a space for te Family Coverage Rate and a space for the administrative fee rate. 2. On page 2 we added a space to provide names of Dependent Children. <p>These items were omitted in error from the last filing.</p> <p>Group Cancer Application CA4000GAM(Rev. 6/07) will be used to solicit Group Cancer Indemnity Insurance Policy CA1000GPM, which was approved by your Department on September 26, 1991.</p> <p>This application is not intended to be filed in our domiciliary state of Iowa.</p> <p>We request approval of this form in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print.</p> <p>Completed filing forms are attached. Our filing fee is being sent via EFT.</p> <p>I respectfully request your favorable review and approval. We appreciate your consideration of this form. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6289 or contact me by e-mail at mfrei@aegonusa.com.</p> <p>Sincerely,</p> <p>MONUMENTAL LIFE INSURANCE COMPANY Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA</p>	

16.	Certification (If required)	
	<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p> <p>Print Name <u>Margaret A. Frei, AIRC, ACS, ACP</u> Title <u>Product Filing Specialist</u></p> <p>Signature <u></u> Date <u>January 19, 2009</u></p>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	CA4000GAM(Rev. 6/07)	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Group Cancer Application	CA4000GAM Rev-6-07	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

MONUMENTAL LIFE INSURANCE COMPANY

Explanation of Variability Cancer Application CA4000GAM(Rev. 6-07)

- A** One of these phrases will appear based on the wishes of the group.
- B** Applicant information will be personalized – name, date of birth, address and residence will vary. Will include when known.
- C** Will vary by administrator.
- D** Will be included if payment is required at time of application. Billing methods, frequency and Deduction Authorization requirements will vary by administrator.
- E** Will vary based on whether Spouse Only or Family coverage is being offered.
- F** Will use Item 4 on page 2 or Items 4 & 5 on page 3. The bracketed items within these sections will be included or not.
- H** Will be included when mailing in states where it is required.
- I** Fraud language will vary by State and will be inserted here. The last fraud language sentence will be used for states that do not require state specific language.
- J** Will be included if no payment is required at time of application. May appear at top of application, bottom or both.
- K** Will be included at either the top of the application, bottom or both.

Note: All reference to ABC throughout the application will reflect the group specific name/logo since this information varies by group.