

SERFF Tracking Number: CAIC-126012567 State: Arkansas
 Filing Company: HM Life Insurance Company State Tracking Number: 41395
 Company Tracking Number: 5241
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: AR CI & Combo 08 Apps
 Project Name/Number: AR CI & Combo 08 Apps/5241

Filing Contact Information

Lindsay Morden, Imorden@caicworksite.com
 2801 Devine Street (803) 461-4335 [Phone]
 Columbia, SC 29205

Filing Company Information

HM Life Insurance Company CoCode: 93440 State of Domicile: Pennsylvania
 2801 Devine Street Group Code: Company Type: LAH
 Columbia, SC 29205 Group Name: HM Life Insurance CoState ID Number:
 (866) 849-2954 ext. [Phone] FEIN Number: 06-1041332

Filing Fees

Fee Required? Yes
 Fee Amount: \$0.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HM Life Insurance Company	\$50.00	01/29/2009	25354943

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/02/2009	02/02/2009

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Form Schedule

Lead Form Number: HML2011AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	HML2011A	R	Application/ Enrollment Form	Initial		44	HML2011AR.pdf
Approved-Closed	HML0011A	R	Application/ Enrollment Form	Initial		43	HML0011AR.pdf



HM WORKSITE ADVANTAGE

Administered By:
Continental American Insurance Company
Post Office Box 2048
Columbia, South Carolina 29202
(866) 849-2954

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
CRITICAL ILLNESS		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)		S.S.N./ ID Number	Gender	Date of Birth
Street Address		City	State	Zip
Employer	Job Class	Location		Date of Hire
Hours Worked	Daytime Phone No. ()	Beneficiary Name / Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)		Gender	Spouse Date of Birth	

	Employee	Spouse
Are you actively at work?	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Employee Face Amount: \$ _____ **Employee Cost per pay period:** \$ _____

Spouse Face Amount: \$ _____ **Spouse Cost per pay period:** \$ _____

	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 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 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 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 The 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 The Company the premium required thereafter each pay period for my insurance.

Deduction start date _____

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 _____ Signature of Applicant _____

Date _____ Signature of Agent _____ State of Enrollment _____

The commissioner may investigate fraudulent insurance acts and persons engaged in the business of insurance.



HM WORKSITE ADVANTAGE

Administered By:
 Continental American Insurance Company
 Post Office Box 2048
 Columbia, South Carolina 29202
 (866) 849-2954

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)		S.S.N./ ID Number	Gender	Date of Birth
Street Address		City	State	Zip
Employer		Job Class	Location	Date of Hire
Hours Worked	Daytime Phone No. ()	Beneficiary Name / Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)		Gender	Spouse Date of Birth	
			Employee	Spouse
Are you actively at work?			<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

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	CRITICAL ILLNESS	<input type="checkbox"/> Employee	<input type="checkbox"/> [Employee & Spouse]	[Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No]	
	Employee Face Amount: \$ _____	Employee Cost per pay period: \$ _____			
	Spouse Face Amount: \$ _____	Spouse Cost per pay period: \$ _____			
				Employee	Spouse
1a	Have you used tobacco products in the last 12 months?			<input type="checkbox"/> Yes <input 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 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 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	ACCIDENT	<input 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"/> Employee	<input type="checkbox"/> Employee & Spouse]	<input type="checkbox"/> Employee & Children]	<input type="checkbox"/> Family]	Cost per pay period: \$ _____

This application is not complete unless signed and dated on Page 3

3	HOSPITAL INDEMNITY	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]
If NOT Guaranteed Issue, answer the following questions:				

		Employee	Spouse	Children
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: \$** _____
[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 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 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 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.

		Employee
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 The 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.

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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 The Company the premium required thereafter each pay period for my insurance.

Deduction start date _____

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 _____ Signature of Applicant _____

Date _____ Signature of Agent _____ State of Enrollment _____

The commissioner may investigate fraudulent insurance acts and persons engaged in the business of insurance

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 Filing Company: HM Life Insurance Company State Tracking Number: 41395
 Company Tracking Number: 5241
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: AR CI & Combo 08 Apps
 Project Name/Number: AR CI & Combo 08 Apps/5241

Supporting Document Schedules

<p> Satisfied -Name: Flesch Certification Comments: Attachment: HM Readability Cert.pdf </p>	<p> Review Status: Approved-Closed 02/02/2009 </p>
<p> Bypassed -Name: Application Bypass Reason: attached to forms tab Comments: </p>	<p> Review Status: Approved-Closed 02/02/2009 </p>
<p> Satisfied -Name: Submission Letter Comments: Attachment: HM Cover Letter.pdf </p>	<p> Review Status: Approved-Closed 02/02/2009 </p>
<p> Satisfied -Name: Authorization Letter Comments: Attachment: HM Authorization Form.pdf </p>	<p> Review Status: Approved-Closed 02/02/2009 </p>



A HIGHMARK COMPANY

HM Life Insurance
Company

HM Life Insurance
Company of New York

HM Benefits
Administrators

READABILITY CERTIFICATION

I, James J. Hennessy, hereby certify that the following form has the following readability score as calculated by the Flesch Reading Ease Test:

<u>Form</u>	<u>Readability Score</u>
HML2011	44.2
HML0011	42.6

James J. Hennessy, AIRC, ACP, CCP
Authorized Consultant
Vice President, Compliance, CAIC

Administrator Mailing Address

Continental American
Insurance Company
P.O. Box 2048
Columbia, SC 29202

Overnight Deliveries

2801 Devine Street
Columbia, SC 29205

TDD Telephone

866-849-2954

Fax

803-779-4406

October 9, 2008

Date



A HIGHMARK COMPANY

HM Life Insurance
Company

HM Life Insurance
Company of New York

HM Benefits
Administrators

January 29, 2009

Mr. Harris Shearer
Rate and Form Analyst
Arkansas Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-19

Re: HM LIFE INSURANCE COMPANY
NAIC 93440 FEIN 06-1041332 NAIC Group Number 812

HML2011AR Critical Illness Application
HML0011AR Combo Application

Dear Mr. Shearer:

Enclosed for your review and approval are the captioned applications. These applications will replace CA-2006-CI(AR) and CA-2006-Combo(AR) which were approved on 12/20/05.

HM Life Insurance Company has retained Continental American Insurance Company to submit this filing on their behalf. A letter of authorization from HM Life Insurance Company is enclosed.

Thank you for your consideration in this matter. Please contact Lindsay Morden at 888-730-2244, ext: 4335 or at CompanyCompliance@caicworksites.com if you need any additional information.

Sincerely,

Administrator Mailing Address

Continental American
Insurance Company
P.O. Box 2048
Columbia, SC 29202

Overnight Deliveries

2801 Devine Street
Columbia, SC 29205

TDD Telephone

866-849-2954

Fax

803-779-4406

James J. Hennessy, AIRC, ACP, CCP
Authorized Consultant
Vice President, Compliance, CAIC
/lwm



A HIGHMARK COMPANY

HM Life Insurance
Company

HM Life Insurance
Company of New York

HM Benefits
Administrators

January 29, 2009

To: The Insurance Commissioner

AUTHORIZATION

This letter, or a copy thereof, will authorize James J. Hennessy, Vice President, Continental American Insurance Company, to represent HM Life Insurance Company and HM Life Insurance Company of New York in matters before the Insurance Department relating to submission of policy forms and associated rates for approval.

This Authorization shall be valid until revoked by us.

HM Life Insurance Company
HM Life Insurance Company of New York

Administrator Mailing Address

Continental American
Insurance Company
P.O. Box 2048
Columbia, SC 29202

Overnight Deliveries

2801 Devine Street
Columbia, SC 29205

TDD Telephone

866-849-2954

Fax

803-779-4406

By: _____

A handwritten signature in black ink, appearing to read 'Robert L. Frew', is written over a horizontal line.

Robert L. Frew, MHP
Director - Compliance/SIU
HM Life Insurance Company
HM Life Insurance Company of New York

January 29, 2009

DATE