

<i>SERFF Tracking Number:</i>	<i>CNSC-126091428</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Conseco Health Insurance Company</i>	<i>State Tracking Number:</i>	<i>41254</i>
<i>Company Tracking Number:</i>	<i>FB SCHEDULES</i>		
<i>TOI:</i>	<i>H02I Individual Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02I.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>CHIC FB Additional Benefit Levels</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: Conseco Health Insurance Company

Product Name: CHIC FB Additional Benefit Levels      SERFF Tr Num: CNSC-126091428      State: ArkansasLH

TOI: H02I Individual Health - Accident Only	SERFF Status: Closed	State Tr Num: 41254
Sub-TOI: H02I.000 Health - Accident Only	Co Tr Num: FB SCHEDULES	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Michelle Garba, Stacey Farmer, Beth Blackwell	Disposition Date: 05/11/2009
	Date Submitted: 04/16/2009	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/11/2009	Explanation for Other Group Market Type:
	State Status Changed: 05/11/2009
Deemer Date:	Corresponding Filing Tracking Number:
Filing Description:	
Dear Sir or Madam:	

Enclosed please find the noted forms under the form schedule tab for your review and approval. These forms are new and will not replace any forms currently on file with your department.

SERFF Tracking Number: CNSC-126091428 State: Arkansas  
Filing Company: Conseco Health Insurance Company State Tracking Number: 41254  
Company Tracking Number: FB SCHEDULES  
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only  
Product Name: CHIC FB Additional Benefit Levels  
Project Name/Number: /

The forms included in this filing will be used with a previously approved Accidental Injury Policy, which is a policy providing benefits for loss resulting from specified events due to accidental injury. The department approved Policy Form FB000/PS3AR-C, on 03/22/2000. The current product provides the following levels of benefits: ½ unit, ¾ unit, 1 unit, 1 ¼ unit, and 1 ½ unit. Two additional levels of benefits are proposed in this filing: 1 ¾ units and 2 units to meet consumers demand.

Since the company has chosen to expand the base policy with these additional benefits levels the following forms are being filed for approval:

FB000/AA3AR-E is an application to be used with the previously approved policy form. The application is designed to elicit health information to determine if applicants are eligible for coverage. If any person applying for coverage answers "yes" to questions 2 through 3, that person will be listed in the space provided and be excluded from any coverage under the policy. Section 1, 2, 4 and 5 of the application are being filed as variable, which contains general application information. The information will either be included or not included. The bar code information at the top of the application is also being filed as variable. The bar code will contain the company information only and is used for internal processing. This application will be used for electronic purposes.

FB000/ER3ST-I is an exclusion rider. This rider is completed if one of the applicants answers yes to health questions 2 through 3 on the application. The rider limits or excluded coverage from the policy. It will be attached to the policy at the time the policy is issue.

FB000/OC3ST-D is the outline of coverage for this product. This is only intended to outline the benefits available with this product.

The policy will be marketed through licensed agents.

The actuarial memorandum and rates are attached.

The forms will be effective upon your approval. To the best of our knowledge, attached are any necessary fees and certifications as required by your state.

Thank you for your time and consideration on this filing. If you have any further questions regarding this filing, please

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 Product Name: CHIC FB Additional Benefit Levels  
 Project Name/Number: /

feel free to contact me.

Sincerely,  
 Stacey Farmer  
 Policy Approval and Compliance

## Company and Contact

### Filing Contact Information

Michelle Garba, Compliance Analyst Michelle\_Garba@consec.com  
 11815 N Pennsylvania St (800) 888-4918 [Phone]  
 Carmel, IN 46032 (317) 817-2333[FAX]

### Filing Company Information

Consec Health Insurance Company CoCode: 78174 State of Domicile: Arizona  
 11815 N Pennsylvania St. Group Code: 233 Company Type:  
 Carmel, IN 46032 Group Name: State ID Number:  
 (800) 888-4918 ext. [Phone] FEIN Number: 34-1083130  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$290.00  
 Retaliatory? No  
 Fee Explanation: \$20 X 12 FORMS = \$240  
 \$50 FOR RATES  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Consec Health Insurance Company	\$290.00	04/16/2009	27217038

SERFF Tracking Number: CNSC-126091428 State: Arkansas  
Filing Company: Conseco Health Insurance Company State Tracking Number: 41254  
Company Tracking Number: FB SCHEDULES  
TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
Product Name: CHIC FB Additional Benefit Levels  
Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/11/2009	05/11/2009

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Product Name: CHIC FB Additional Benefit Levels  
Project Name/Number: /

## Disposition

Disposition Date: 05/11/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CNSC-126091428 State: Arkansas  
 Filing Company: Conseco Health Insurance Company State Tracking Number: 41254  
 Company Tracking Number: FB SCHEDULES  
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
 Product Name: CHIC FB Additional Benefit Levels  
 Project Name/Number: /

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Benefit Schedule	Approved-Closed	Yes
<b>Form</b>	Benefit Schedule	Approved-Closed	Yes
<b>Form</b>	Benefit Schedule	Approved-Closed	Yes
<b>Form</b>	Benefit Schedule	Approved-Closed	Yes
<b>Form</b>	Surgical Schedule	Approved-Closed	Yes
<b>Form</b>	Surgical Schedule	Approved-Closed	Yes
<b>Form</b>	Surgical Schedule	Approved-Closed	Yes
<b>Form</b>	Surgical Schedule	Approved-Closed	Yes
<b>Form</b>	Application	Approved-Closed	Yes
<b>Form</b>	Rider	Approved-Closed	Yes
<b>Form</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Conversion Amendment	Approved-Closed	Yes
<b>Rate</b>	RATES	Approved-Closed	Yes

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 Product Name: CHIC FB Additional Benefit Levels  
 Project Name/Number: /

## Form Schedule

**Lead Form Number:** FB035/IS3ST-C, et al

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	FB035IS3S T-C	Schedule Pages	Benefit Schedule	Initial		0	FB035IS3ST-C.pdf
Approved-Closed	FB035IS3S T-C1	Schedule Pages	Benefit Schedule	Initial		0	FB035IS3ST-C1.pdf
Approved-Closed	FB035IS3S T-CS	Schedule Pages	Benefit Schedule	Initial		0	FB035IS3ST-CS.pdf
Approved-Closed	FB035IS3S T-CS1	Schedule Pages	Benefit Schedule	Initial		0	FB035IS3ST-CS1.pdf
Approved-Closed	FB040IS3S T-C	Schedule Pages	Surgical Schedule	Initial		0	FB040IS3ST-C.pdf
Approved-Closed	FB040IS3S T-C1	Schedule Pages	Surgical Schedule	Initial		0	FB040IS3ST-C1.pdf
Approved-Closed	FB040IS3S T-CS	Schedule Pages	Surgical Schedule	Initial		0	FB040IS3ST-CS.pdf
Approved-Closed	FB040IS3S T-CS1	Schedule Pages	Surgical Schedule	Initial		0	FB040IS3ST-CS1.pdf
Approved-Closed	FB000AA3 AR-E	Application/ Enrollment Form	Application	Initial		0	FB000AA3AR-E.pdf
Approved-Closed	FB000ER3 ST-I	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0	FB000ER3ST-I.pdf
Approved-Closed	FB000OC3 ST-D	Outline of Coverage	Outline of Coverage	Initial		0	FB000OC3ST-D.pdf
Approved-Closed	FB000CA3 CR-C1	Policy/Cont ract/Fraternal Amendment	Conversion	Initial		0	FB000CA3CR-C1.pdf

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Product Name: CHIC FB Additional Benefit Levels  
Project Name/Number: /  
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**SECTION 6:****BENEFIT SCHEDULE****(POLICYOWNER)**

This is a summary of your benefits. Please read your policy/certificate for further explanations and limitations.

HOSPITAL CONFINEMENT – Monthly Benefit Maximum Benefit Period: 6 months	\$7,000	
HOSPITAL RELEASE BONUS – Monthly Benefit Maximum Benefit Period: 6 months	\$3,500	
AMBULANCE	Actual charges up to \$437.50 per one-way trip	
<b>SURGERY</b>		
Tendons/ligaments		
Single	\$1,050	
Multiple	\$1,575	
Ruptured disc	\$1,050	
Torn cartilage	\$1,050	
Hernia	\$1,050	
<b>FRACTURES</b>		
	<u>Without</u>	<u>With</u>
	<u>Open Reduction</u>	<u>Open Reduction</u>
Hip/thigh	\$5,250	\$7,875
Vertebrae (except processes)	\$4,725	\$7,088
Pelvis	\$4,200	\$6,300
Skull (depressed)	\$3,500	\$5,250
Skull (simple)	\$1,750	\$2,625
Leg	\$3,500	\$5,250
Foot/ankle/knee cap	\$2,450	\$3,675
Forearm/hand/wrist	\$2,800	\$4,200
Lower jaw	\$2,100	\$3,150
Shoulder blade/collar bone	\$2,100	\$3,150
Upper arm/upper jaw (maxilla)	\$1,750	\$2,625
Facial bones (except teeth)	\$1,750	\$2,625
Vertebrae process	\$1,050	\$1,575
Coccyx/rib/finger/toe	\$350	\$525
OUTPATIENT SURGERY	\$875	
EMERGENCY MEDICAL FEES	Actual charges up to \$200	
ACCIDENTAL DEATH	\$35,000	
<b>DISMEMBERMENT</b>		
Entire finger or toe	\$350	
Hand, foot or eye		
Single loss	\$17,500	
Double loss	\$35,000	

**1 3/4 UNITS**

**SECTION 6:****BENEFIT SCHEDULE****(POLICYOWNER)**

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AMBULANCE	Actual charges up to \$437.50 per one-way trip	
<b>SURGERY</b>		
Tendons/ligaments		
Single	\$1,050	
Multiple	\$1,575	
Ruptured disc	\$1,050	
Torn cartilage	\$1,050	
Hernia	\$1,050	
<b>FRACTURES</b>		
	<u>Without</u>	<u>With</u>
	<u>Open Reduction</u>	<u>Open Reduction</u>
Hip/thigh	\$5,250	\$7,875
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Vertebrae process	\$1,050	\$1,575
Coccyx/rib/finger/toe	\$350	\$525
OUTPATIENT SURGERY	\$875	
EMERGENCY MEDICAL FEES	Actual charges up to \$200	
ACCIDENTAL DEATH	\$45,000	
<b>DISMEMBERMENT</b>		
Entire finger or toe	\$350	
Hand, foot or eye		
Single loss	\$17,500	
Double loss	\$35,000	

**1 3/4 UNITS INCLUDING \$10,000 ADDITIONAL ACCIDENTAL DEATH**

**SECTION 6:****BENEFIT SCHEDULE****(SPOUSE)**

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Tendons/ligaments		
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Ruptured disc	\$1,050	
Torn cartilage	\$1,050	
Hernia	\$1,050	
<b>FRACTURES</b>		
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ACCIDENTAL DEATH	\$35,000	
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Hand, foot or eye		
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Double loss	\$35,000	

**1 3/4 UNITS**

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**1 3/4 UNITS INCLUDING \$10,000 ADDITIONAL ACCIDENTAL DEATH**

**SECTION 6:****BENEFIT SCHEDULE****(POLICYOWNER)**

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HOSPITAL CONFINEMENT – Monthly Benefit Maximum Benefit Period: 6 months	\$8,000	
HOSPITAL RELEASE BONUS – Monthly Benefit Maximum Benefit Period: 6 months	\$4,000	
AMBULANCE	Actual charges up to \$500 per one-way trip	
<b>SURGERY</b>		
Tendons/ligaments		
Single	\$1,200	
Multiple	\$1,800	
Ruptured disc	\$1,200	
Torn cartilage	\$1,200	
Hernia	\$1,200	
<b>FRACTURES</b>		
	<u>Without</u>	<u>With</u>
	<u>Open Reduction</u>	<u>Open Reduction</u>
Hip/thigh	\$6,000	\$9,000
Vertebrae (except processes)	\$5,400	\$8,100
Pelvis	\$4,800	\$7,200
Skull (depressed)	\$4,000	\$6,000
Skull (simple)	\$2,000	\$3,000
Leg	\$4,000	\$6,000
Foot/ankle/knee cap	\$2,800	\$4,200
Forearm/hand/wrist	\$3,200	\$4,800
Lower jaw	\$2,400	\$3,600
Shoulder blade/collar bone	\$2,400	\$3,600
Upper arm/upper jaw (maxilla)	\$2,000	\$3,000
Facial bones (except teeth)	\$2,000	\$3,000
Vertebrae process	\$1,200	\$1,800
Coccyx/rib/finger/toe	\$400	\$600
OUTPATIENT SURGERY	\$1,000	
EMERGENCY MEDICAL FEES	Actual charges up to \$200	
ACCIDENTAL DEATH	\$40,000	
<b>DISMEMBERMENT</b>		
Entire finger or toe	\$400	
Hand, foot or eye		
Single loss	\$20,000	
Double loss	\$40,000	

**2 UNITS**

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AMBULANCE	Actual charges up to \$500 per one-way trip	
<b>SURGERY</b>		
Tendons/ligaments		
Single	\$1,200	
Multiple	\$1,800	
Ruptured disc	\$1,200	
Torn cartilage	\$1,200	
Hernia	\$1,200	
<b>FRACTURES</b>		
	<u>Without</u>	<u>With</u>
	<u>Open Reduction</u>	<u>Open Reduction</u>
Hip/thigh	\$6,000	\$9,000
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EMERGENCY MEDICAL FEES	Actual charges up to \$200	
ACCIDENTAL DEATH	\$50,000	
<b>DISMEMBERMENT</b>		
Entire finger or toe	\$400	
Hand, foot or eye		
Single loss	\$20,000	
Double loss	\$40,000	

**2 UNITS INCLUDING \$10,000 ADDITIONAL ACCIDENTAL DEATH**

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Single	\$1,200	
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Hand, foot or eye		
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**2 UNITS INCLUDING \$10,000 ADDITIONAL ACCIDENTAL DEATH**



**[SECTION V**

Applicant	Accident Spouse	Mode of Payment	Premium				
<input type="checkbox"/> 1/2 Unit <input type="checkbox"/> Applicant <input type="checkbox"/> 3/4 Unit <input type="checkbox"/> 1 Unit <input type="checkbox"/> 1 1/4 Units <input type="checkbox"/> 1 1/2 Units <input type="checkbox"/> 1 3/4 Units <input type="checkbox"/> 2 Units <input type="checkbox"/> Additional Accidental Death \$ _____ (Ind)	<input type="checkbox"/> 1/2 Unit <input type="checkbox"/> Spouse <input type="checkbox"/> 3/4 Unit <input type="checkbox"/> 1 Unit <input type="checkbox"/> 1 1/4 Units <input type="checkbox"/> 1 1/2 Units <input type="checkbox"/> 1 3/4 Units <input type="checkbox"/> 2 Units <input type="checkbox"/> Additional Accidental Death \$ _____ (Spouse)	<input type="checkbox"/> Monthly – Automatic Check Deduction  <input type="checkbox"/> Annual – Direct Bill	Individual      \$ _____  Additional Accidental Death      \$ _____  Spouse      \$ _____  Additional Accidental Death      \$ _____  Children      \$ _____  Intensive Care      \$ _____  Total Premium      \$ _____  Amount Collected      \$ _____				
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Children</th> <th style="width:50%;">Intensive Care</th> </tr> </thead> <tbody> <tr> <td> <input type="checkbox"/> Child Insurance  <input type="checkbox"/> Yes  <input type="checkbox"/> No               </td> <td> <input type="checkbox"/> Rider  <input type="checkbox"/> Policy   <input type="checkbox"/> Individual  <input type="checkbox"/> Family  <input type="checkbox"/> Individual w/ Children   <input type="checkbox"/> \$500    <input type="checkbox"/> \$750    <input type="checkbox"/> \$1000               </td> </tr> </tbody> </table>		Children	Intensive Care	<input type="checkbox"/> Child Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rider <input type="checkbox"/> Policy  <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Individual w/ Children  <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000		
Children	Intensive Care						
<input type="checkbox"/> Child Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rider <input type="checkbox"/> Policy  <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Individual w/ Children  <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000						

Special Instructions: ]

**SECTION VI**

**Applicant's Statement:** I have read or have had read to me, the completed application; all representations are true and complete. I understand that: any false statements or misrepresentations in this application may result in loss of insurance if such false statement materially affected either the acceptance of the risk or the hazard assumed by the Company. The agent has no authority to approve the application, change the policy or waive any policy provisions. For ages 65 and above, I have received the booklet containing insurance advice for people eligible for Medicare. Additionally, I acknowledge that I have received an Outline of Coverage. No proposed insured to be covered under this policy is also covered under Title XIX program, such as Medicaid. **No coverage will be effective until all eligibility requirements are met and until the later of: (1) the Effective Date as shown on the Policy Schedule, if issued; or (2) the date the first premium is accepted by Conseco Health Insurance Company.**

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

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_ Signed In: \_\_\_\_\_  
City, State

**This Section to be Completed by Agent:** I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the insurance applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being solicited by me and signed by the applicant.

[Did you interview each proposed insured in person, ask all questions and witness the signature?     Yes     No  
 If "No", please check one of the boxes below:  
 Application completed over the phone  
 Application completed by the applicant and returned via mail  
 Other, provide explanation: \_\_\_\_\_ ]

Date: \_\_\_\_\_ Signature of Agent: \_\_\_\_\_

Agency: \_\_\_\_\_ Agent Number: \_\_\_\_\_

Agent's E-mail address: \_\_\_\_\_

Agent's Phone Number: \_\_\_\_\_

Mail to Policyholder       Mail to Agent

**Exclusion Rider**

- 1  **PERSON WITH A PRE-EXISTING HEART CONDITION APPLYING FOR ICU**

\_\_\_\_\_ has been named in the application, as having been treated for or diagnosed as having a heart attack, heart condition or other abnormality of the heart.

This person will not be insured for any Intensive Care Unit confinement resulting from any disorder of the heart, and is limited to benefits for three days for any other Intensive Care Unit confinement.

- 2  **PERSON WITH A HISTORY OF HIV, AIDS OR ARC**

\_\_\_\_\_ has been named in the application, as having been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).

The Company will not be liable for any loss incurred by this person.

- 3  **PERSON INELIGIBLE FOR INSURANCE DUE TO AGE**

\_\_\_\_\_ does not meet the issue age requirement for Hospital Intensive Care insurance. This person is not eligible for any benefits under the Hospital Intensive Care insurance.

- 4  **FOR CONVERSION ONLY**

For any person(s) named above, the Company will not be liable for any benefits under this policy unless currently insured by the Company under an existing accident policy. For any person(s) named above currently insured by the Company under an existing accident policy, benefits under this policy will be limited to the level of benefits provided under the existing policy.

If issued at the same time as the policy, this Rider will have the same Effective Date as the policy. If issued after the policy Effective Date, we will notify the Policyowner of the date this rider becomes effective. This rider is part of the policy and will terminate when the policy terminates. This rider is subject to all terms of the policy to which it is attached unless any such terms are inconsistent with the terms of this rider.

Conseco Health Insurance Company



President

**APPLICANT'S STATEMENT**

I have read, or have had read to me, the above statements; the above representations are true and complete. I understand the applicable exclusions.

Signature of Applicant/Policyowner: \_\_\_\_\_ Date: \_\_\_\_\_

*CONSECO HEALTH INSURANCE COMPANY*  
*Home Office: Phoenix, AZ*  
*Administrative Office: 11825 N. Pennsylvania Street*  
*Carmel, IN 46032-4555 • Telephone: 1-800-541-1225*

## **ACCIDENTAL INJURY COVERAGE OUTLINE OF COVERAGE**

**THE POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

**PLEASE READ YOUR POLICY CAREFULLY:** This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

**ACCIDENT** coverage is designed to provide, to persons insured, benefits for specific losses resulting from an accident subject to any limitations and exclusion contained in the policy.

### **BENEFITS PROVIDED UNDER THIS POLICY:**

Benefits are available to you, your spouse and dependent children in the amount of coverage you select.

**HOSPITAL CONFINEMENT BENEFIT:** We will pay the amount shown in the benefit schedule for up to 6 months for hospital confinement required as a result of a covered accident.

**HOSPITAL RELEASE BONUS BENEFIT:** We will pay the amount shown in the benefit schedule after discharge from a hospital for up to 6 months. This benefit is payable for the same number of months for which benefits are received under the Hospital Confinement Benefit.

**AMBULANCE BENEFIT:** We will pay the amount shown in the benefit schedule per one-way trip for transportation by an ambulance to a hospital within 90 days of a covered accident.

**SURGERY BENEFIT:** We will pay for surgical repair of specific injuries depending upon the type of injury.

This benefit is limited to surgical repair of the following: torn, severed, or ruptured tendons or ligaments; ruptured disc; torn cartilage; and, hernia.

**FRACTURE BENEFIT:** We will pay the amount show in the benefit schedule for multiple or chip fracture, if diagnosed and treated by a physician within 90 days of a covered accident. We will pay for the affected bone and the treatment required (either open or closed reduction).

**OUTPATIENT SURGERY BENEFIT:** If the Surgery Benefit is payable under this policy and you are not confined to a hospital as an inpatient within 48 hours of surgery, this benefit is payable. This benefit is also payable if the Fracture Benefit is payable under this policy for an open reduction and confinement to a hospital as an inpatient does not occur within 48 hours of your surgery.

**EMERGENCY MEDICAL FEES BENEFIT:** We will pay the amount shown in the benefit schedule per accident for the following types of services: Emergency room services and supplies; X-rays; Dental treatment for sound natural teeth; or, Physician services.

**ACCIDENTAL DEATH BENEFIT:** If death occurs within 90 days of a covered accident, we will pay the amount you selected.

**DISMEMBERMENT BENEFIT:** If you lose a hand, foot, an entire finger or toe or an eye, an additional benefit will be paid. If you lose more than one hand, foot or eye, we will pay twice the benefit amount.

**INFLATION FIGHTER BENEFIT:** The Hospital Confinement, Hospital Release Bonus, and Accidental Death and Dismemberment benefits will be increased by 10% of the initial amount selected each year for the first 20 years that a person is insured.

**RETURN OF PREMIUM BENEFIT:** We will pay this benefit if the policy is kept in force until a maturity date. The Return of Premium Benefit is equal to the premiums paid for the insurance provided under the policy during the return of premium period. The policy need not be surrendered at a maturity date to receive a return of premium benefit.

**LIMITATIONS AND EXCLUSIONS:**

Some benefits are limited to actual charges as described in the policy and the benefit schedule. Additional limitations and exclusion are described in the policy. We will not pay benefits for an injury or death contributed to, caused by, or resulting from: Participating in war or any act of war, declared or not, or participation in or contracting with the armed forces of any country or international authority. Committing or attempting to commit suicide, regardless of mental capacity. Injuring or attempting to injure yourself intentionally, regardless of mental capacity. Having any disease or bodily/mental illness or degenerative process. We also will not pay for any related medical/surgical treatment or diagnostic procedures for such illness. Riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or while testing any vehicle on any racecourse or speedway. Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven. Being intoxicated, or being under the influence of any narcotic, unless such narcotic is taken under the direction of and as directed by a physician. Having a blood alcohol level that exceeds the level permitted by the laws of the state where the accident occurs which pertain to driving a motor vehicle will be presumptive proof of intoxication. Participating or attempting to participate in an illegal activity, or working at an illegal job. Participating in professional or semi-professional sports.

**SUMMARY OF CLAIMS DETERMINATION PROCESS:**

As provided for in the eligibility for benefits and the limitations and exclusions sections of your policy, the following steps are taken in order to determine eligibility under any claim filed: (1) determine when the claim was incurred, and whether the loss is covered by the policy. This step may require the collection of medical records, a death certificate, autopsy findings from a medical examiner or coroner, and information regarding medical history from physicians, hospitals, other insurance companies, government agencies and medical records copying services; (2) determine if the claim was incurred at a time when your coverage was in force, or during a lapse in coverage; and (3) determine if any policy exclusions exist for the claim.

**RENEWABILITY OF THE POLICY:** The policy is continuously renewed by the payment of premiums when due. We do not reserve the right to cancel or refuse renewal of the policy, except for non-payment of premiums. Nor can we change premium rates, reduce benefits, or change any policy provisions without your agreement.

**PREMIUM:** Your premium for the benefits selected is \$\_\_\_\_\_per month.

**THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE COVERAGE PROVIDED. PLEASE CONSULT THE POLICY ITSELF TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**

**PLEASE RETAIN THIS FOR YOUR RECORDS**

**CONSECO HEALTH INSURANCE COMPANY**  
*Home Office: Phoenix, AZ*  
*Administrative Office: 11825 N. Pennsylvania Street*  
*Carmel, IN 46032-4555 • Telephone: 1-800-541-1225*

## CONVERSION AMENDMENT

Applicant's Name (First, MI, Last)	Social Security Number	Account Number
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You are applying to convert Existing Insurance. If your application is accepted, the Company will issue new policy forms, as applicable, which describe the new, Converted Insurance. The new forms replace and supersede the existing forms. This amendment modifies the new forms only in the following ways:

- **DEFINITIONS**

**Existing Insurance:** Your insurance policy and level of benefits as it exists immediately prior to any conversion to the level of benefits for which you are making application.

**Converted Insurance:** The new insurance policy and level of benefits for which you are making application.

**Existing Cash Value Benefit:** The cash value benefit, if any, in force with your Existing Insurance.

**Converted Return of Premium Benefit:** The return of premium benefit contained in your Converted Insurance.

**Claims Incurred:** Claims are considered incurred on the date an event for which we pay benefits occurs or, in the case of a continuing claim, an earlier date as determined by the company based on a related prior event.

**Original Maturity Date:** The next date on which you would become entitled to a cash value benefit under the terms of your Existing Cash Value Benefit if that benefit were to remain in force until that date.

**Accumulated Cash Value Benefit Under Existing Accidental Injury Insurance ("Accumulated Accidental Injury Benefit"):** The portion of premiums paid for existing accidental injury insurance prior to the Effective Date of the converted accidental injury insurance that would have been returned by the Existing Cash Value Benefit on the Original Maturity Date, less accidental injury Claims Incurred prior to the Effective Date of the converted accidental injury insurance.

**Accumulated Cash Value Benefit Under Existing Hospital Intensive Care Insurance ("Accumulated ICU Benefit"):** The portion of premiums paid for any existing hospital intensive care insurance prior to the Effective Date of Converted Insurance that would have been returned by the Existing Cash Value Benefit on the Original Maturity Date, less hospital intensive care Claims Incurred prior to the Effective Date of the converted intensive care insurance.

**Accumulated Benefit Payment Date:** The earlier of the Original Maturity Date and the date we receive written proof of the Accidental Death Benefit being payable for the Policyowner under the Converted Insurance.

- **ACCIDENTAL INJURY POLICY**

**Eligibility:** You will be eligible for the converted level of benefits for covered accidents occurring on or after the Effective Date of the new, Converted Insurance.

**Time Limit on Certain Defenses (Paragraph 2):** To the extent that this period has been satisfied under the Existing Insurance, the time period under the new, converted policy is waived for the prior level of benefits.

**Pre-existing Conditions:** To the extent that these conditions have been satisfied under the Existing Insurance, the time period under the new, converted policy is waived for the prior level of benefits.

• **RETURN OF PREMIUM BENEFIT**

Only premiums paid for the Converted Insurance will be used in determining benefits under the Converted Return of Premium benefit.

The Accumulated Accidental Injury Benefit will be payable on the Accumulated Benefit Payment Date provided the Converted Return of Premium Benefit is then in force. Any Accumulated ICU Benefit will also be payable on the Accumulated Benefit Payment Date provided both hospital intensive care insurance and the Converted Return of Premium Benefit are then in force. Neither the Accumulated Accidental Injury Benefit nor any Accumulated ICU Benefit will be paid more than once.

This amendment modifies the new policy forms, as applicable, only as stated above. All other terms and conditions of these forms remain in full force and effect. This amendment attaches to and is part of the policy issued by Conseco Health Insurance Company.

Conseco Health Insurance Company



President

**APPLICANT'S STATEMENT:** I have read, or have had read to me, the above amendment. I understand that:

- any Existing Insurance will terminate on the date Converted Insurance becomes effective;
- the Converted Insurance will not be in effect until the Effective Date stated in the converted policy;
- if any person is excluded under the Existing Insurance, that person may be excluded under the Converted Insurance;
- if the application for Converted Insurance is rejected for any person insured under the Existing Insurance, that person will only be insured under the Converted Insurance up to the benefit levels provided under the Existing Insurance; and,
- all insurance not converted will remain the same.

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

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**THIS SECTION TO BE COMPLETED BY AGENT:** I hereby certify that I have explained to the applicant the amendment above. I further certify that I am a licensed agent in the state where this statement is being signed by the applicant.

Date: \_\_\_\_\_ Signature of Agent: \_\_\_\_\_ Agency: \_\_\_\_\_

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*SERFF Tracking Number:* CNSC-126091428      *State:* Arkansas  
*Filing Company:* Conseco Health Insurance Company      *State Tracking Number:* 41254  
*Company Tracking Number:* FB SCHEDULES  
*TOI:* H02I Individual Health - Accident Only      *Sub-TOI:* H02I.000 Health - Accident Only  
*Product Name:* CHIC FB Additional Benefit Levels  
*Project Name/Number:* /

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: CNSC-126091428 State: Arkansas  
 Filing Company: Conseco Health Insurance Company State Tracking Number: 41254  
 Company Tracking Number: FB SCHEDULES  
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
 Product Name: CHIC FB Additional Benefit Levels  
 Project Name/Number: /

## Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed	RATES	FB035/IS3ST-CS1, FB035/IS3ST-C, FB035/IS3ST-C1, FB035/IS3ST-CS, FB040/IS3ST-C, FB040/IS3ST-C1, FB040/IS3ST-CS, FB040/IS3ST-CS1	New		FB96 - ROP - ST.pdf

**Conseco Health Insurance Company**  
**Administrative Office: 11815 N. Pennsylvania St.**  
**Carmel, IN 46032**

**ACCIDENT INJURY POLICY**  
**WITH RETURN OF PREMIUM**

ISSUE AGE	MONTHLY		ANNUAL	
	INSURED	SPOUSE	INSURED	SPOUSE
			<b>1-3/4 UNITS</b>	
<b>18-49</b>	85.20	55.50	921.00	600.00
<b>50-55</b>	96.80	68.70	1,046.00	742.00
<b>56-60</b>	111.80	88.20	1,208.00	953.00
<b>61-65</b>	118.60	94.50	1,281.00	1,021.00
<b>66-70</b>	128.80	112.00	1,392.00	1,210.00
<b>71-75</b>	168.70	178.80	1,822.00	1,932.00
			<b>2 Units</b>	
<b>18-49</b>	96.50	62.80	1,043.00	679.00
<b>50-55</b>	109.60	77.80	1,184.00	841.00
<b>56-60</b>	126.70	100.00	1,369.00	1,080.00
<b>61-65</b>	134.40	107.10	1,452.00	1,157.00
<b>66-70</b>	145.90	127.00	1,576.00	1,372.00
<b>71-75</b>	191.10	203.10	2,064.00	2,194.00

SERFF Tracking Number: CNSC-126091428 State: Arkansas  
Filing Company: Conseco Health Insurance Company State Tracking Number: 41254  
Company Tracking Number: FB SCHEDULES  
TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
Product Name: CHIC FB Additional Benefit Levels  
Project Name/Number: /

## Supporting Document Schedules

<b>Satisfied -Name:</b> Flesch Certification	<b>Review Status:</b> Approved-Closed	05/11/2009
<b>Comments:</b>		
<b>Attachment:</b>		
AR Certif of Compliance with Rule 19.pdf		
<b>Bypassed -Name:</b> Application	<b>Review Status:</b> Approved-Closed	05/11/2009
<b>Bypass Reason:</b> LOCATED UNDER FORM SCHEDULE		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved-Closed	05/11/2009
<b>Bypass Reason:</b> LOCATED UNDER FORM SCHEDULE TAB		
<b>Comments:</b>		

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

Insurer: Conseco Health Insurance Company

Form Number(s): FB035/IS3ST-C, FB035/IS3ST-C1, FB035/IS3ST-CS, FB035/IS3ST-CS1,  
FB040/IS3ST-C, FB040/IS3ST-C1, FB040/IS3ST-CS, FB040/IS3ST-CS1,  
FB000/AA3AR-E, FB000/ER3ST-I, FB000/CA3CR-C1, and FB000/OC3ST-D

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

*Mariann Dobbs*

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Signature of Company Officer

Mariann Dobbs

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Name

Senior Director and Assistant Secretary

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Title

04/16/2009

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Date