

SERFF Tracking Number: SKML-126255002 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number: 43141
Company Tracking Number: 1664 5/09
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Hospital Indemnity
Project Name/Number: Info Filing - Applicant Letter/1664 5/09

Filing at a Glance

Company: Kanawha Insurance Company

Product Name: Hospital Indemnity

TOI: H14I Individual Health - Hospital Indemnity

Sub-TOI: H14I.000 Health - Hospital Indemnity

Filing Type: Form

SERFF Tr Num: SKML-126255002 State: ArkansasLH

SERFF Status: Closed State Tr Num: 43141

Co Tr Num: 1664 5/09 State Status: Filed-Closed

Co Status:

Authors: Pamela Kelly, Alvah Shelton

Date Submitted: 08/06/2009

Reviewer(s): Rosalind Minor

Disposition Date: 08/06/2009

Disposition Status: Accepted For Informational Purposes

Implementation Date:

Implementation Date Requested:

State Filing Description:

General Information

Project Name: Info Filing - Applicant Letter

Project Number: 1664 5/09

Requested Filing Mode: Informational

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: This filing is only being submitted for informational purposes in your state. It is not for use in the company's state of domicile.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/06/2009

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/06/2009

Corresponding Filing Tracking Number: 1664 5/09

Deemer Date:

Filing Description:

The enclosed filing is being submitted on behalf of Kanawha Insurance Company for your information. This application form included in this submission is not intended to replace any forms currently on file with your Department. The purpose of this submission is to notify your department that this application was printed in error, and inadvertently

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distributed for use in your state.

This application is identical to Application form 1664, which was approved by your department for use with Policy Form No. 90840 AL, on 6/2/09, except as follows:

- This application is entitled "Application for Hospital Fund", while the approved application form is entitled "Application for Hospital Indemnity";
- Check boxes were used in this application as opposed to the radial buttons printed in the approved application form;
- Formatting of boxes, lines and fonts may differ from the approved form; and
- The form number was printed with a "5/09" revised date.

Although the company has recalled all of the misprinted applications from its representatives, there were a handful of applications taken in your state. Therefore, the company plans to notify each applicant that the application he or she signed was printed in error, and that the coverage applied for is for a "Hospital Indemnity" policy, and not a "Hospital Fund". The Company will not ask the applicant to complete a new application, but that a copy of the letter should be retained in his or her records with this application.

We are enclosing a copy of the letter that will be sent to the applicants that completed the misprinted application.

If you have any questions regarding this submission, please feel free to contact me as shown below.

Sincerely,

Pamela F. Kelly, FLMI, AIRC
Consultant
(800) 711-5813
pam@skminc.com

Company and Contact

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Filing Contact Information

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

Pamela Kelly, Compliance Consultant pam@skminc.com
1925 Century Blvd (404) 633-5353 [Phone]
Atlanta, GA 30345 (404) 633-6304[FAX]

Filing Company Information

Kanawha Insurance Company CoCode: 65110 State of Domicile: South Carolina
210 South White Street Group Code: -99 Company Type: Life
Lancaster, SC 29720 Group Name: State ID Number:
(803) 283-5301 ext. [Phone] FEIN Number: 57-0380426

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kanawha Insurance Company	\$0.00	08/06/2009	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Rosalind Minor Informational Purposes		08/06/2009	08/06/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Authorization Letter	Supporting Document	Pamela Kelly	08/06/2009	08/06/2009

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Disposition

Disposition Date: 08/06/2009

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Accepted for Informational Purposes	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	Yes
Supporting Document	Outline of Coverage	Accepted for Informational Purposes	Yes
Supporting Document	Letter to Applicant	Accepted for Informational Purposes	Yes
Supporting Document (revised)	Authorization Letter	Accepted for Informational Purposes	Yes
Supporting Document	Authorization Letter	Replaced	Yes

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Amendment Letter

Amendment Date:

Submitted Date: 08/06/2009

Comments:

The purpose of this amendment is to replace the document attached to Letter of Authorization with the correct authorization letter. We apologize for any confusion this error may have caused you.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Authorization Letter

Comment:

Metlzer's auth.pdf

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:
Bypassed -Name: Flesch Certification Accepted for Informational Purposes 08/06/2009
Bypass Reason: The enclosed application is not being submitted for approval.
Comments:

Review Status:
Satisfied -Name: Application Accepted for Informational Purposes 08/06/2009
Comments:

The attached application was inadvertently printed and used in your state. It has been pulled from the field and destroyed. It is being submitted for your information only.

Attachment:
HospitalFund_forWeb.pdf

Review Status:
Bypassed -Name: Health - Actuarial Justification Accepted for Informational Purposes 08/06/2009
Bypass Reason: Not applicable to this filing.
Comments:

Review Status:
Bypassed -Name: Outline of Coverage Accepted for Informational Purposes 08/06/2009
Bypass Reason: Not applicable to this filing.
Comments:

Review Status:
Satisfied -Name: Letter to Applicant Accepted for Informational Purposes 08/06/2009

Comments:
This letter will be sent to all applicants that completed the incorrect application. It is being submitted for your information.

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Attachment:

Hospital Indemnity app letter v2.pdf

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Satisfied -Name: Authorization Letter

Review Status:

Accepted for Informational 08/06/2009
Purposes

Comments:

Attachment:

Metzler's auth.pdf

BENEFIT SECTION

Plan Type Individual (adult or child) Family (2 parents and all children) Single Parent (parent and all children)

Base Benefit \$250 \$500 \$1,000 \$1,500 \$2,000

Optional Benefit: Hospital Confinement Daily Benefit Rider/Intensive Care Unit (ICU) Daily Benefit

\$50/day (\$200/day if ICU) \$100/day (\$400/day if ICU) \$200/day (\$800/day if ICU)

Payment Method Bank Draft Credit Card Direct Bill/Check (Annual Billing Only)

(Complete Bank Draft or Credit Card Authorization. Annual fee of \$12 applies to credit card billing.)

Payment Mode Monthly Semi-annual Annual

Total Modal Premium \$.

APPLICANT'S REPRESENTATION AND AGREEMENT

	Primary Insured Yes/No	Spouse Yes/No	Child 1 Yes/No	Child 2 Yes/No	Child 3 Yes/No
1. Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession as having:					
a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive to the antibodies for Human Immunodeficiency Virus (HIV).....	<input type="checkbox"/> <input type="checkbox"/>				
b. Alzheimer's Disease.....	<input type="checkbox"/> <input type="checkbox"/>				
c. Senile dementia.....	<input type="checkbox"/> <input type="checkbox"/>				
d. Uncorrected congenital heart defect (excluding mitral valve prolapse).....	<input type="checkbox"/> <input type="checkbox"/>				
e. Kidney disease (not including kidney stones).....	<input type="checkbox"/> <input type="checkbox"/>				
f. Systemic lupus.....	<input type="checkbox"/> <input type="checkbox"/>				
g. Insulin-dependent diabetes.....	<input type="checkbox"/> <input type="checkbox"/>				
h. Liver disease or disorder (excluding Hepatitis A).....	<input type="checkbox"/> <input type="checkbox"/>				
2. a. Is any person proposed for coverage currently confined in a hospital, nursing home, or any medical facility?.....	<input type="checkbox"/> <input type="checkbox"/>				
b. Has a member of the medical profession recommended hospitalization, surgery, or nursing home confinement that has not yet occurred?.....	<input type="checkbox"/> <input type="checkbox"/>				
3. Within the last 5 years has any person proposed for coverage been diagnosed or treated by a member of the medical profession for internal cancer (except basal cell cancer)?.....	<input type="checkbox"/> <input type="checkbox"/>				
4. Within the past 2 years has any person proposed for coverage been hospitalized or seen in an emergency room by a member of the medical profession for:					
a. Angioplasty, stent placement, heart surgery.....	<input type="checkbox"/> <input type="checkbox"/>				
b. Angina (heart related chest pain), heart attack, hypertension, congestive heart failure, peripheral vascular disease (circulatory problems).....	<input type="checkbox"/> <input type="checkbox"/>				
c. Emphysema, chronic lung disease, asthma.....	<input type="checkbox"/> <input type="checkbox"/>				
d. Cerebral vascular accident (CVA, stroke), cerebral vascular insufficiency, transient ischemic attack (TIA, ministroke).....	<input type="checkbox"/> <input type="checkbox"/>				
e. Type II diabetes.....	<input type="checkbox"/> <input type="checkbox"/>				
f. Parkinson's Disease.....	<input type="checkbox"/> <input type="checkbox"/>				
g. Crohn's Disease, ulcerative colitis.....	<input type="checkbox"/> <input type="checkbox"/>				
h. Sickle cell anemia.....	<input type="checkbox"/> <input type="checkbox"/>				
i. Transplants.....	<input type="checkbox"/> <input type="checkbox"/>				

5. Does any person proposed for coverage have any other Hospital Indemnity coverage in force or an application for similar insurance pending with this or any other company? Yes No
If "YES", please provide details with specific benefit amounts below.

6. Will the policy applied for replace any coverage currently in force? Yes No
If "YES", please complete the following:
Company _____ Person Covered _____
Policy Number _____

PAYOR INFORMATION

Payor Information (First Name, MI, Last Name) (If Different than the Proposed Insured) Suffix

--	--	--	--

Social Security Number

--	--	--	--	--	--	--	--	--	--

Address (Street or R.R.)

--

City State Zip Code

--	--	--

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

I have read or had read to me all the questions on this Application and I represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I also realize that any false statements or misrepresentation may result in loss of coverage under the policy subject to the time limit on certain defenses or incontestability provisions of the policy. I understand and agree that the policy will not take effect unless it is issued by Kanawha Insurance Company, the total modal premium must accompany Application, and any check, bank draft or credit card payment is honored on first presentation. No agent or producer has the authority to waive any of the conditions or questions in this Application.

I acknowledge, if required in my state, that I have been furnished:

- Outline of Coverage Medicare Buyer's Guide (If 65 or over)

Signed at _____

--	--

City State

--	--	--	--	--	--	--

Signature of Primary Insured/Owner
(Parent or Guardian if Child only coverage)

Date (MM/DD/YYYY)

FOR INSURANCE PRODUCER'S USE ONLY

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Will this insurance replace any existing insurance? Yes No

Signature of Licensed Insurance Producer _____

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 /

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 /

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Date (MM/DD/YYYY)

Insurance Producer Number	% Credit	Insurance Producer Number	% Credit	Insurance Producer Number	% Credit



AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

ATTACH VOIDED CHECK

Name of Depositor (First Name, MI, Last Name) (Attach Voided Check) Suffix

Route & Transit Number Account Number

Bank Name and Address

Debit on the day of the month (1-28 only; 29, 30, 31 not available). **If no election is made, debits will be made on the day of Policy.**

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to make deductions automatically every payment period for payments of premiums from my: savings account checking account

- Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if no day is selected, the day of Policy.
- This Authorization shall not become effective unless and until the coverage is issued.
- This Authorization shall not be construed as modifying any provisions of the coverage.
- Kanawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions.
- This Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5) business days prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be payable annually.
- Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Depositor _____ Date (MM/DD/YYYY) / /

CREDIT CARD INFORMATION

CARD HOLDER INFORMATION

Credit Card Number Expiration Date (MM/DD/YYYY) Card Type

Visa MasterCard

3 or 4-digit security code found on the back of most cards:

Signature of Card Holder _____ Date (MM/DD/YYYY) / /

Name as it appears on the credit card statement. (If different from Proposed Insured)

Card Holder (First Name, MI, Last Name) Suffix

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to charge my credit card every payment period for payment of premiums.

- Each charge shall constitute proper notice of premium due.
- This Authorization shall not become effective unless and until the Policy is issued.
- This Authorization shall not be construed as modifying any provisions of the Policy.
- Kanawha shall not incur any liability if the credit card company does not honor the charge and the Policy shall lapse subject to nonforfeiture provisions.
- This Authorization may be discontinued by Kanawha or by the undersigned at any time within FIVE (5) business days prior to the payment date. Upon termination of this Authorization, premiums for the Policy will be payable annually.
- Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Card Holder _____ Date (MM/DD/YYYY) / /

HUMANA[®]

Guidance when you need it most

KANAWHA
INSURANCE COMPANY

210 South White Street
Lancaster, SC 29720

August 7, 2009

Mr./Mrs./Ms./Full name of recipient
100 Main street
Anywhere KY 12345

Re: Hospital Indemnity Policy Application

Dear **Ms./Mrs./Mr. Last Name:**

This letter is for your information and requires no action on your part.

We wanted to let you know that the Kanawha Insurance Company application you recently completed for hospital indemnity coverage was an incorrect version of the application. The application you filled out has *Application For Hospital Fund* printed and located at the top left hand side of the page. The application should have read *Application For Hospital Indemnity*, which is the product for which you applied. Please accept our apology for any confusion or inconvenience this may have caused.

We assure you your application for coverage [**will be/has been**] processed according to our normal procedures, the same as if the correct application had been provided. Again, no action is needed on your part. If you have any questions regarding this letter or your hospital indemnity policy, please contact our Customer Service Department at 877-207-0158.

Sincerely



Paul Esselman
Director

Cc: Agent



210 South White Street
Post Office Box 610
Lancaster, SC 29721-0610

R. Dale Vaughan, CLU, CEBS, FLMI
President and Chief Operating Officer
Kanawha Insurance Company

Direct Line: 803-283-5490
dale.vaughan@kmgamerica.com

March 18, 2009

Ms. Sandra K. Meltzer, President
Sandra K. Meltzer & Associates, Inc.
1925 Century Boulevard, Suite 1
Atlanta, Georgia 30345

Re: NAIC 65110

Dear Ms. Meltzer:

Please accept this letter as authorization from Kanawha Insurance Company to your firm, Sandra K. Meltzer & Associates, Inc., to file any or all policy forms as referenced on the attached form listing on Kanawha's behalf.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Dale Vaughan". The signature is fluid and cursive, with a long horizontal stroke at the end.

R. Dale Vaughan

Attachment

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Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Supporting Document	Authorization Letter	08/06/2009	STATEMENT OF VARIABLE.pdf

**STATEMENT OF VARIABLES
HOSPITAL INDEMNITY POLICY FORM 90840**

FACE PAGE

In the event of a change in the administrative address and telephone number of the Company, the following bracketed text will be changed accordingly.

[210 S. WHITE STREET]
[LANCASTER, SC 29720]
TELEPHONE: [877-207-0158]

[PO BOX 610]
[LANCASTER, SC 29721-0610]

The signature of the Company President is also bracketed in the event of a change in company administration.

POLICY SCHEDULE

The bracketed information shown in the Policy Schedule is "John Doe" specific, with the exception of the following:

[Notice: Annual fee of [\$12.00] applies to credit card billing.] - The "[\$12.00]" annual fee may be adjusted in accordance with the credit card billing for the policy owner.

DEFINITIONS

The bracketed text shown below will be included depending on the Policy Owner's selection of individual only, spouse and/or dependent children coverage.

[**Plan Type** means either:

- coverage for an individual (Individual);
- coverage for an individual and his or her Dependent Children (Single Parent); [or]
- coverage for an individual, his or her spouse and their Dependent Children (Family)[.]; [or]
- [coverage for an individual and his or her spouse (Couple).]

[Plan Type is the coverage option You chose on the Application.]

BENEFITS

The bracketed text shown under the Emergency Room Treatment Lump Sum Benefit and Outpatient Lump Sum Benefit will be included if the Plan Type for dependent coverage is also included:

Emergency Room Treatment Lump Sum Benefit

- [no more than three such Hospital emergency room visits for all Covered Persons per Calendar Year if this Policy provides Couple Plan Type coverage;]

Outpatient Surgery Lump Sum Benefit

- [no more than three such Outpatient Surgical Procedures for all Covered Persons per Calendar Year if this Policy provides Couple Plan Type coverage;]

MAKING A CLAIM UNDER THIS POLICY

The amount shown under **Payment of Benefits** "[\$2,500]" will vary in accordance with the requirements of your state. This amount will never be greater than the amount shown, nor the amount required by the law in the state in which the policy is issued.