

SERFF Tracking Number: ANTX-126470244 State: Arkansas
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 44674
Company Tracking Number:
TOI: H13G Group Health - Short Term Care Sub-TOI: H13G.002 Nursing Home
Product Name: RCAPP10 RESUBMISSION
Project Name/Number: RCAPP10 RESUBMISSION/RCAPP10 RESUBMISSION

Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: RCAPP10 RESUBMISSION SERFF Tr Num: ANTX-126470244 State: Arkansas
TOI: H13G Group Health - Short Term Care SERFF Status: Closed-Approved- State Tr Num: 44674
Closed

Sub-TOI: H13G.002 Nursing Home Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Sherry Wiegman Disposition Date: 01/28/2010
Date Submitted: 01/26/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: RCAPP10 RESUBMISSION
Project Number: RCAPP10 RESUBMISSION
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: Resubmission
Group Market Size: Small and Large
Group Market Type: Association
Explanation for Other Group Market Type:
State Status Changed: 01/28/2010
Created By: Sherry Wiegman
Corresponding Filing Tracking Number:
Filing Description:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Previous Filing Number: ANTX-126470244
Overall Rate Impact:
Filing Status Changed: 01/28/2010
Deemer Date:
Submitted By: Sherry Wiegman

We are resubmitting a previously approved/filed application for reconsideration. Form RCAPP10 was very recently approved/filed for use under SERFF tracking number ANTX-126470244 on 01/21/2010.

This form is being resubmitted to include a disclaimer regarding telephonic applications so that this application can be used for telephone applicants in addition to wet ink signature applicants.

Thanking you in advance for your further consideration.

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Company and Contact

Filing Contact Information

Sherry Wiegman, Sr. Compliance Analyst sherry.wiegman@anico.com
 One Moody Plaza 17th Floor 409-621-7779 [Phone]
 Galveston, TX 77550 409-766-2950 [FAX]

Filing Company Information

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Texas
 One Moody Plaza 17th Floor Group Code: 408 Company Type: Health Insurance
 Galveston, TX 77550 Group Name: State ID Number:
 (281) 538-4842 ext. [Phone] FEIN Number: 73-0994234

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$50.00	01/26/2010	33801435

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/28/2010	01/28/2010

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Disposition

Disposition Date: 01/28/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: RCAPP10

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 01/28/2010	RCAPP10	Application/ Enrollment Form	Initial		50.100	GENERIC TELE APPLICATIO N.pdf

RECOVERY CARE II APPLICATION - ASSOCIATION MEMBER (Please Print - Black Ink)

SECTION A

1. Applicant _____ Date of Birth _____ Age _____
First Name Middle Initial Last Name
 Home Address _____ City _____ State _____ Zip _____
 Phone (____) _____ Best Time to Call _____ Email _____
2. Billing Address (if different) _____ City _____ State _____ Zip _____
3. Height _____ Weight _____

SECTION B

- New Policy Reinstatement
4. Male Female
5. **I, AS A MEMBER OF THE ASSOCIATION, AM APPLYING FOR:**
- a) Daily Benefit \$ _____ b) Lifetime Maximum Benefit Period (days): 180 270 360
- c) Elimination Period (days): 0 20 d) Inflation Protection Rider: Compound Simple
- e) Home Health Care Rider (if Inflation Protection Rider included in Base Plan, it is automatically included in Home Health Care Rider)
6. **Payment Mode:** Annual Semi-Annual Quarterly Monthly PAC
7. **Requested Effective Date:** _____

SECTION C

If the answer to any question in Section C (8-11h) is Yes, the application should not be submitted.

8. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency?..... Yes No
9. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection? ... Yes No
10. Within the past **2 years**, have you:
- a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given? Yes No
- b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip? Yes No
- c) required the use of a wheelchair, walker or cane? Yes No
- d) been advised to have cataract surgery or other eye surgery that has not been performed? Yes No

11. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:
- a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission? Yes No
 - b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement? Yes No
 - c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene? Yes No
 - d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?..... Yes No
 - e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment?..... Yes No
 - f) Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder?..... Yes No
 - g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse?..... Yes No
 - h) incontinence, any ostomy present due to disease, an organ transplant other than corneal? Yes No
12. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack?..... Yes No

If Yes, give information regarding diagnosis or condition. (use additional sheet if necessary) _____

SECTION D

Will any health, recovery short term, long term, or home health care insurance be replaced with this certificate? Yes No

If Yes, which company? _____ Policy Number _____

If Yes, read and complete the Notice to Applicant Regarding Replacement.

SECTION E

AGREEMENT — I have read or had read to me my completed application. My answers are true and complete to the best of my knowledge and belief. I understand my coverage, if issued, will begin on the date of issue shown in my certificate. I realize any false statement or misrepresentation in my application may result in loss of coverage under my certificate. If application taken over the phone, I agree that my electronic signature serves as my original signature.

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ACKNOWLEDGMENT — If Medicare eligible, I have received the *Guide to Health Insurance for People with Medicare* and a Duplication of Medicare Coverage form from the Agent.

The certificate provides limited benefits. Review your certificate carefully.

Applicant's Signature _____ Date _____

City _____ State _____ Zip _____

A TELEPHONE INTERVIEW WILL BE CONDUCTED.

What will be the best time to contact the Applicant for the telephone interview? _____

**AUTHORIZATION TO OBTAIN, RELEASE
AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY's or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

(Turn over to continue)

**AUTHORIZATION TO OBTAIN, RELEASE
AND DISCLOSE MEDICAL INFORMATION (continued)**

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* If application taken over the phone, I agree that my electronic signature serves as my original signature.

Date

Applicant's Signature

Witness

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian-in-fact, guardian, payee representative or other



DISCLOSURE NOTICE

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

Medical Information Bureau (MIB) Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community. No information collected concerning the sexual orientation of the proposed insured will be used to determine eligibility for insurance.

Standard Life and Accident Insurance Company

P.O. Box 696870, San Antonio, Texas 78269

888.350.1488

RECEIPT

IF PREMIUM IS COLLECTED, CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY.

If coverage is not issued, the initial premium will be refunded to the Applicant. If coverage is issued, it will begin on the date of issue shown in the certificate.

Received from _____

on _____

Date

an application for _____ Recovery Care II

and a Check Money Order

for \$ _____

Applicant's Signature

Agent's Signature



Standard Life and Accident Insurance Company

P.O. Box 696870, San Antonio, Texas 78269

888.350.1488

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Supporting Document Schedules

	Item Status:	Status
Satisfied - Item: Flesch Certification	Approved-Closed	Date: 01/28/2010
Comments:		
Attachment:		
Readability Certification RECAPP10 Resub.pdf		



READABILITY CERTIFICATION

We hereby certify that RCAPP10 has achieved a Flesch scale readability score which meets the minimum reading ease score as required by the state of Arkansas.

A handwritten signature in black ink that reads "James P. Stelling".

James P. Stelling.
Asst. Vice President, Health Compliance

01/25/2010

Date of Signature