

SERFF Tracking Number: AFDL-126463635 State: Arkansas
Filing Company: American Fidelity Assurance Company State Tracking Number: 45099
Company Tracking Number: AMD2107
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: AMD2107 COBRA Premium Limited Benefit Rider
Project Name/Number: AMD2107 Cross Divisional Rider/AMD2107

Filing at a Glance

Company: American Fidelity Assurance Company

Product Name: AMD2107 COBRA Premium SERFF Tr Num: AFDL-126463635 State: Arkansas
Limited Benefit Rider

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 45099
Closed

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: AMD2107 State Status: Approved-Closed
Long Term

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Lisa Blaiich, Tina Crooks, Joelle Harbour
Disposition Date: 03/08/2010

Date Submitted: 03/03/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AMD2107 Cross Divisional Rider

Project Number: AMD2107

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 12/08/2009

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association,
Trust

Filing Status Changed: 03/08/2010

Explanation for Other Group Market Type:

State Status Changed: 03/08/2010

Deemer Date:

Created By: Joelle Harbour

Submitted By: Joelle Harbour

Corresponding Filing Tracking Number:
AMD2107

Filing Description:

Submitted for your review is amendment rider AMD2107, COBRA Premium Limited Benefit Rider. This optional rider will be used with all approved group disability income policies. Domiciliary state approval was granted on December 8, 2009.

SERFF Tracking Number: AFDL-126463635 State: Arkansas
 Filing Company: American Fidelity Assurance Company State Tracking Number: 45099
 Company Tracking Number: AMD2107
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
 Product Name: AMD2107 COBRA Premium Limited Benefit Rider
 Project Name/Number: AMD2107 Cross Divisional Rider/AMD2107

Amendment rider AMD2107 allows the Insured to purchase an additional benefit to aid in the payment of COBRA premiums. If the Insured is Disabled, as defined in the policy, and his or her employment terminates, upon receipt of proof of COBRA continuation, a monthly benefit will be paid directly to the Insured to be used for the payment of their COBRA premium. The variable fields in the rider will be used to allow for the various benefit amounts.

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of the state of Arkansas and such forms contain no provisions previously disapproved by the Department. The Flesch score is 50.

Thank you for your assistance in this matter. If you have any questions, please contact me at 1-800-654-8489, extension 5997 or at Joelle.Harbour@af-group.com.

Company and Contact

Filing Contact Information

Joelle Harbour, Compliance Analyst I joelle.harbour@af-group.com
 2000 N Classen Blvd 405-523-5997 [Phone]
 Oklahoma City, OK 73106

Filing Company Information

American Fidelity Assurance Company CoCode: 60410 State of Domicile: Oklahoma
 2000 North Classen Blvd Group Code: Company Type: LAH
 Oklahoma City, OK 73106 Group Name: State ID Number:
 (405) 523-2000 ext. [Phone] FEIN Number: 73-0714500

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Fidelity Assurance Company	\$50.00	03/03/2010	34585588

SERFF Tracking Number: AFDL-126463635 State: Arkansas
Filing Company: American Fidelity Assurance Company State Tracking Number: 45099
Company Tracking Number: AMD2107
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: AMD2107 COBRA Premium Limited Benefit Rider
Project Name/Number: AMD2107 Cross Divisional Rider/AMD2107

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/08/2010	03/08/2010

SERFF Tracking Number: *AFDL-126463635* *State:* *Arkansas*
Filing Company: *American Fidelity Assurance Company* *State Tracking Number:* *45099*
Company Tracking Number: *AMD2107*
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.005 Combined Short Term and Long Term*
Product Name: *AMD2107 COBRA Premium Limited Benefit Rider*
Project Name/Number: *AMD2107 Cross Divisional Rider/AMD2107*

Disposition

Disposition Date: 03/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AFDL-126463635 State: Arkansas
 Filing Company: American Fidelity Assurance Company State Tracking Number: 45099
 Company Tracking Number: AMD2107
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
 Product Name: AMD2107 COBRA Premium Limited Benefit Rider
 Project Name/Number: AMD2107 Cross Divisional Rider/AMD2107

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group COBRA Premium Limited Benefit Rider	Approved-Closed	Yes

SERFF Tracking Number: AFDL-126463635 State: Arkansas
 Filing Company: American Fidelity Assurance Company State Tracking Number: 45099
 Company Tracking Number: AMD2107
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
 Product Name: AMD2107 COBRA Premium Limited Benefit Rider
 Project Name/Number: AMD2107 Cross Divisional Rider/AMD2107

Form Schedule

Lead Form Number: AMD2107

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/08/2010	AMD2107	Certificate	Group COBRA Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.000	AMD2107.pdf



2000 N. Classen Boulevard

Oklahoma City, Oklahoma 73106

Effective Date _____
(If different from the Policy or Certificate)

COBRA PREMIUM LIMITED BENEFIT RIDER

The Policy or Certificate to which this Rider is attached is hereby amended as follows:

We will pay an additional benefit of [\$300, \$400, \$500, \$600] per month to You for Your medical COBRA premium. This benefit will pay up to the end of the disability benefit period or to the end of Your medical COBRA benefit period, whichever occurs first, if:

- (1) You are Disabled;
- (2) You have satisfied the Elimination Period and Monthly Disability Benefits are payable;
- (3) Your employment has terminated;
- (4) You were covered under Your employer's medical coverage at the time of termination; and
- (5) You elected medical continuation of coverage as provided for under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

You must provide proof to Us of Your election of medical COBRA continuation. Proof of continued medical COBRA participation will be required before benefits are paid under this Rider.

This Rider is subject to all the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.



Secretary

SERFF Tracking Number: AFDL-126463635 State: Arkansas
 Filing Company: American Fidelity Assurance Company State Tracking Number: 45099
 Company Tracking Number: AMD2107
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
 Product Name: AMD2107 COBRA Premium Limited Benefit Rider
 Project Name/Number: AMD2107 Cross Divisional Rider/AMD2107

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AMD2107_Certification_AR.pdf	Approved-Closed	03/08/2010

	Item Status:	Status Date:
Satisfied - Item: Application Comments: A1264 group application was approved in Arkansas on October 30,2009. Attachment: A1264.pdf	Approved-Closed	03/08/2010

 **American Fidelity
Assurance Company**
A member of the American Fidelity Group.

2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125

**CERTIFICATION
ARKANSAS**

This is to certify that the attached group hospital indemnity product, Form Number:
AMD2107, complies with the requirements of:

Arkansas Rule & Regulation 19

Arkansas Rule & Regulation 49

ACA 23-80-206

ACA 23-79-138


Signature

John Lanier
Name

Vice President
Title

03/01/2010
Date

GROUP APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N. Classen Blvd Oklahoma City, Oklahoma 73106

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

1. PROPOSED INSURED INFORMATION:

Last Name		First Name		Full Middle Name		Suffix	
Age	Date of Birth Mo Day Yr	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Soc Sec Number	Requested Eff Date Mo Day Yr	Date of Employment Mo Day Yr		
Residence Address: Number & Street (Not a P.O. Box)				Work Phone # () ()	Home Phone # () ()		
City		State	Zip	Country of Citizenship			
Mailing Address (if different than Residence)			City	State	Zip		
Employer Name		Employer/MCP #	Salary: \$ Annual <input type="checkbox"/> Monthly <input type="checkbox"/>	Occupation			
Are you currently able to perform the duties of your occupation?						Yes <input type="checkbox"/>	No <input type="checkbox"/>

Applicant's E-mail Address:

2. BENEFITS APPLIED FOR:

Product	New/Chg	Billing Distribution ID	Persons Covered ¹	Plan Code	Plan Amount	Employee	PREMIUM:		
							Employer	Mode	Total
[LTD]	<input type="checkbox"/>	<input type="checkbox"/>							
[STD]	<input type="checkbox"/>	<input type="checkbox"/>							
[Other]	<input type="checkbox"/>	<input type="checkbox"/>							
[Other]	<input type="checkbox"/>	<input type="checkbox"/>							
[Other]	<input type="checkbox"/>	<input type="checkbox"/>							
[Other]	<input type="checkbox"/>	<input type="checkbox"/>							
[Other]	<input type="checkbox"/>	<input type="checkbox"/>							
[Other]	<input type="checkbox"/>	<input type="checkbox"/>							
z=Individual; y=Individual & Spouse; x=Individual, Spouse & Child(ren); v=Individual & Children; s=Spouse							TOTAL		

3. BENEFICIARY:

First Name	Middle Name	Last Name	Relationship to Insured	Country of Citizenship
------------	-------------	-----------	-------------------------	------------------------

4. ELECTION: I hereby enroll, add or change, as checked above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay.

5. ACKNOWLEDGMENT: I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
- If applying for disability income coverage, **OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.**
- "Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any.

• BROCHURE(S) # _____ HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S). (Please initial):

6. FRAUD NOTICE: Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents 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. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)

AGENT SIGNATURE (where required by law) _____ Date _____

Agent # _____ SIGNATURE (Applicant) _____

**GROUP
APPLICATION**

**AMERICAN FIDELITY ASSURANCE COMPANY
2000 N. Classen Blvd Oklahoma City, Oklahoma 73106**

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

PROPOSED INSURED'S NAME: _____

HEALTH HISTORY:

7. Within the **past 5 years**, have you received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following:

Cancer (other than basal or squamous cell skin cancer), heart and/or circulatory disorder, peripheral vascular disease (PVD), stroke or transient ischemic attack, liver or kidney disorder/disease (excluding stones), pulmonary disease, diabetes requiring insulin, rheumatoid arthritis, epilepsy, ulcerative colitis, Crohn's disease, organ transplant, systemic lupus erythematosus, disorder of blood cells or blood clotting disorder, seizures, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV), Chronic Fatigue Syndrome (CFS), fibromyalgia, alcohol or drug addiction or abuse, or neurological disorder (excluding headaches or migraines).

Yes **No**

8. Within the **past 12 months**, have you:

Received advice from a medical provider, taken medication, incurred an expense, undergone tests, or received treatment (including, but not limited to, spinal manipulation, physical therapy, or counseling) for a condition related to: (a) your back, neck or spine; (b) a mental or nervous condition; or (c) had surgery recommended that has not yet been performed or received a referral for surgery consultation?

Yes **No**

9. Are you currently pregnant?

Yes **No**

10. I hereby certify that I have read the above statements and all of the medical conditions or they have been read to me. I also understand that additional investigation could occur at time of claim and any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.

(Please initial): _____