

SERFF Tracking Number: AFDL-126463646 State: Arkansas  
Filing Company: American Fidelity Assurance Company State Tracking Number: 45098  
Company Tracking Number: AMD2108  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: AMD2108 Hospital Indemnity Limited Benefit Rider  
Project Name/Number: AMD2108/AMD2108

## Filing at a Glance

Company: American Fidelity Assurance Company

Product Name: AMD2108 Hospital Indemnity Limited Benefit Rider SERFF Tr Num: AFDL-126463646 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved-Closed State Tr Num: 45098

Sub-TOI: H11G.005 Combined Short Term and Long Term Co Tr Num: AMD2108 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Lisa Blaich, 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: AMD2108

Project Number: AMD2108

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

Explanation for Other Group Market Type:

State Status Changed: 03/08/2010

Created By: Joelle Harbour

Corresponding Filing Tracking Number: AMD2108

Filing Status Changed: 03/08/2010

Deemer Date:

Submitted By: Joelle Harbour

Filing Description:

Submitted for your review is amendment rider AMD2108, Hospital Indemnity Limited Benefit Rider. This optional rider will be used with all approved group disability income policies. Domiciliary state approval was granted on December .

Amendment rider AMD2108 pays a limited daily benefit if the insured is confined to a hospital as an inpatient. The

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benefit is paid directly to the insured.

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

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## 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	34585714

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## Correspondence Summary

### Dispositions

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

*SERFF Tracking Number:*      *AFDL-126463646*                      *State:*                      *Arkansas*  
*Filing Company:*              *American Fidelity Assurance Company*              *State Tracking Number:*      *45098*  
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*TOI:*                      *H11G Group Health - Disability Income*              *Sub-TOI:*                      *H11G.005 Combined Short Term and Long Term*  
*Product Name:*              *AMD2108 Hospital Indemnity Limited Benefit Rider*  
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## **Disposition**

Disposition Date: 03/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.



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## Form Schedule

**Lead Form Number: AMD2108**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/08/2010	AMD2108	Certificate	Group Hospital Amendmen Indemnity Limited t, Insert Benefit Rider Page, Endorseme nt or Rider	Initial		50.000	AMD2108.pdf

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

2000 N. Classen Boulevard

Oklahoma City, Oklahoma 73106

Effective Date \_\_\_\_\_  
(If different from the Policy or Certificate)

**HOSPITAL INDEMNITY LIMITED BENEFIT RIDER**

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

**You** or **Your** as used throughout shall mean the Insured or the Insured's. **We**, **Us**, **Our** shall mean the Company.

**RIDER SCHEDULE**

**Daily Hospital Confinement Benefit:** [\$100, \$150, \$200, \$250] per day, per confinement

**Maximum Hospital Confinement Period:** 90 days per confinement

**Reduction in Benefits at Age 70:** 50% of the Daily Hospital Confinement Benefit

If You are confined to a Hospital as an Inpatient due to a covered Injury or Sickness, the Daily Hospital Confinement Benefit listed in the Rider Schedule will be paid to You for the number of days You are hospital confined and are charged for room and board facilities, up to the Maximum Hospital Confinement Period.

Successive Hospital stays will be considered as one confinement if they are separated by less than 90 days of confinement to a Hospital.

**Inpatient** means You are admitted as a resident patient to a Hospital for at least 18 continuous hours and are being charged for room and board facilities.

The Hospital Confinement Benefit will not be payable for an Injury or Sickness incurred in the first 12 months of coverage if the Injury or Sickness is caused by or resulting from a Pre-Existing Condition as defined in the Policy.

**EXCLUSIONS**

In addition to the Exclusions listed in the Policy, no benefits will be payable under this Rider for any Hospital Confinement that is caused by or resulting from Mental Illness or Drug or Alcohol Abuse.

**TERMINATION**

Your coverage under this Rider will end on the earliest of:

- (a) the end of the last period for which premium payment has been made to Us; or
- (b) the date You notify Us in writing to terminate coverage; or
- (c) the date this Rider is discontinued; or
- (d) the date the Policy is discontinued.

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

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	03/08/2010
<b>Comments:</b>		
<b>Attachment:</b> AMD2108_Certification_AR.pdf		

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

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

2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125

**CERTIFICATION  
ARKANSAS**

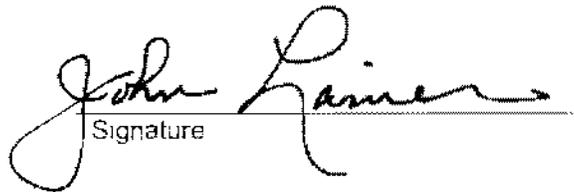
This is to certify that the attached group hospital indemnity product, Form Number:  
AMD2108, complies with the requirements of:

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**

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**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 <sup>1</sup>	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
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**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**

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**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): \_\_\_\_\_