

SERFF Tracking Number: CMBD-126531839 State: Arkansas
Filing Company: Combined Insurance Company of America State Tracking Number: 45219
Company Tracking Number: 19845-AR-1109
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Disability Income
Project Name/Number: 19845-AR-1109/19845-AR-1109

Filing at a Glance

Company: Combined Insurance Company of America

Product Name: Disability Income

SERFF Tr Num: CMBD-126531839 State: Arkansas

TOI: H111 Individual Health - Disability Income

SERFF Status: Closed-Approved-
Closed State Tr Num: 45219

Sub-TOI: H111.004 Other

Co Tr Num: 19845-AR-1109

State Status: Approved-Closed

Filing Type: Form

Author: Anita Sibley

Reviewer(s): Rosalind Minor

Date Submitted: 03/19/2010

Disposition Date: 03/31/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 19845-AR-1109

Status of Filing in Domicile: Pending

Project Number: 19845-AR-1109

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: 03/31/2010

Explanation for Other Group Market Type:

State Status Changed: 03/31/2010

Deemer Date:

Created By: Anita Sibley

Submitted By: Anita Sibley

Corresponding Filing Tracking Number:

Filing Description:

This is a new filing, related to our Individual Disability Income Policy, which is sold to persons 18 to 63 and is guaranteed renewable to age 65, and thereafter at our option, to age 70.

Insert Page 19845-AR-1109 will replace the policy schedule page (page 3) of Disability Income Policy 19845-AR, which was originally approved by your department on December 22, 1999. Reference to a "Pre-Existing Condition Waiver" was later added to the schedule as part of a filing approved by your department on July 10, 2006, under SERFF Tracking No. USPH-6RCRS7649.

Application 192051-1109 will replace Application 192051, which was approved by your department on February 27,

SERFF Tracking Number: CMBD-126531839 State: Arkansas
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 2003 under SERFF Tracking No. USPH-5K4JDM816.

The replacement forms are identical to the previously approved versions except we have modified the Extended Benefit for Total Disability section, by adding three distinct categories for the monthly benefit. These changes allow us to separately identify the benefit amount and premium for Off-the-job Injuries, On-the-job Injuries, and Sicknesses, as shown in Rate Sheet 5406, which was approved by your department on December 14, 1999. We have also modified the agent's statement at the bottom of page 1 of the application, to clarify whether or not the agent is aware of the proposed insured's intent to replace existing insurance. The changes are identified on the highlighted versions attached to the supporting documentation tab. Also included in the supporting documentation tab are a Variability Memorandum, as well as the required Certification of Compliance and Readability Certification.

Thank you for your consideration of this filing submission. If you have any questions or concerns, please feel free to contact me.

Company and Contact

Filing Contact Information

Anita Sibley, Policy Analyst Anita.Sibley@combined.com
 1000 N Milwaukee Avenue 847-953-1526 [Phone]
 6th Floor 847-953-1557 [FAX]
 Glenview, IL 60025

Filing Company Information

Combined Insurance Company of America CoCode: 62146 State of Domicile: Illinois
 1000 Milwaukee Avenue Group Code: 626 Company Type:
 Glenview, IL 60025 Group Name: State ID Number:
 (847) 953-1531 ext. [Phone] FEIN Number: 36-2136262

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 x 2 forms = \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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SERFF Tracking Number: CMBD-126531839 State: Arkansas
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Combined Insurance Company of America \$100.00 03/19/2010 35023162

SERFF Tracking Number: CMBD-126531839 State: Arkansas
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TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/31/2010	03/31/2010

SERFF Tracking Number: CMBD-126531839 *State:* Arkansas
Filing Company: Combined Insurance Company of America *State Tracking Number:* 45219
Company Tracking Number: 19845-AR-1109
TOI: H111 Individual Health - Disability Income *Sub-TOI:* H111.004 Other
Product Name: Disability Income
Project Name/Number: 19845-AR-1109/19845-AR-1109

Disposition

Disposition Date: 03/31/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CMBD-126531839 State: Arkansas
 Filing Company: Combined Insurance Company of America State Tracking Number: 45219
 Company Tracking Number: 19845-AR-1109
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income
 Project Name/Number: 19845-AR-1109/19845-AR-1109

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Highlighted Copies	Approved-Closed	Yes
Supporting Document	Variability Memorandum	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Schedule Page	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

SERFF Tracking Number: CMBD-126531839 State: Arkansas
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 Product Name: Disability Income
 Project Name/Number: 19845-AR-1109/19845-AR-1109

Form Schedule

Lead Form Number: 19845-AR-310

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/31/2010	19845-AR-1109	Schedule Pages	Schedule Page	Initial			19845-AR-1109.pdf
Approved-Closed 03/31/2010	192051-1109	Application/Enrollment Form	Application	Initial		40.100	192051-1109-2.pdf

SCHEDULE

FORM
NUMBER

19845-AR

MONTHLY BENEFIT AMOUNT

Off-the-job accident	[\$]	[\$]
On-the-job accident	[\$]	[\$]
Sickness	[\$]	[\$]

Premium

ELIMINATION PERIOD

Accident	[] days
Sickness	[] days

MAXIMUM BENEFIT PERIOD [] months

19433

**EXTENDED BENEFIT FOR
TOTAL DISABILITY**

BENEFIT AMOUNT/MONTH

Off-the- job accident	\$	\$
On-the-job accident	\$	\$
Sickness	\$	\$

EXTENDED BENEFIT PERIOD [] months

[194047

PRE-EXISTING CONDITION WAIVER]

TOTAL ANNUAL PREMIUM:

RENEWAL PREMIUM: ANNUAL SEMI-ANNUAL MONTHLY APC [PAYROLL PERIOD]

INSURED:

AGE:

POLICY NO:

OCCUPATIONAL CLASS:

ISSUE DATE:

SCHEDULE EFFECTIVE DATE:

Application for Disability Income Insurance Coverage

[FORM #19845]

I am applying for this coverage based on the following health and employment information:

Application Date: / /

EMPLOYEE'S (Proposed Insured) NAME (First MI Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age	State of Birth
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)					Home Phone No.
[Social Security No.]	EMPLOYER	Hire Date: Mo/Day/Yr		Employee ID#	Gross Annual Income
Occupation	BUSINESS OF EMPLOYER			Height ft. in.	Weight lbs.
Please describe your job duties:				Occupation Class	Industry Code

AMOUNT OF INSURANCE BEING APPLIED FOR:		PREMIUM – Mode	
[Off-the-job accident per month]	[On-the-job accident per month]		
[Sickness per month]			
Maximum Benefit Period (months) [3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/>			
Elimination Period (days, A/S) [0/7 <input type="checkbox"/> 7/7 <input type="checkbox"/> 14/14 <input type="checkbox"/> 30/30 <input type="checkbox"/> 90/90 <input type="checkbox"/> 180/180 <input type="checkbox"/>			
Extended Benefits Rider [Yes <input type="checkbox"/> No <input type="checkbox"/> Extended Benefit Period (months) [12 <input type="checkbox"/> 48 <input type="checkbox"/> Amount of Insurance [Off-the-job accident per month] [On-the-job accident per month] [Sickness per month]		Total:	

1. Are you employed in your primary occupation for less than 30 hours each week? Yes No

Answer questions 2, 3, and 4 if applying on a Non-Guaranteed issue basis.

2. Have you been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. Have you missed more than 5 consecutive days of work due to accident or sickness during the past 6 months? (if yes, also answer questions 6 and 7)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
4. Have you received treatment in an outpatient or emergency facility or been hospitalized during the past 12 months? (if yes, also answer questions 6 and 7)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
5. Do you have any existing disability coverage? No <input type="checkbox"/> Yes <input type="checkbox"/> (fill in below)	Monthly Benefit	Elimination Period	Benefit Period
Carrier			

Answer questions 6 and 7 if your existing coverage plus what you are applying for exceeds 40% of your gross monthly earnings, or if "Yes" is answered to questions 3 or 4.

6. Have you been convicted of reckless driving or driving under the influence of alcohol or drugs in the last 5 years? Driver's License No. & State _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you had any advice, treatment or taken any prescription medication for any heart condition, cancer, stroke, or any other sickness, injury, or defect, excluding flu, colds, or routine physicals in the last 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>

(If "Yes" is answered to question 7, explain on Page 2. In any case, please provide information on your physician.)

Will the policy applied for replace or cause the change of any existing Disability Insurance contract? Yes No

It is very important that you review the application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent if any information is not correct or not complete or if any medical history has not been included. **I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.**

In applying for this coverage, I represent and affirm the following:

- The information which I have given as recorded on this Application is true and complete to the best of my knowledge and belief.
- I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, and Notice of Information Practices.
- I acknowledge receipt of the Outline of Coverage.
- I will only receive the benefit(s) selected on this application.

X _____ City: _____ State: _____ Date: ____/____/____
Signature of Proposed Insured

I, the authorized agent, have on the Date of Application recorded the information as given to me by the Proposed Insured. To the best of my knowledge and belief the policy will - will not replace any existing insurance. I have delivered the Notice of Information Practices. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent _____ Code # _____

**PLEASE READ CAREFULLY
HEALTH & MEDICATIONS INFORMATION**

Health Condition & Medication	Date	Surgery?	Receiving Treatment?	Physician's Name and Address (street, city, state)

CONFIDENTIALITY OF MEDICAL INFORMATION

The information disclosed on this application will not be disclosed to the employer or any other person without the authorization of the applicant.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), Bureau of Motor Vehicles, or consumer reporting agency to release to Combined Insurance Company of America any information regarding me for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available upon request to the Company.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

X _____ City: _____ State: _____ Date: ____ / ____ / ____
Signature of Proposed Insured

Proposed Insured's Name _____ Social Security # _____
(Print)

SERFF Tracking Number: CMBD-126531839 State: Arkansas
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 Company Tracking Number: 19845-AR-1109
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income
 Project Name/Number: 19845-AR-1109/19845-AR-1109

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	03/31/2010
Comments:		
Attachments:		
Certification of Compliance.pdf		
192051-1109-Readability.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	03/31/2010
Bypass Reason: The new application for policy 19845-AR is included in the forms schedule.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	03/31/2010
Bypass Reason: This is a forms only filing that does not affect the existing rates or actuarial memorandum, which were approved by the Arkansas Insurance Department on December 22, 1999 (Rate Sheet 5407 for Policy 19845-AR) and December 14, 1999 (Rate Sheet 5406 for Rider 19433).		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	03/31/2010
Bypass Reason: The new schedule page and application do not affect the Outline of Coverage (form no. 019845), which was approved by the Arkansas Insurance Department on December 22, 1999.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Highlighted Copies	Approved-Closed	03/31/2010

SERFF Tracking Number: CMBD-126531839 State: Arkansas
 Filing Company: Combined Insurance Company of America State Tracking Number: 45219
 Company Tracking Number: 19845-AR-1109
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Disability Income
 Project Name/Number: 19845-AR-1109/19845-AR-1109

Comments:

Attachments:

19845-AR-1109-highlighted.pdf
 192051-1109-2-highlighted.pdf

		Item Status:	Status
			Date:
Satisfied - Item:	Variability Memorandum	Approved-Closed	03/31/2010
Comments:			
Attachment:			
	VariableMemo.pdf		

		Item Status:	Status
			Date:
Satisfied - Item:	Cover Letter	Approved-Closed	03/31/2010
Comments:			
Attachment:			
	19845-1109-CvrLtr.pdf		

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Combined Insurance Company of America

Form Number(s): 19845-AR-1109 - Insert Page (Page 3) for Disability Income Policy
192051-1109 - Application for Disability Income Insurance

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

Michael J. Hollar

Signature of Company Officer

Michael J. Hollar

Name

Assistant Secretary

Title

March 18, 2010

Date



March 19, 2010

READABILITY CERTIFICATION

RE: Form No. 192051-1109 – Application for Disability Income Insurance

We hereby certify that Form No. 192051-1109 has a Flesch Index Score of 40.1, and that it meets the reading ease requirements.

A handwritten signature in black ink that reads "Michael J. Hollar".

Michael J. Hollar
Assistant Secretary

SCHEDULE

FORM
NUMBER

19845-AR

MONTHLY BENEFIT AMOUNT

Off-the-job accident	[\$]	[\$]
On-the-job accident	[\$]	[\$]
Sickness	[\$]	[\$]

Premium

ELIMINATION PERIOD

Accident	[] days
Sickness	[] days

MAXIMUM BENEFIT PERIOD

[] months

19433

**EXTENDED BENEFIT FOR
TOTAL DISABILITY**

BENEFIT AMOUNT/MONTH

Off-the-job accident	\$	\$
On-the-job accident	\$	\$
Sickness	\$	\$

EXTENDED BENEFIT PERIOD

[] months

[194047

PRE-EXISTING CONDITION WAIVER]

TOTAL ANNUAL PREMIUM:

RENEWAL PREMIUM: ANNUAL SEMI-ANNUAL MONTHLY APC [PAYROLL PERIOD]

INSURED:

AGE:

POLICY NO:

OCCUPATIONAL CLASS:

ISSUE DATE:

SCHEDULE EFFECTIVE DATE:

Application for Disability Income Insurance Coverage

[FORM #19845]

I am applying for this coverage based on the following health and employment information:

Application Date: / /

EMPLOYEE'S (Proposed Insured) NAME (First MI Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age	State of Birth
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)					Home Phone No.
[Social Security No.]	EMPLOYER	Hire Date: Mo/Day/Yr		Employee ID#	Gross Annual Income
Occupation	BUSINESS OF EMPLOYER			Height ft. in.	Weight lbs.
Please describe your job duties:				Occupation Class	Industry Code

AMOUNT OF INSURANCE BEING APPLIED FOR:		PREMIUM – Mode
[Off-the-job accident per month]		
[On-the-job accident per month]		
[Sickness per month]		
Maximum Benefit Period (months) [3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/>		
Elimination Period (days, A/S) [0/7 <input type="checkbox"/> 7/7 <input type="checkbox"/> 14/14 <input type="checkbox"/> 30/30 <input type="checkbox"/> 90/90 <input type="checkbox"/> 180/180 <input type="checkbox"/>		
Extended Benefits Rider [Yes <input type="checkbox"/> No <input type="checkbox"/>		
Extended Benefit Period (months) [12 <input type="checkbox"/> 48 <input type="checkbox"/>		
Amount of Insurance		
[Off-the-job accident per month]		
[On-the-job accident per month]		
[Sickness per month]		
		Total:

1. Are you employed in your primary occupation for less than 30 hours each week? Yes No

Answer questions 2, 3, and 4 if applying on a Non-Guaranteed issue basis.

2. Have you been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. Have you missed more than 5 consecutive days of work due to accident or sickness during the past 6 months? (if yes, also answer questions 6 and 7)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
4. Have you received treatment in an outpatient or emergency facility or been hospitalized during the past 12 months? (if yes, also answer questions 6 and 7)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
5. Do you have any existing disability coverage? No <input type="checkbox"/> Yes <input type="checkbox"/> (fill in below)	Monthly Benefit	Elimination Period	Benefit Period
Carrier			

Answer questions 6 and 7 if your existing coverage plus what you are applying for exceeds 40% of your gross monthly earnings, or if "Yes" is answered to questions 3 or 4.

6. Have you been convicted of reckless driving or driving under the influence of alcohol or drugs in the last 5 years? Driver's License No. & State _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you had any advice, treatment or taken any prescription medication for any heart condition, cancer, stroke, or any other sickness, injury, or defect, excluding flu, colds, or routine physicals in the last 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>

(If "Yes" is answered to question 7, explain on Page 2. In any case, please provide information on your physician.)

Will the policy applied for replace or cause the change of any existing Disability Insurance contract? Yes No

It is very important that you review the application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent if any information is not correct or not complete or if any medical history has not been included. **I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.**

In applying for this coverage, I represent and affirm the following:

- The information which I have given as recorded on this Application is true and complete to the best of my knowledge and belief.
- I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, and Notice of Information Practices.
- I acknowledge receipt of the Outline of Coverage.
- I will only receive the benefit(s) selected on this application.

X _____ City: _____ State: _____ Date: ____/____/____
Signature of Proposed Insured

I, the authorized agent, have on the Date of Application recorded the information as given to me by the Proposed Insured. To the best of my knowledge and belief the policy will - will not replace any existing insurance. I have delivered the Notice of Information Practices. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent _____ Code # _____

**PLEASE READ CAREFULLY
HEALTH & MEDICATIONS INFORMATION**

Health Condition & Medication	Date	Surgery?	Receiving Treatment?	Physician's Name and Address (street, city, state)

CONFIDENTIALITY OF MEDICAL INFORMATION

The information disclosed on this application will not be disclosed to the employer or any other person without the authorization of the applicant.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), Bureau of Motor Vehicles, or consumer reporting agency to release to Combined Insurance Company of America any information regarding me for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available upon request to the Company.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

X _____ City: _____ State: _____ Date: ____ / ____ / ____
Signature of Proposed Insured

Proposed Insured's Name _____ Social Security # _____
(Print)



March 19, 2010

Variability Memorandum

**Variability List for Insert Page 19845-AR-1109
(For use with policy 19845-AR)**

Variable	Options
Base Policy Benefits/Amount(s) Base Policy Elimination Period Base Policy Maximum Benefit Period	\$100 to \$50,000/month (each benefit) 0 (accident only, 7, 14, 30, 90, 180 days) 3, 6, 12 months
Extended Benefit Rider section Extended Benefit Rider Benefits/Amount(s) Extended Benefit Rider Maximum Benefit Period	All inclusive – Remove if Rider not offered or applied for \$100 to \$50,000/month (each benefit) 12, 48 month
Pre-Existing Condition Waiver	All-inclusive – Remove if Pre-Existing Condition Waiver not issued
Premium Modes	Bracketed to allow us the flexibility to remove one or more premium modes if not available. Payroll Period may be specified as Weekly, Bi-Weekly, Semi-Monthly, Monthly
Page Number	Computer Generated – to allow for repositioning due to change in font. Will always be 10-point type and 1 point leaded.

Variability List for Application 192051-1109

Variable	Options
Home Office Address	Bracketed to address any future change in address
Form Number	Bracketed to allow for a future change in the form number
Social Security Number	May be deleted if we decide not to use this field
Base Policy Benefits/Amount(s) Base Policy Maximum Benefit Period Base Policy Elimination Period	\$100 to \$50,000/month (each benefit) 3, 6, 12 months 0 (accident only, 7, 14, 30, 90, 180 days)
Extended Benefit Rider section Extended Benefit Rider Benefits/Amount(s) Extended Benefit Rider Maximum Benefit Period	All inclusive – Remove if Rider not offered or applied for \$100 to \$50,000/month (each benefit) 12, 48 months

Anita Sibley, ACS, AIRC – Policy Analyst – Policy Filings/Government Relations
Toll Free to Product Filings: 888-449-3623 Direct: 847-953-1526 Fax: 847-953-1557 E-Mail: anita.sibley@combined.com



VIA SERFF

March 19, 2010

Honorable Jay Bradford
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: **Combined Insurance Company of America**
SERFF Tracking Number CMBD-126531839
FEIN Number 3602136262 NAIC Number 626-62146
Form No.: 19845-AR-1109 -- Insert Page (Page 3) for Disability Income Policy 19845-AR
192051-1109 -- Application for Disability Income Insurance
Individual Disability Income Insurance

Dear Commissioner Bradley:

Attached for your review and approval are the above-referenced forms. This is a new filing, related to our Individual Disability Income Policy, which is sold to persons 18 to 63 and is guaranteed renewable to age 65, and thereafter at our option, to age 70.

Insert Page 19845-AR-1109 will replace the policy schedule page (page 3) of Disability Income Policy 19845-AR, which was originally approved by your department on December 22, 1999. Reference to a "Pre-Existing Condition Waiver" was later added to the schedule as part of a filing approved by your department on July 10, 2006, under SERFF Tracking No. USPH-6RCRS7649.

Application 192051-1109 will replace Application 192051, which was approved by your department on February 27, 2003 under SERFF Tracking No. USPH-5K4JDM816.

The replacement forms are identical to the previously approved versions except we have modified the Extended Benefit for Total Disability section, by adding three distinct categories for the monthly benefit. These changes allow us to separately identify the benefit amount and premium for Off-the-job Injuries, On-the-job Injuries, and Sicknesses, as shown in Rate Sheet 5406, which was approved by your department on December 14, 1999. We have also modified the agent's statement at the bottom of page 1 of the application, to clarify whether or not the agent is aware of the proposed insured's intent to replace existing insurance. The changes are identified on the highlighted versions attached to the supporting documentation tab. Also included in the supporting documentation tab are a Variability Memorandum, as well as the required Certification of Compliance and Readability Certification.

Thank you for your consideration of this filing submission. If you have any questions or concerns, please feel free to contact me.

Sincerely,

Anita Sibley
Policy Analyst

Anita Sibley, ACS, AIRC – Policy Analyst – Policy Filings/Government Relations
Toll Free to Product Filings: 888-449-3623 Direct: 847-953-1526 Fax: 847-953-1557 E-Mail: anita.sibley@combined.com