

SERFF Tracking Number: AFLA-126735564 State: Arkansas  
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 46297  
Company Tracking Number: A35PAPPBAR  
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only  
Product Name: Accident Only - Application Forms  
Project Name/Number: /

## Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Accident Only - Application Forms SERFF Tr Num: AFLA-126735564 State: Arkansas

TOI: H02I Individual Health - Accident Only SERFF Status: Closed-Approved-Closed State Tr Num: 46297

Sub-TOI: H02I.000 Health - Accident Only Co Tr Num: A35PAPPBAR State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Disposition Date: 08/06/2010

Authors: Connie Gates, Otis  
Robinson, Eve Black, Bridget  
Berryman

Date Submitted: 07/22/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/06/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/06/2010

Created By: Bridget Berryman

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Bridget Berryman

Filing Description:

Re: Application Form A35PAPPBAR and Signature Form AsignpAR

The above referenced forms are submitted for your review and approval.

Application Form A35PAPPBAR is a payroll application and will be used to make application for Accident-Only Policy

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Forms A35B24AR, A35100AR and A35200AR, and Off-the-Job Accident-Only Policy Forms A35BOFAR, A35300AR and A35400AR, all of which were previously approved by your department on January 30, 2009. Brackets have been included around the company name and address, and coverage selection under the CHECK COVERAGE DESIRED text box in the event these change in the future.

Signature Form AssignAR will be used to collect the applicant's and agent's signature, in conjunction with Application Form A35PAPPBAR noted above. Form AssignAR will also be used with application and signature forms previously approved for use with the Accident-Only Policy Form Series A35000 as noted above, as well as Aflac's Short-Term Disability Policy Form Series A57500, Lump Sum Critical Illness Policy Form Series A72100 and Lump Sum Cancer Policy Form Series A72200, all of which were previously approved by your department on February 2, 2009.

Form AssignAR does not contain the agent's certification statement, as it will be used in situations where the associate/agent is unable to be present at the time of application. Brackets have been included around the company address, telephone number and website address, as well as around the listing of products, in the event this information changes in the future.

When the final application prints and is attached to the policy at the time of issue, the application form and signature page will be combined to reflect a complete application.

This submission will not affect the premium rates currently on file with your department.

Certifications addressing Rule & Regulation 19 and 49, as well as the standards for minimum reading ease, have been noted under the Supporting Documentation schedule tab.

The appropriate filing fee is being submitted via EFT.

## Company and Contact

### Filing Contact Information

Bridget Berryman, Policy Analyst                      bberryman@aflac.com  
1932 Wynnton Road                                      706-660-7132 [Phone]  
Columbus, GA 31999                                    706-660-7080 [FAX]

### Filing Company Information

American Family Life Assurance Company of      CoCode: 60380                                      State of Domicile: Nebraska

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**Columbus**

1932 Wynnton Road  
Columbus, GA 31999  
(706) 323-3431 ext. [Phone]

Group Code:  
Group Name:  
FEIN Number: 58-0663085

Company Type: Life and Health  
State ID Number:

**Filing Fees**

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? No  
Fee Explanation: Two application forms at \$50.00 = \$100.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	\$100.00	07/22/2010	38224670

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/06/2010	08/06/2010

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## Disposition

Disposition Date: 08/06/2010

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
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Payroll Application	Approved-Closed	Yes
Form	Signature Application	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: A35PAPPBAR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/06/2010	A35PAPPBAR	Application/ Payroll Application Enrollment Form	Application/ Payroll Application Enrollment Form	Initial		70.074	A35PAPPBAR.pdf
Approved-Closed 08/06/2010	AsignpAR	Application/ Signature Application Enrollment Form	Application/ Signature Application Enrollment Form	Initial		80.996	AsignpAR.pdf



01 28-Day Biweekly     12 Annual

**PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.**

Employee No. \_\_\_\_\_ Dept. No. \_\_\_\_\_ Assoc./Agent No. \_\_\_\_\_

Billable Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_ Sit. Code \_\_\_\_\_

**CHECK COVERAGE DESIRED:**  Individual  Two-Parent Family  
 One-Parent Family  Named Insured/Spouse Only

Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E			
<b>SELECT ONLY ONE POLICY SERIES</b>		<b>Premium</b>	
<b>24-Hour Accident</b>			
<input type="checkbox"/> Accident Essentials Policy Series A35B24			<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Plan 1 Accident Policy Series A35100			
<input type="checkbox"/> Plan 2 Accident Policy Series A35200			
<b>Off-the-Job Accident ONLY</b>			
<input type="checkbox"/> Off-the-Job Accident Essentials Policy Series A35BOF			
<input type="checkbox"/> Plan 1 Off-the-Job Accident Policy Series A35300			
<input type="checkbox"/> Plan 2 Off-the-Job Accident Policy Series A35400			
	<b>Total Premium]</b>		

**BENEFICIARY INFORMATION**

**PLEASE NOTE: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.**

**PRIMARY BENEFICIARY**

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

**CONTINGENT BENEFICIARY**

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

**APPLICANT'S STATEMENTS AND AGREEMENTS**

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I acknowledge receipt of, if applicable:
  - Replacement Notice
  - Outline of Coverage
  - Guide to Health Insurance for People With Medicare*
  - Fair Credit Reporting Notice
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy.

#### **NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

#### **AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- \* hospitalization
- \* physician services
- \* hospice
- \* outpatient prescription drugs if you are enrolled in Medicare Part D
- \* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- \* Check the coverage in **all** health insurance policies you already have.
- \* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, available from the insurance company.
- \* For help in understanding your health insurance, contact your state insurance department (website = [www.accessarkansas.org/insurance](http://www.accessarkansas.org/insurance)) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

American Family Life Assurance Company of Columbus (Aflac)  
[Worldwide Headquarters: Columbus, Georgia 31999]

[I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac for the following insurance policy(ies).

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Lump Sum Critical Illness | <input type="checkbox"/> Dental                 | <input type="checkbox"/> Vision                   |
| <input type="checkbox"/> Lump Sum Cancer           | <input type="checkbox"/> Hospital Confinement   | <input type="checkbox"/> Specified Disease/Cancer |
| <input type="checkbox"/> Short Term Disability     | <input type="checkbox"/> Specified Health Event | <input type="checkbox"/> Hospital Intensive Care  |
| <input type="checkbox"/> Accident]                 |   |   |

I would prefer to receive an electronic copy of my policy(ies) instead of paper.  Yes  No

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.

Signed and Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Date

Proposed Insured's/Employee's Signature \_\_\_\_\_

Associate's/Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Licensed Resident Associate/Agent

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.  
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),  
CLIENT SERVICES AND ADMINISTRATION,  
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]  
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).  
VISIT OUR WEB SITE AT AFLAC.COM.]**

Writing Associate/Agent: Please complete the following – it will become part of the policy.

Associate/Agent's Name \_\_\_\_\_

Associate/Agent's Address \_\_\_\_\_ Telephone \_\_\_\_\_

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:  
**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION  
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR  
TOLL-FREE 1-800-852-5494.**

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## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	08/06/2010
<b>Comments:</b>			
We certify that this filing meets the standards of Rule and Regulation 19, as well as Rule & Regulation 49 (Guaranty Association Notice Form A14640R is attached here for your information). The Flesch score meets minimum standards and have been noted on the form schedule. The Consumer Information Notice for this product is included on the policy and application, and is not affected by this filing.			
<b>Attachment:</b>			
A14640R.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	08/06/2010
<b>Comments:</b>			
Forms are included under the Form Schedule tab.			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	08/06/2010
<b>Bypass Reason:</b>	This filing consists only of application form components to be used with a previously approved policy form, the rates for which are not being impacted.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	08/06/2010
<b>Bypass Reason:</b>	This filing consists only of application form components to be used with a previously approved policy form.		
<b>Comments:</b>			

## LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

### DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life and variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
C/O The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

### COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000—no matter how many policies or contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values—again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which these benefits could be provided out of the assets of the impaired or insolvent insurer.