

SERFF Tracking Number: CAIC-126804344 State: Arkansas
Filing Company: Continental American Insurance Company State Tracking Number: 46735
Company Tracking Number: 7971
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Dependent Dental Rider & Revised App AR
Project Name/Number: Dependent Dental Rider & Revised App AR/7971

Filing at a Glance

Company: Continental American Insurance Company

Product Name: Dependent Dental Rider & Revised App AR SERFF Tr Num: CAIC-126804344 State: Arkansas

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Status: Closed-Approved-Closed
State Tr Num: 46735

Co Tr Num: 7971

Author: Cindy Lama

Date Submitted: 09/08/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 09/16/2010

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Dependent Dental Rider & Revised App AR

Project Number: 7971

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/16/2010

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 09/02/2010

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Group Market Type: Employer, Other

Explanation for Other Group Market Type:
Union

State Status Changed: 09/16/2010

Created By: Cindy Lama

Corresponding Filing Tracking Number: 7971

Deemer Date:

Submitted By: Cindy Lama

Filing Description:

Please see Cover Letter under Supporting Docs tab.

Company and Contact

Filing Contact Information

Cindy Lama, Compliance Analyst

2801 Devine Street

companycompliance@caicworksite.com

888-730-2244 [Phone] 4333 [Ext]

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 Columbia, SC 29205 803-929-4992 [FAX]

Filing Company Information

Continental American Insurance Company CoCode: 71730 State of Domicile: South Carolina
 2801 Devine Street Group Code: Company Type: LAH
 Columbia, SC 29205 Group Name: Continental Amer Ins State ID Number:
 Co
 (803) 256-6265 ext. [Phone] FEIN Number: 57-0514130

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation:
 Filing or review of life and health policy/contracts, endorsements, certificate, riders, applications
 or annuity forms, per form...\$50.00.
 2 forms x \$50 = \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	\$100.00	09/08/2010	39310093

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/16/2010	09/16/2010

SERFF Tracking Number: CAIC-126804344 *State:* Arkansas
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Disposition

Disposition Date: 09/16/2010

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	Cover Letter	Approved-Closed	Yes
Form	Dependent Children Rider	Approved-Closed	Yes
Form	Dental Enrollment Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CAI1121AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/16/2010	CAI1121AR	Certificate	Dependent Children Amendmen Rider t, Insert Page, Endorseme nt or Rider	Initial		40.000	CAI1121AR Dental Dependent Age 26 Rider.pdf
Approved-Closed 09/16/2010	CAI1113	Application/Enrollment Form	Dental Enrollment Application	Revised	Replaced Form #: CAI1111 Previous Filing #: CAIC-126627201	40.000	CAI1113 App.pdf



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

DEPENDENT CHILDREN RIDER

This rider is a part of the document to which it is attached. Unless amended by this rider Policy, and Certificate Definitions, Exclusions and Limitations, other term and provisions apply to this rider.

The definition of Dependent Children and Type of Coverage are deleted and replaced by the following:

Dependent Children: an employee's natural children, stepchildren, or legally adopted children who are under age 26. Coverage of a Dependent Child will terminate on the child's 26th birthday. Coverage provided under any One-Parent or Two-Parent Family coverage will include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 26 and while covered under this Plan. An employee must furnish proof of such incapacity and dependency to us. An employee must furnish proof of continued incapacity and dependency at our request, but not more often than annually, after the two-year period following the Dependent Child's 26th birthday.

Type of Coverage

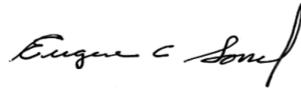
1. **Employee:** coverage for only the employee, the Insured listed in the Certificate Schedule.
2. **Employee/Spouse:** coverage for only the employee (the Insured) and his spouse. "Spouse" is defined as the person to whom an employee is legally married and who is listed on his application.
3. **Employee and Children:** coverage for an employee (the Insured) and all of his Dependent Children.
4. **Family:** coverage for an employee (the Insured), his spouse, and all of his Dependent Children (or those of his spouse).

Persons covered under Employee, Employee/Spouse, Employee and Children, or Family coverage are referred to as "Insureds." Newborn children are automatically covered under the terms of the Plan from the moment of birth. Adopted children are covered from the date of petition. If Employee or Employee/Spouse coverage is in force and an employee desires uninterrupted coverage for a newborn or adopted child, he must notify us in writing within 90 days of the child's birth or within 60 days from the date the petition is filed for adoption of a child. Coverage for newborn will be in effect through the 90th day. Coverage for adopted children will be in effect through the 60th day following the date of such event. Upon notification, we will convert his certificate to Employee and Children or Family coverage and advise him of the additional premium due. If Employee and Children or Family coverage is in force, it is not necessary for an employee to notify us of the birth of a child or the date the petition is filed for adoption of a child, and an additional premium payment will not be required.

The insurance on any Dependent Child will terminate on the Dependent Child's 26th birthday. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under the Plan. When coverage on all Dependent Children terminates, the employee must notify us, in writing, and elect whether to continue his certificate on an Employee or Employee/Spouse basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium. Coverage provided under any Employee and Children or Family certificate will include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 26 and while covered under the employee's certificate. The employee must furnish proof of such incapacity and dependency to us. He must furnish proof of continued incapacity and dependency at our request, but not more often than annually after the two-year period following the Dependent Child's 26th birthday.

This rider is subject to all of the terms of the document to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed by the Company at its Home Office.

A handwritten signature in cursive script, appearing to read "Eugene C. Smith".

President



ENROLLMENT FORM
Please Mail: Post Office Box 427
Columbia, South Carolina 29202
(800) 433-3036

FOR HOME OFFICE USE ONLY		
<i>PLAN</i>	<i>PLAN CODE</i>	<i>ID NUMBER</i>
<i>Dental</i>		
Endorsement:		
EFFECTIVE DATE:		

Employee Name (First, MI, Last)		S.S.N./ ID Number		Gender	Date of Birth
Street Address		City		State	Zip
Employer		Job Class	Location		Date of Hire
Hours Worked	Daytime Phone No. ()	E-mail Address			
Spouse's Name (First, MI, Last) (if coverage is requested)			Spouse's S.S.N.	Gender	Spouse Date of Birth

Applicant - Are you actively at work? YES NO

List all eligible children for whom you are proposing coverage (from Youngest to Oldest):

Name & S.S.N.	Gender	Date of Birth	Name & S.S.N.	Gender	Date of Birth

DENTAL Employee Employee/Spouse Employee & Children Family [Section 125: YES NO]
 Level 1 Plan \$25 Dental Wellness] Level 2 Plan \$50 Dental Wellness] Level 3 Plan \$50 Dental Wellness]
 Orthodontic Benefit Rider] Cosmetic Benefit Rider - Not available with 125 Plans]

Cost Per Pay Period [Including any Riders] _____

1. I understand that the dental plan I am applying for will not cover any person who has attained age 71 before the Effective Date of my certificate.
2. I understand that the dental plan I am applying for contains different Waiting Periods for benefits listed in the Schedule of Dental Procedures. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the Effective Date of my certificate.
3. I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.

To the best of my knowledge and belief, the statements and answers I have provided on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace or change any existing dental insurance? YES NO
- If "Yes," provide carrier, policy number and effective date : _____

CERTIFICATION: I have read the completed application, and I realize any false statement or misrepresentation on the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved.

I understand that coverage will not become effective unless I am actively at work on the date of the enrollment and the effective date of coverage.

I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance. Deduction start date _____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ Agent # _____ State of Enrollment _____

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Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments:</p> <p>Attachments: Readability Certification.pdf AR Life and Health Insurance Guaranty Association Notice.pdf</p>	Approved-Closed	09/16/2010

	Item Status:	Status Date:
<p>Satisfied - Item: Application</p> <p>Comments: The application is attached under the Form Schedule.</p>	Approved-Closed	09/16/2010

	Item Status:	Status Date:
<p>Satisfied - Item: Cover Letter</p> <p>Comments:</p> <p>Attachment: Cover Letter AR.pdf</p>	Approved-Closed	09/16/2010



READABILITY CERTIFICATION

I, James J. Hennessy, hereby certify that the following form has the following readability score as calculated by the Flesch Reading Ease Test:

CAI1121AR	40
CAI1113	40

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance
Continental American Insurance Company

September 8, 2010

Date

**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 or 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.



September 8, 2010
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201-1904

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130

Line of Insurance:

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Proposed Effective Date: On Approval

Domicile State Approval: SC 09/02/2010

FORM NUMBER: CAI1121AR Dependent Children Rider
CAI1113 Dental Enrollment Application

Dear Sir or Madam:

The above captioned rider and application are being filed for your review and approval. The forms will be used with our Group Dental forms, CAI1100AR, et al., recently approved by your state on 05/19/2010 with SERFF Tracking # CAIC-126627201.

The rider changes the definition of Dependent Children and Type of Insurance by deleting references to the child being unmarried and being legal dependents for tax purposes. It also changes the termination date of a covered child's insurance from the anniversary date of the employee's Certificate following the child's 26th birthday to the child's 26th birthday. These changes are also reflected in the application on statement 3. The application will replace the previously approved application, CAI1111.

Thank you for your consideration in this matter. If you have any questions please contact Cindy Lama at 1-800-433-3036, ext. 4333 or at companycompliance@caicworksites.com.

Sincerely,

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance
/clc