

SERFF Tracking Number: CNSC-126679129 State: Arkansas
 Filing Company: Conseco Insurance Company State Tracking Number: 46625
 Company Tracking Number: R1058, ET AL
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
 Product Name: CIC Accident Additional Riders
 Project Name/Number: 2010 Accident/

Filing at a Glance

Company: Conseco Insurance Company

Product Name: CIC Accident Additional Riders SERFF Tr Num: CNSC-126679129 State: Arkansas

TOI: H03I Individual Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved- Closed State Tr Num: 46625

Sub-TOI: H03I.000 Health - Accidental Death & Co Tr Num: R1058, ET AL State Status: Approved-Closed
 Dismemberment

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Beth Blackwell, David
 Dennie, Stacey Farmer, Michelle
 Garba, Janet Jones

Disposition Date: 09/02/2010

Date Submitted: 08/26/2010

Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2010 Accident

Status of Filing in Domicile: Pending

Project Number:

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: 09/02/2010

Explanation for Other Group Market Type:

State Status Changed: 09/02/2010

Deemer Date:

Created By: Stacey Farmer

Submitted By: Beth Blackwell

Corresponding Filing Tracking Number:

Filing Description:

Subject: Conseco Insurance Company

NAIC Number: 60682

Individual Accidental Death and Dismemberment Product

Forms: AP-1059 – Application

OC1022R – Outline of Coverage

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Product Name: CIC Accident Additional Riders
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R1057 –Waiver of Premium Rider
R1058 – Physician’s Office Benefit Rider
R1056ROPAR – Return of Premium Rider

The above referenced forms are being filed for use with a previously approved accidental death and dismemberment product. These forms are new and do not replace any previously filed forms.

The accidental death and dismember product was previously approved on 1/19/2007 in your state.

AP-1059 is the application. This is a simplified issue product. The applicant will be asked to provide information on the application for the type of coverage being applied for. Questions 4 through 13 are for the disability benefits and only pertain to the primary applicant. If the applicant answers “yes” to questions 5 thru 13 then disability benefits/sickness rider will not be available. Section 5 of the application is being filed as variable. This section allows for the choices of benefits as well as the payment methods. The bar code information at the top of the application is also being filed as variable. The bar code will contain the company information only and is used for internal processing. This application will be used for electronic purposes.

R1057 is an optional Waiver of Premium Rider. This rider waives the premium for a period of Total Disability.

R1058 is an optional Physician Office Benefit Rider. This rider provides additional benefits when they visit a Physician’s Office due to a Covered Accident.

R1056ROPAR is an optional Return of Premium Rider. This rider provides for a premium return benefit minus any claims incurred after a specified amount of time. This rider is exactly like the previously approved R1022ROP, except that waiver of premium language has been added in consideration of the selection of the waiver of premium optional rider.

OC1022R, is the outline of coverage for this product. This is only intended to outline the benefits available with this product.

A sample of the previously approved policy schedule is enclosed for your information. SCHEDULE-ACC, is the policy schedule page that will be used with this product. The schedule includes variable information that is populated with the applicant’s choices as selected on the application.

The actuarial memorandum and rates are included. The rates for this product have been revised. Under the previously approved product the class structure was broken into two. The class structure for the product has now been revised into

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four. The new rate structure will apply to new business issues after approval and implementation.

Licensed agents will market this product.

Any filing fees, transmittals or certifications, as required are attached.

Thank you for your time and consideration on this filing. If you have any further questions regarding this, please feel free to contact me.

Company and Contact

Filing Contact Information

Stacey Farmer, Compliance Analyst stacey_farmer@consecoco.com
 11825 N Pennsylvania St 800-888-4918 [Phone] 2954 [Ext]
 Carmel, IN 46032 317-817-2333 [FAX]

Filing Company Information

Conseco Insurance Company CoCode: 60682 State of Domicile: Illinois
 11815 N Pennsylvania St Group Code: 233 Company Type:
 Carmel, IN 46032 Group Name: State ID Number:
 (800) 888-4918 ext. [Phone] FEIN Number: 45-0103436

Filing Fees

Fee Required? Yes
 Fee Amount: \$350.00
 Retaliatory? No
 Fee Explanation: 6 X \$50 per form
 \$50 for rates
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Conseco Insurance Company	\$350.00	08/26/2010	39046672

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/02/2010	09/02/2010

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Disposition

Disposition Date: 09/02/2010

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	Application	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Policy Schedule	Approved-Closed	Yes
Form	Return of Premium Rider	Approved-Closed	Yes
Form	Waiver of Premium Rider	Approved-Closed	Yes
Form	Physicians Office Additional Benefit Rider	Approved-Closed	Yes
Rate	Actuarial Materials	Approved-Closed	No

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Form Schedule

Lead Form Number: R1058

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/02/2010	AP-1059	Application/ Enrollment Form	Application	Initial		0.000	AP-1059.pdf
Approved-Closed 09/02/2010	OC1022R	Outline of Coverage	Outline of Coverage	Initial		0.000	OC-1022R.pdf
Approved-Closed 09/02/2010	SCHEDUL E-ACC	Schedule Pages	Policy Schdule	Initial		0.000	POLICY SCHEDULE - ACC WOP.pdf
Approved-Closed 09/02/2010	R1056ROP AR	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Return of Premium Rider	Initial		0.000	R1056ROPA R.pdf
Approved-Closed 09/02/2010	R1057	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Waiver of Premium Rider	Initial		0.000	R1057.pdf
Approved-Closed	R1058	Policy/Cont ract/Fratern	Physicians Office Additional Benefit	Initial		50.000	R1058.pdf

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09/02/2010 al Rider
Certificate:
Amendment,
Insert
Page,
Endorsement
or Rider

[BAR CODE]

Application to: **Conseco Insurance Company**

[11825 N. Pennsylvania St., Carmel, Indiana 46032]

SECTION I	Accident Insurance Application
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Is this a reinstatement? Yes No Is this an upgrade of existing coverage? Yes No
Is this a guaranteed conversion? Yes No
If "Yes" to any of the above, provide existing policy number: _____
Requested Effective Date: _____

SECTION II	Applicant Information
-------------------	------------------------------

[Please Print Primary Applicant's Name (First, Middle Initial, Last)]				
(Applicant) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yy)	Age	Social Security Number	(Area Code) Phone Number
Spouse's Name (If applying for Spouse Insurance) (First, Middle Initial, Last)				(Spouse) <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yy)	Age	Social Security Number	If applying for Child(ren) Insurance, complete Section VI.	
Applicant's Street Address				
City		State	Zip Code	
E-mail Address:				
Beneficiary's Full Name			Relationship to Primary Applicant:]	

SECTION III	Employer Information
--------------------	-----------------------------

[Employer's Name:		
Occupation: _____	Length of time employed by this employer: _____ Years _____ Months	Job Class (circle one) 1 2 3 4]
Hours per week worked at this job _____		

SECTION IV

Health Questions

Do not complete this section if you are applying through a guaranteed conversion.

Please answer the questions below for the type of insurance being applied for:

For All Insurance Applied For:

1. Will this insurance replace any accident and sickness insurance currently in force with us or another company for any person to be insured?
If "Yes," please complete the "Notice to Applicant" form.
2. Do you own any other accident, hospital indemnity and/or disability insurance which is not being ended (not including Worker's Compensation)?
If "Yes", complete the appropriate information below.

Yes No

Yes No

Other Accident and Sickness Insurance (Please Print and fill out completely.)

Name of Company	Type of Insurance	Monthly Benefit Amount(s)

Check here if additional space is needed and attach separate sheet.

3. Within the past 5 years, have you or any person applying for coverage been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol?
If "Yes", the named individual(s) is not eligible for coverage. Please list individual(s) name: _____

Yes No

For Disability Coverage (Only available for Primary Applicant).

4. Provide your gross monthly income from your employer as listed in Section III, Employer Information. Gross monthly income for the purposes of this application is your regular income excluding overtime, bonuses, and any incentives.

\$ _____

If the answer to any question 5 through 8 is "Yes", you are not eligible for the disability coverage.

5. Are you covered under any other disability income insurance which is not ending and when combined with this application for insurance will exceed 66 2/3% of your monthly gross income (pre-tax)? Please include only disability income coverage with an elimination period/waiting period of 30 days or less.
6. Are there any material or substantial job duties you are currently unable to perform due to sickness, maternity or injury?
7. In the past 12 months have you been off work for 10 or more consecutive workdays due to illness or injury (other than for normal pregnancy)?
8. In the past 6 months, have you taken prescribed medication for the treatment of an injury, disease or disorder of the back, neck or joints?

Yes No

Yes No

Yes No

Yes No

For Sickness Disability Rider (Only available for Primary Applicant). If the answer to any question 10 through 13 is "Yes", you are not eligible for the Sickness Disability Rider.

9. What is your height and weight?

Height _____

Weight _____

10. Have you ever been treated for or diagnosed by a physician as having any of the following conditions?

Yes No

- | | |
|----------------------------|--|
| Alzheimer's Disease | Cardiomyopathy |
| Chronic Fatigue Syndrome | Chronic Hepatitis |
| Chronic Liver Disease | Chronic Obstructive Pulmonary Disease (COPD) |
| Crohns Disease | Emphysema |
| Fibromyalgia | Heart Valve Replacement |
| Insulin Dependent Diabetes | Diabetes Diagnosed Prior to age 40 |
| Multiple Sclerosis | Muscular Dystrophy |
| Pulmonary Fibrosis | Regional Enteritis/Ileitis |
| Rheumatoid Arthritis | Psoriatic Arthritis |
| Rheumatic Fever | Stroke or TIA (mini-stroke) |
| Systemic Lupus | Cerebrovascular Accident |
| Ulcerative Colitis | Schizophrenia |
| Vascular Insufficiency | Parkinson's Disease |

11. In the past 10 years, have you been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

Yes No

12. In the past 5 years, have you been treated for or diagnosed by a physician or had surgery for any of the following conditions:

Yes No

- | | |
|-------------------------------|--------------------------|
| Angina and/or Chest Pain | Atrial Fibrillation |
| Carpel Tunnel Syndrome | Congestive Heart Failure |
| Coronary Artery Disease (CAD) | Coronary Angioplasty |
| Heart Disease or Disorder | Coronary Bypass Surgery |
| Drug or Alcohol Abuse | Heart Attack |
| Kidney Disease | Sciatica |
| Cancer | |

13. In the past 12 months, have you been confined to a hospital or received medical treatment in an emergency room for any of the following:

Yes No

- | | |
|----------------------------|-------------------|
| Sickle Cell Anemia | Hypertension |
| Chronic Bronchitis | Asthma |
| Epilepsy/Seizure | Pancreatitis |
| Gastric Bypass | Blood Disorder |
| Diverticulitis | Joint Replacement |
| Mental or Nervous Disorder | Aneurysm |

[SECTION V		Coverage Selection	
Accidental Death and Dismemberment (base coverage only)		<input type="checkbox"/> Level 1	<input type="checkbox"/> Level 2
Disability Coverage/Rider Options (*Available to Primary Applicant only)			
<input type="checkbox"/> Off the Job Disability*	<input type="checkbox"/> 24 hour Accident Short Term Disability*	<input type="checkbox"/> Sickness Disability Rider*	
<input type="checkbox"/> Waiver of Premium Rider*	<input type="checkbox"/> None		
Choose One Disability Benefit Amount, this amount will be for any disability coverage or disability rider selected (based on income):			
Disability Coverage:			
<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000
Sickness Disability Rider:			
<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000
Optional Riders:			
<input type="checkbox"/> Public Safety*	<input type="checkbox"/> Return of Premium/Cash Value**	<input type="checkbox"/> Physician's Office Additional Benefits Rider	
*only available for Primary applicant		**not available with Section 125	
Select Type of Coverage:			
<input type="checkbox"/> Individual	<input type="checkbox"/> Individual plus child(ren)	<input type="checkbox"/> Individual plus spouse	<input type="checkbox"/> Family]

SECTION VI		
Dependent Child Coverage (Please Print and fill out completely)		
(Each Child to be insured must meet policy eligibility requirements)		
Name	Child(ren) Relationship to Primary Applicant	Date of Birth

Check here if additional space is needed and attach separate sheet.

SECTION VIII**Applicant's Statement and Authorization to Obtain Information**

I have read or have had read to me, the completed application; all representations are true and complete. I understand that: any false statements or misrepresentations in this application may result in loss of insurance if such false statement materially affected either the acceptance of the risk or the hazard assumed by the Company. The agent has no authority to approve the application, change the policy or waive any policy provisions. **No coverage will be effective until all eligibility requirements are met and until the later of: (1) the Effective Date as shown on the Policy Schedule, if issued; or (2) the date the first premium is accepted by Consecro Insurance Company.**

I acknowledge receipt of an Outline of Coverage; if age 65 or over the booklet containing insurance advice for people eligible for Medicare; and the Disclosure Statement, which includes the Medical Information Bureau Notice, the Notice of Insurance Information Practices and the Fair Credit Reporting Act Notice.

1. **This authorization to obtain and disclose information complies with HIPAA regulations as they relate to accident insurance.** I authorize Consecro Insurance Company or its representatives (Company) to obtain and use any information about or relating to me that may affect my insurability. The Company may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. The Company may also obtain and use non-health and non-medical information including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All this information may be used to evaluate an application for insurance, a claim for insurance benefits or both.
2. I authorize the following persons and organizations to release and disclose the information described in paragraph 1 to the Company or its representatives acting on its behalf: (i) my doctor(s); (ii) medical practitioners; (iii) pharmacies and pharmacy-related organizations; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau (MIB); (viii) my current and previous employers; and (ix) commercial consumer reporting agencies (CRA). All of these persons and organizations other than MIB may release information described above to a CRA acting for the Company. MIB may not release the information described in paragraph 2 to a CRA.
3. I authorize the Company to release and disclose the information described in paragraph 1 to its affiliates, reinsurers, persons or organizations providing services relating to insurance underwriting for the Company, MIB, and as otherwise required or permitted by law. The Company may release and disclose the information described in paragraph 1 to the insurance Agent to provide an explanation of the reason(s) for the Company's underwriting decisions about me, or in connection with my claim(s) for benefits.
4. I understand that: (i) I have the right to revoke this Authorization by writing to the Company – Attention New Business, 11825 N. Pennsylvania Street, Carmel IN 46032; (ii) if I revoke this authorization, the Company will not be able to evaluate this application for accident insurance or subsequent claim(s) if a policy is issued to me; (iii) signing this authorization does not effect my ability to obtain health care benefits (treatment/payment/enrollment); and (iv) authorizing the release or disclosure of health information to persons not regulated by HIPAA may result in the information being redisclosed.
5. This authorization shall be valid for twenty-four (24) months or, in the event of a claim for benefits, for the duration of the claim. A copy of this Authorization is as valid as the original.
6. I am entitled to a copy of this Authorization upon request.

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

Date: _____ Signature of Applicant: _____

Printed Name: _____

Where Signed: _____

(City, State)

SECTION IX

Agent's Statement

This Section to be Completed by Agent: I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the insurance applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being solicited by me and signed by the applicant.

[Did you interview each proposed insured in person, ask all questions and witness the signature? Yes No

If "No", please check one of the boxes below:

- Application completed over the phone
- Application completed by the applicant and returned via mail
- Other, provide explanation: _____

Worksite Business Only: Submitted for Guaranteed Issue

NOTE: Guaranteed Issue Rules apply. If the group does not meet participation requirements, the application will not qualify for Guaranteed Issue.]

Date: _____ Signature of Agent: _____

Agency: _____ Agent Number: _____

Agent's E-mail address: _____

Agent's Phone Number: _____

Mail to Policyholder

Mail to Agent

CONSECO INSURANCE COMPANY
Chicago, Illinois
Administrative Office: 11825 N. Pennsylvania Street
Carmel, IN 46032-4555 • Telephone: 1-800-981-8404

OUTLINE OF COVERAGE

ACCIDENTAL DEATH AND DISEMEMBERMENT

THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

POLICY FORM CIC1022

PLEASE READ YOUR POLICY CAREFULLY: This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

Accidental Death and Dismemberment coverage is designed to provide, to persons insured, coverage for certain Losses resulting from a Covered Accident **ONLY**, subject to any limitations and exclusions contained in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS PROVIDED UNDER THE POLICY:

Please indicate the proposed insured's choice by checking the appropriate box:

LEVEL 1
 LEVEL 2

ACCIDENTAL DEATH: If an Accidental Injury causes and Insured to die within 90 days after the Covered Accident, We will pay a lump sum Accidental Death Benefit for Accidental Death, Motorized Vehicle Accident, Pedestrian Accident, or Common Carrier in accordance with the Policy.

DISEMEMBERMENT: If a Covered Accident causes the Dismemberment of a finger, hand, toe, foot, arm, leg, or eye within one year after the Covered Accident We will pay a benefit in accordance with the Policy.

FRACTURE: If as part of a Covered Accident You fracture a bone and it is diagnosed and treated by a Physician within 90 days after the Covered Accident, We will pay a benefit in accordance with the Policy. If the fracture requires surgical incision We will pay in accordance with the Policy.

DISLOCATION: If as part of a Covered Accident You dislocate a joint and it is diagnosed and treated by a Physician within 90 days after the Covered Accident, We will pay a benefit in accordance with the Policy. If the dislocation requires surgical incision to relocate the joint, We will pay in accordance with the Policy.

LACERATION: If as part of a Covered Accident You are lacerated and Your laceration is repaired with sutures by a Physician within 72 hours after the Covered Accident, We will pay in accordance with the Policy.

INJURIES REQUIRING SURGERY:

EYE INJURY: If as part of a Covered Accident You injure Your eye and eye surgery is performed due to the Covered Accident by a Physician within 90 days after the Covered Accident, We will pay in accordance with the Policy.

TENDON AND LIGAMENT: If as part of a Covered Accident You tear, sever or rupture Your tendon or ligament and have the injured tendon or ligament repaired through surgical incision by a Physician within 90 days after the Covered Accident, We will pay in accordance with the Policy. If the dislocation or fracture benefit is payable due to the same Covered Accident this benefit is not payable.

RUPTURED DISC: If as part of a Covered Accident You rupture a disc in Your spine and receive treatment for the rupture from a Physician within 60 days after the Covered Accident, and have the rupture repaired through surgical incision by a Physician within one year after the Covered Accident, We will pay in accordance with the Policy. The amount payable will be based on the length of time You have been insured under this Policy on the date Your Covered Accident occurred.

TORN CARTILAGE: If as part of a Covered Accident You tear cartilage and receive treatment for the torn cartilage from a Physician within 60 days after the Covered Accident and have the torn cartilage repaired through surgical incision by a Physician with one year after the Covered Accident, We will pay in accordance with the Policy. The amount payable will be based on the length of time You have been insured under this Policy on the date Your Covered Accident occurred.

HERNIA: If as part of a Covered Accident You suffer a hernia and receive treatment for the hernia from a Physician within 60 days after the Covered Accident, and have the hernia repaired through a surgical incision by a Physician within one year after the Covered Accident, We will pay in accordance with the Policy. The amount payable will be based on the length of time You have been insured under this Policy on the date Your Covered Accident occurred. If Your hernia is a herniated disc, We will pay the ruptured disc benefit in lieu of the hernia benefit.

PARALYSIS: If as part of a Covered Accident Your injury causes paraplegia or quadriplegia which is diagnosed by a Physician within 90 days after the Covered Accident, We will pay in accordance with the Policy. If you also die as a result of the same Covered Accident, We will reduce the Accidental Death benefit by the amount paid under the paralysis benefit.

BURN: If as part of a Covered Accident You are burned and Your burns are treated by a Physician within 72 hours after the Covered Accident, We will pay in accordance with the Policy. Benefits are not payable for first degree burns.

HOSPITAL CONFINEMENT: If as part of a Covered Accident You are hospital confined, We will pay in accordance with the Policy.

INTENSIVE CARE UNIT: If as part of a Covered Accident You are confined to an intensive care unit, we will pay in accordance with the Policy. This benefit is payable for up to 15 days per Covered Accident.

EMERGENCY ROOM SERVICES: If as part of a Covered Accident You are admitted to an emergency room within 72 hours of the Covered Accident, we will pay in accordance with the Policy.

AMBULANCE: If as part of a Covered Accident You are transported by ambulance to a Hospital within 72 hours, We will pay in accordance with the Policy.

PHYSICIAN'S OFFICE VISIT BENEFIT: If due to a Covered Accident You visit a Physician's office for which charges are made, We will pay in accordance with the Policy. This benefit is limited to 2 visits per Covered Accident.

PHYSICAL THERAPY BENEFIT: If due to a Covered Accident You have physical therapy, We will pay in accordance with the Policy. This benefit is limited to 8 therapy sessions per Covered Accident.

MEDICAL IMAGING BENEFIT: If due to a Covered Accident You have any of the following medical imaging exams CT (computerized tomography) scan, MRI (magnetic resonance imaging), EEG (electroencephalogram), We will pay in accordance with the Policy.

BLOOD AND PLASMA BENEFIT: If due to a Covered Accident You incur a Loss for receiving whole blood, plasma, red cells, packed cells or platelets, We will pay in accordance with the Policy. We will not pay for processing, administration, storage, laboratory charges, blood or blood components replaced by donors. This benefit is payable once per Covered Accident.

PROSTHESES BENEFIT: If due to a Covered Accident for which You received benefits under this Policy You are prescribed prosthetic devices as prescribed by a Physician, We will pay in accordance with the Policy. Devices must be received within three years after the date of the Covered Accident for which we paid benefits.

TRANSPORTATION BENEFIT: If as part of a Covered Accident You requires special treatment and confinement in a Hospital for injuries sustained, We will pay in accordance with the Policy. This benefit is payable for the trip to the Hospital. The local attending Physician must prescribe the treatment, and the treatment must not be available locally. This benefit is not payable for transportation to any hospital located within a 100-mile radius of the site of the Accident or residence of the Insured. Ambulance or air ambulance transportation is only payable under the Ambulance benefit. This benefit is payable for up to three trips per calendar year per Insured.

FAMILY LODGING BENEFIT: If as part of a Covered Accident When the Insured must travel more than 100 miles from their residence to be confined in a Hospital because treatment for injuries sustained in a Covered Accident are not available locally, We will pay in accordance with the Policy for one hotel/motel room for the member(s) of their Immediate Family who accompanied the Insured. This benefit is only payable during the Insured's Period of Confinement. The local attending Physician must prescribe the treatment. This benefit is payable up to 30 days per Covered Accident. The Hospital and hotel/motel must be more than 100 miles from the residence of the Insured.

Please indicate the proposed insured's choice by checking the appropriate box, if any. The Disability benefits are only available for the Policyowner:

- OFF-THE-JOB ACCIDENT TOTAL DISABILITY BENEFIT**
 24 HOUR ACCIDENT SHORT TERM DISABILITY BENEFIT

OFF-THE-JOB ACCIDENT TOTAL DISABILITY BENEFIT: The Policyowner will be eligible for this benefit, if employed at least 27.5 hours per week at the time the Off-The-Job Covered Accident occurs and if, as the result of Accidental Injury, the Policyowner is:

- Totally Disabled within 90 Days of the Covered Accident;
- not engaged in any employment or occupation for pay, benefit, or profit; and,
- being cared for on a regular basis (at least monthly) by a Physician. This requirement is waived if the Physician states that maximum recovery has been reached and continued future treatment is of no benefit.

If the eligible Policyowner is not Totally Disabled for a full month, We will pay benefits for each full Day of Total Disability during the Policyowner's eligibility for this benefit. Daily benefits will be paid at the rate of 1/30 of the monthly amount.

If the Policyowner becomes Totally Disabled again due to the same type of bodily injury within six (6) months of the end of a period during which the Policyowner was Totally Disabled, We will treat this disability as the same disability. The maximum benefit period for a covered disability is 12 months.

We will pay only one disability benefit for a period of Total Disability even if the disability is caused by more than one Covered Accident.

This benefit is guaranteed renewable until the Policyowner's attainment of age 70. At age 70 this benefit will end.

24 HOUR ACCIDENT SHORT TERM DISABILITY BENEFIT: The Policyowner will be eligible for this benefit, if employed at least 27.5 hours per week at the time the Covered Accident occurs and if, as the result of an Accidental Injury, the Policyowner is:

- Totally Disabled within 90 Days of the Covered Accident;
- not engaged in any employment or occupation for pay, benefit, or profit; and,
- being cared for on a regular basis (at least monthly) by a Physician. This requirement is waived if the Physician states that maximum recovery has been reached and continued future treatment is of no benefit.

We will pay this benefit beginning with the first full Day of the Policyowner's total disability.

If the eligible Policyowner is not Totally Disabled for a full month, We will pay benefits for each full Day of Total Disability during the Policyowner's eligibility for this benefit. Daily benefits will be paid at the rate of 1/30 of the monthly amount.

If the Policyowner becomes Totally Disabled again due to the same type of bodily injury within six (6) months of the end of a period during which the Policyowner was Totally Disabled, We will treat this disability as the same disability. The maximum benefit period for a covered disability is 12 months.

We will pay only one disability benefit for a period of Total Disability even if the disability is caused by more than one Covered Accident.

This benefit is guaranteed renewable until the Policyowner's attainment of age 70. At age 70 this benefit will end.

LIMITATIONS AND EXCLUSIONS:

You will be eligible for benefits under the Policy if: You have a Covered Accident; You incur a Loss while You are insured under the Policy; and, Your Loss is not excluded by name or specific description in the Policy.

We will not pay benefits for Loss contributed to, caused by, or resulting from Your:

FLYING: Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft including those which are not motor-driven.

HAZARDOUS ACTIVITIES: Hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, or mountaineering.

ILLEGAL ACTS: Participating or attempting to participate in an illegal act, or working at an illegal job.

INTOXICATION: Being legally intoxicated, or so intoxicated that mental or physical abilities are seriously impaired, being under the influence of any illegal drugs, or being under the influence of any narcotic, unless such narcotic is taken under the direction of and as directed by a Physician.

PRE-EXISTING CONDITIONS: Having any injury or conditions not otherwise excluded by name or specific description which was diagnosed by or for which You consulted a Physician within 12 months prior to the date You become insured under this Policy. Benefits will not be paid for Losses related to such injury or condition which occur during the first 12 months after the date You become insured under this Policy.

RACING: As a rider in or driving any motor-driven vehicle in a race, stunt show or speed test; or while testing any vehicle on any racecourse or speedway.

SELF-INFLICTED INJURIES (SANE OR INSANE): Injuring or attempting to injure Yourself intentionally, regardless of mental capacity.

SICKNESS: Having any disease, bodily or mental illness, or degenerative process. We also will not pay benefits for any related medical treatments or diagnostic procedures.

SPORTS: Participating in any sporting event for pay or prize money.

SUICIDE (SANE OR INSANE): Committing or attempting to commit suicide, regardless of mental capacity.

TRAVEL: Being in an Accident which occurs more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas and the Virgin Islands, Bermuda and Jamaica, except under the Accidental Death Benefit.

WAR/MILITARY SERVICE: Being exposed to war or any act of war, declared or not, or participating in or contracting with the armed forces (including Coast Guard) of any country or international authority. We will return, at Your request, the prorated Premium paid for You for any period You are not insured by this Policy while You are in such service.

SUMMARY OF CLAIMS DETERMINATION PROCESS:

As provided for in the Eligibility for Benefits and the Limitations and Exclusions sections of Your Policy, the following steps are taken in order to determine eligibility under any claim filed: (1) determine when the claim was incurred, and whether the loss is covered by the Policy. This step may require the collection of medical records, a death certificate, autopsy findings from a medical examiner or coroner, and information regarding medical history from Physicians, Hospitals, other insurance companies, government agencies and medical records copying services; (2) determine if the claim was incurred at a time when Your coverage was in force, or during a lapse in coverage; and (3) determine if any Policy exclusions exist for the claim.

RENEWABILITY OF THIS POLICY:

This Policy is continuously renewed by the payment of Premiums when due. However, disability benefits are guaranteed renewable only until age 70, if included.

PREMIUM:

Your initial premium depends on the optional benefits You selected. We reserve the right to change premium rates upon written notice at least 31 days before the change is to become effective.

OPTIONAL RIDERS: Please indicate the proposed insured's choices by checking the appropriate box(es).

SICKNESS DISABILITY RIDER:

The Policyowner will be eligible for this benefit, if employed at least 27.5 hours per week at the time the Sickness is diagnosed and if, as the result of Sickness, the Policyowner is:

- Totally Disabled;
- not engaged in any employment or occupation for pay, benefit, or profit; and,
- being cared for on a regular basis (at least monthly) by a Physician. This requirement is waived if the Physician states, that maximum recovery has been reached and continued future treatment is of no benefit.

The benefit contains an Elimination Period of 14 days for each Sickness. This means that We will not pay benefits for the first 14 days of Your Total Disability.

If the Policyowner is not Totally Disabled for a full month, We will pay benefits for each full Day of Total Disability during the Policyowner's eligibility for this benefit. Daily benefits will be paid at the rate of 1/30 of the monthly amount.

If the Policyowner becomes Totally Disabled again due to the same Sickness within six (6) months of the end of a period during which the Policyowner was Totally Disabled, We will treat this disability as the same disability. The maximum benefit period for a covered disability is 12 months. We will pay only one Total Disability Benefit during a period of Total Disability even if the disability is caused by more than one Sickness.

PUBLIC SAFETY RIDER

The Policyowner only is eligible for this benefit if he/she receives a gunshot wound from a conventional firearm while working in the line of duty as a public safety officer and within the course and scope of duty and within 24 hours of the shooting receives treatment for the wound from a physician at a hospital, we will pay \$2,000.

WAIVER OF PREMIUM RIDER

When the Policyowner is Totally Disabled as determined under the Policy or the Sickness Disability Rider (if attached to the Policy), We will waive the Premium for the period of disability. We will waive the Premium for no longer than a continuous period of Total Disability and for no longer than the maximum period of 12 months.

PHYSICIAN'S OFFICE ADDITIONAL BENEFITS RIDER

When an Insured person visits a Physician's Office due to a Covered Accident this Rider will pay an additional benefit for each Covered Accident: (1) \$50 when the Physician's Office Visit benefit and other Policy benefits are payable; or, (2) \$200 when the Physician's Office Visit benefit is the only Policy benefit payable. We will only pay this benefit once per Covered Accident for each Insured.

THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE BENEFITS PROVIDED. PLEASE CONSULT THE POLICY ITSELF TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLEASE RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.

Conseco Insurance Company
Chicago, Illinois
Administrative Office: 11825 N. Pennsylvania Street
Carmel, IN 46032-4555 • Telephone: 1-800-981-8404

POLICY SCHEDULE

DO NOT DETACH FROM POLICY AND OR RIDER(S)

POLICYOWNER

[John Doe]
[123 Main Street]
[Any City, GA]

POLICY ACCOUNT NUMBER	POLICY EFFECTIVE DATE	MODE OF PAYMENT	MODAL PREMIUM	ANNUAL PAYMENT
[XXXXXXXXXX]	[XX/XX/XXXX]	[MONTHLY]	[\$XXXX.XX]	[\$XXXX.XX]

Effective Date	Description of Coverage	Form Number	Payment
[XX/XX/XXXX]	[Accidental Death and Dismemberment Policy] or [Accidental Death and Dismemberment Policy with Disability]: [Individual] [Individual plus Child(ren)] [Individual plus Spouse] [Family]	CIC1022	[\$XXX.XX]
[XX/XX/XXXX]	[Accidental Death and Dismemberment Policy] or [Accidental Death and Dismemberment Policy with Disability] with Return of Premium/Cash Value Rider	R1056ROP/R1056CV	[\$XXX.XX]
[XX/XX/XXXX]	Sickness Disability Rider	R1022SD	[\$XXX.XX]
[XX/XX/XXXX]	Sickness Disability Rider with Return of Premium/Cash Value Rider	R1056ROP/R1056CV	[\$XXX.XX]
[XX/XX/XXXX]	Public Safety Rider	R1022PS	[\$XXX.XX]
[XX/XX/XXXX]	Public Safety Rider with Return of Premium/Cash Value Rider	R1056ROP/R1056CV	[\$XXX.XX]
[XX/XX/XXXX]	Waiver of Premium Rider	R1057	[\$XXX.XX]
[XX/XX/XXXX]	Waiver of Premium Rider with Return of Premium/Cash Value	R1056ROP/R1056CV	[\$XXX.XX]
[XX/XX/XXXX]	Physician's Office Additional Benefits Rider	R1058	[\$XXX.XX]
[XX/XX/XXXX]	Physician's Office Additional Benefits Rider with Return of Premium/Cash Value	R1056ROP/R1056CV	[\$XXX.XX]

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RETURN OF PREMIUM RIDER

This Rider is a part of the Policy to which it is attached. That Policy is called "the Policy" in this Rider. This Rider is subject to all of the terms, provisions, definitions and exclusions of the Policy, except as stated in this Rider.

CONSIDERATION – EFFECTIVE DATE

We have issued this Rider in consideration of the advance payment of the Premium (EXCEPTION: During the time, if any, that it is agreed between the Policyowner and the Company that Premiums will be billed and remitted through payroll deduction or credit union share account deduction, the Premium is due on the date indicated in the billing provided to the administrator coordinating Premium payments on the Policyowner's behalf). This Rider takes effect at the same time and will continue for the same term as the Policy unless a different Rider Effective Date is indicated on the Policy Schedule.

RENEWABILITY – TERMINATION - REINSTATEMENT

This Rider is renewable at the same time and under the same terms as the Policy, and is subject to the payment of the Rider Term Premium. The Rider Term Premium is shown in the Policy Schedule. Premium rates for this Rider may be changed in the same way as Premium rates for the Policy. If the Premium for the Policy or any Rider changes for any reason, You will be notified of the revised Premium. We will calculate Your Return of Premium Benefit Amount based on both the original Premium paid and the revised Premium paid.

This Rider will terminate on the earliest of: (1) the date the Policy terminates; or (2) the end of the last period for which the Rider Term Premium required to keep this Rider in force is paid, subject to the Grace Period in the Policy. If You allow the Policy to terminate and it is later reinstated, then all Benefit Eligibility Dates will be deferred by the period of time that the Policy was inactive.

EXCEPTION: If a Benefit Eligibility Date occurs on the Rider anniversary date after You reach age 75, We will not defer that Benefit Eligibility Date.

CONTINUATION PRIVILEGE

If this is a family policy and You die, Your spouse may elect to continue insurance under the Policy and this Rider by paying the Premium. All Benefit Eligibility Dates will continue to be based on Your age. The Return of Premium Benefit Amount will be paid to Your spouse.

BENEFIT ASSIGNMENT NOT ALLOWED

You may not assign the benefits under this Rider.

DEFINITIONS

When the terms below are used in this Rider, the following definitions will apply.

RETURN OF PREMIUM PERIOD: means the period of time from the Rider Effective Date to the first Benefit Eligibility Date, or from any Benefit Eligibility Date to the next.

Based on Your age at the beginning of a Return of Premium Period, the length of the period will be as follows:

- Beginning at age 55 or under: 20 years.
- Beginning at age 56 through 65: The number of years from the beginning of the Return of Premium Period to the first anniversary date after You reach age 75.
- Beginning at age 66 or over: 10 YEARS.

BENEFIT ELIGIBILITY DATE: means the date on which a Return of Premium Period ends and You become entitled to the benefit provided by this Rider.

BENEFITS

OUR PROMISE TO PAY: We will pay You a Return of Premium Benefit if You keep Your Policy and this Rider in force until a Benefit Eligibility Date. You do not need to surrender Your Policy and this Rider at a Benefit Eligibility Date to receive a Return of Premium Benefit.

After each Benefit Eligibility Date, You will automatically begin a new Return of Premium Period.

RETURN OF PREMIUM BENEFIT AMOUNT:

- **FOR A RETURN OF PREMIUM PERIOD BEGINNING AT AGE 65 OR UNDER:** The benefit amount is equal to the Premiums paid for the insurance provided during the Return of Premium Period, minus any claims incurred during the Return of Premium Period. For other information which may affect this amount, please refer to the Renewability, Termination, Reinstatement Provision in this Rider.
- **FOR A RETURN OF PREMIUM PERIOD BEGINNING AT AGE 66 OR OVER:** The benefit amount is equal to one half of the Premiums paid for the insurance provided during the Return of Premium Period, minus any claims incurred during the Return of Premium Period. For other information which may affect this amount, please refer to the Renewability, Termination, Reinstatement Provision in this Rider.

EFFECT OF WAIVER OF PREMIUM ON RETURN OF PREMIUM: Premiums waived under any Waiver of Premium Rider attached to the Policy will be treated both as Premiums paid and claims incurred for purposes of calculating the Return of Premium Benefit Amount.



Secretary

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WAIVER OF PREMIUM RIDER

This Rider is a part of the Policy to which it is attached. That Policy is called "the Policy" in this Rider. This Rider is subject to all of the terms, provisions, definitions and exclusions of the Policy, except as stated in this Rider.

CONSIDERATION – EFFECTIVE DATE

We have issued this Rider in consideration of the advance payment of the Premium (EXCEPTION: During the time, if any, that it is agreed between the Policyowner and the Company that Premiums will be billed and remitted through payroll deduction or credit union share account deduction, the Premium is due on the date indicated in the billing provided to the administrator coordinating Premium payments on the Policyowner's behalf). This Rider takes effect at the same time and will continue for the same term as the Policy unless a different Rider Effective Date is indicated on the Policy Schedule.

RENEWABILITY – TERMINATION

This Rider is renewable at the same time and under the same terms as the Policy, and is subject to the payment of the Rider Term Premium. The Rider Term Premium is shown in the Policy Schedule. Premium rates for this Rider may be changed in the same way as Premium rates for the Policy. This Rider will terminate on the earliest of: (1) the date the Policy terminates; (2) the end of the last period for which the Rider Term Premium required to keep this Rider in force is paid, subject to the Grace Period in the Policy; (3) the date any disability benefits or riders terminate; or (4) the Policyowner's attainment of age 70.

REINSTATEMENT

This Rider may be reinstated subject to the terms of the Policy to which it is attached and subject to the Policyowner's age.

BENEFITS

When the Policyowner is Totally Disabled as determined under the Policy or the Sickness Disability Rider (if attached to the Policy), We will waive the Premium for the period of disability. We will waive the Premium for no longer than a continuous period of Total Disability and for no longer than the maximum period of 12 months.

Premium payments are not required for Your coverage beginning the first of the month, in which You are determined to be Totally Disabled under the Policy or the Sickness Disability Rider (if attached to the Policy). Upon determination of Total Disability any Premium already received for that period will be proportionately refunded.

When the Policyowner is no longer Totally Disabled, waiver of premium will continue to the first of the next month. Thereafter, Premiums must be paid in order for the Policy to continue in force.



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PHYSICIAN'S OFFICE ADDITIONAL BENEFITS RIDER

This Rider is a part of the Policy to which it is attached. That Policy is called "the Policy" in this Rider. This Rider is subject to all of the terms, provisions, definitions and exclusions of the Policy, except as stated in this Rider.

CONSIDERATION – EFFECTIVE DATE

We have issued this Rider in consideration of the advance payment of the Premium (EXCEPTION: During the time, if any, that it is agreed between the Policyowner and the Company that Premiums will be billed and remitted through payroll deduction or credit union share account deduction, the Premium is due on the date indicated in the billing provided to the administrator coordinating Premium payments on the Policyowner's behalf). This Rider takes effect at the same time and will continue for the same term as the Policy unless a different Rider Effective Date is indicated on the Policy Schedule.

RENEWABILITY – TERMINATION

This Rider is renewable at the same time and under the same terms as the Policy, and is subject to the payment of the Rider Term Premium. The Rider Term Premium is shown in the Policy Schedule. Premium rates for this Rider may be changed in the same way as Premium rates for the Policy. This Rider will terminate on the earliest of: (1) the date the Policy terminates; or (2) the end of the last period for which the Rider Term Premium required to keep this Rider in force is paid, subject to the Grace Period in the Policy.

REINSTATEMENT

This Rider may be reinstated subject to the terms of the Policy to which it is attached and subject to the Policyowner's age.

BENEFIT

When an Insured person visits a Physician's Office due to a Covered Accident this Rider will pay an additional benefit for each Covered Accident as stated below:

1. \$50 when the Physician's Office Visit benefit and other Policy benefits are payable; or,
2. \$200 when the Physician's Office Visit benefit is the only Policy benefit payable.

We will only pay this benefit once per Covered Accident for each Insured.

LIMITATIONS AND EXCLUSIONS

DENTAL PROCEDURES: We will not pay benefits for Loss contributed to, caused by, or resulting from Your treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident. Dental procedures as a result of a Covered Accident are limited to the natural teeth.



Secretary

SERFF Tracking Number: CNSC-126679129 State: Arkansas
 Filing Company: Conseco Insurance Company State Tracking Number: 46625
 Company Tracking Number: R1058, ET AL
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: CIC Accident Additional Riders
 Project Name/Number: 2010 Accident/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR Certif of Compliance with Rule 19.pdf	Approved-Closed	09/02/2010

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Application listed and attached to Form schedule tab Comments:	Approved-Closed	09/02/2010

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: Outline listed and attached to Form schedule tab Comments:	Approved-Closed	09/02/2010

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Consec Insurance Company

Form Number(s): R1058, R1057, R1056ROPAR, AP-1059, OC-1022R & SCHEDULE-ACC

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



Signature of Company Officer

Mariann Dobbs
Name

Senior Director and Assistant Secretary
Title

07/01/2010
Date