

SERFF Tracking Number: ALST-127871360 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 50416
 Company Tracking Number: AWD500AR2
 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002 Dread Disease
 Limited Benefit
 Product Name: CBP1DAR
 Project Name/Number: /

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: CBP1DAR SERFF Tr Num: ALST-127871360 State: Arkansas
 TOI: H071 Individual Health - Specified Disease SERFF Status: Closed-Approved- State Tr Num: 50416
 - Limited Benefit Closed
 Sub-TOI: H071.002 Dread Disease Co Tr Num: AWD500AR2 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Jennifer Aiello, Lynn Disposition Date: 12/08/2011
 Bautista, Sara Welch
 Date Submitted: 12/07/2011 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: This form will be used to apply for a policy that is specific to and approved in Arkansas; it will not be filed in our domicile state of Florida.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 12/08/2011
 State Status Changed: 12/08/2011
 Deemer Date: Created By: Sara Welch
 Submitted By: Sara Welch Corresponding Filing Tracking Number:
 Filing Description:
 Re: American Heritage Life Insurance Company, NAIC 60534
 Application AWD500AR2

The above referenced form is attached for your review and approval. This form is new and does not replace any form previously approved by your department. This application will be used to apply for cancer coverage of previously

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approved forms used in the direct market.

This application will be used for applications taken through electronic means using a pen-based signature pad, PIN numbers, and any other valid electronic signature method. You have our assurance that appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it.

We have included any filing fees and/or forms required by your state. If you have any questions, feel free to call me at (904) 992-2554. I can also be reached by email at Sara.Welch@allstate.com. Thank you for your consideration.

Company and Contact

Filing Contact Information

Sara Welch , Ettain Group swelc@allstate.com
 1776 American Heritage Life Drive 800-521-3535 [Phone] 2554 [Ext]
 Jacksonville, FL 32224 904-992-2975 [FAX]

Filing Company Information

American Heritage Life Insurance Company CoCode: 60534 State of Domicile: Florida
 ATTN: Legal/Compliance Group Code: 8 Company Type: Life and Health
 1776 American Heritage Life Drive Group Name: Allstate State ID Number:
 Jacksonville, FL 32224-9983 FEIN Number: 59-0781901
 (904) 992-1776 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form X 1 form = \$50.00 total
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	12/07/2011	54324132

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/08/2011	12/08/2011

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Disposition

Disposition Date: 12/08/2011

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	Cancer Insurance Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AWD500AR2

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/08/2011	AWD500A R2	Application/Cancer Insurance Enrollment Application Form	Initial		53.000	AWD500AR2 Filed Version.pdf

(Please Print with Black Ink)

APPLICATION FOR HEALTH INSURANCE TO:

AMERICAN HERITAGE LIFE INSURANCE COMPANY 1776 American Heritage Life Drive, Jacksonville, FL 32224										
Employee/Payor (if other than Proposed Insured)					Employee's DOB		Employee/Payor SSN		Employee's I.D. Number	
Proposed Insured (Last, First, M.I.)			<input type="checkbox"/> Emp. <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F	Age	Birthdate	Height	Weight	
Resident Address			City		State		Zip	Resident Phone Number		
Social Security Number			Occupation				Email Address			
Primary Beneficiary – Full Name Age Relationship					Contingent Beneficiary – Full Name Age Relationship					
DEPENDENTS PROPOSED FOR COVERAGE										
Last Name		First Name		M.I.	Relationship		Date of Birth	Age	Sex	
Cancer <input type="checkbox"/> Individual <input type="checkbox"/> Family		Cancer Riders Units							Mode Premium \$	
1. Is the proposed insured actively at work, for wage or profit, now and has he/she worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for at least 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?								<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Is any person to be insured now being treated, or in the last 10 years, been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus?								<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. a) Has any person to be insured ever been diagnosed or treated for any type of cancer, other than basal cell carcinoma?								<input type="checkbox"/> Yes <input type="checkbox"/> No		
b) If the answer to 3a is yes, has any person to be insured ever been diagnosed with, or treated for, Leukemia, Hodgkin's Disease, Lymphoma or Cancer with any lymph node involvement or more than one metastasis?								<input type="checkbox"/> Yes <input type="checkbox"/> No		
c) If the answer to 3a is yes, has any person to be insured, in the last 5 years, been diagnosed with or received treatment for any other type of cancer (other than those listed in 3b and/or basal cell carcinoma)?								<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. a) Has any person to be insured, in the last 5 years, been treated for a stroke or transient ischemic attack (TIA), a heart attack, a heart condition, heart trouble, any abnormality of the heart or any artery disease?								<input type="checkbox"/> Yes <input type="checkbox"/> No		
b) Has any person to be insured, in the last 5 years, been diagnosed by a licensed health practitioner with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?								<input type="checkbox"/> Yes <input type="checkbox"/> No		
Required Health History (Complete if questions 2-4 are answered "Yes." Use additional paper if necessary.)										
Name		Nature of Illness/Injury			Date		Name/Address of Physician			
Replacement. Is this insurance to replace or change any existing health coverage? If yes, indicate product being replaced or changed.								<input type="checkbox"/> Yes <input type="checkbox"/> No		
Existing. Is there any other cancer insurance in force or applied for on any person to be insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.								<input type="checkbox"/> Yes <input type="checkbox"/> No		
REPRESENTATION. I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. • UNDERSTANDING. I understand that the "effective date" of the policy will be the policy date recorded on the Policy Specifications page. The effective date of the policy is not the date the application is signed. If the policy is not issued, American Heritage Life will refund any premiums it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind this company in any way by making any promise or representation that is not set out in writing in this application. • FRAUD WARNING. Any person who knowingly presents a false or fraudulent claim for a payment of 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. Any person who is already covered by Medicaid should not purchase specified disease coverage.										
Signed at City/State						Date Signed				
Signature of Proposed Insured										
PAC / Credit Card <input type="checkbox"/> Checking Transit Number _____ <input type="checkbox"/> Savings Account Number _____ <input type="checkbox"/> Credit Card Draft Date _____				Premiums / Billing <input type="checkbox"/> Annual <input type="checkbox"/> PAC <input type="checkbox"/> Credit Card			Producer Number		Percentage Credit %	
									%	

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Readability Certification.pdf	Approved-Closed	12/08/2011

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Not applicable to this filing. Comments:	Approved-Closed	12/08/2011

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not applicable to this filing. Comments:	Approved-Closed	12/08/2011

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: Not applicable to this filing. Comments:	Approved-Closed	12/08/2011

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

To the Policy Review Section, Arkansas Department of Insurance.

I certify that I have carefully reviewed the form(s) listed below and to the best of my knowledge and ability, find that the form(s) meet the minimum reading ease score on the test used.

Form
AWD500AR2

Score
53.0

Date: December 7, 2011



Diane Ierna
Assistant Vice President, Compliance Department