

SERFF Tracking Number: ANTX-127661114 State: Arkansas
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 50377
Company Tracking Number:
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit
Product Name: CRIT ILL REPLACEMENTS
Project Name/Number: CRIT ILL REPLACEMENTS/CRIT ILL REPLACEMENTS

Filing at a Glance

Company: Standard Life and Accident Insurance Company
Product Name: CRIT ILL REPLACEMENTS SERFF Tr Num: ANTX-127661114 State: Arkansas
TOI: H071 Individual Health - Specified Disease SERFF Status: Closed-Approved State Tr Num: 50377
- Limited Benefit
Sub-TOI: H071.001 Critical Illness Co Tr Num: State Status: Approved-Closed
Filing Type: Form/Rate Reviewer(s): Donna Lambert
Author: Sherry Wiegman Disposition Date: 12/08/2011
Date Submitted: 12/01/2011 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date: 01/09/2012
State Filing Description:

General Information

Project Name: CRIT ILL REPLACEMENTS Status of Filing in Domicile: Pending
Project Number: CRIT ILL REPLACEMENTS Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
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: Sherry Wiegman
Submitted By: Sherry Wiegman Corresponding Filing Tracking Number:

Filing Description:

Attached for your review and consideration are revisions to recently approved individual critical illness product applications and rates. This is a new submission that will replace previously approved forms and rates.

This product was previously approved on 5/5/2011 under ANTX-127031871.

The applications attached will replace the previously approved applications as noted on the forms tab. The new applications contain a \$5,000 benefit option as well as an age group range listing that was not included in the previously approved forms.

This product was originally filed with annual rates. The refilled rates are monthly rates. We refilled with monthly rates

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because we changed the modal factors, for this line of business, which are based on a monthly premium (the new modal factors are shown in the actuarial memorandum and on the rate sheets). The final monthly rate, which represents the vast majority of sales is unchanged. There is a small increase associated with other modes compared to the originally filed annual rates.

We are resubmitting a revised statement of variability to include a \$5,000 benefit option that was not previously included in the variables in the policy schedule page.

We trust this information is complete and look forward to receiving your favorable reply. Please contact me should you feel additional information is needed.

Company and Contact

Filing Contact Information

Sherry Wiegman, Sr. Compliance Analyst sherry.wiegman@anico.com
 One Moody Plaza, SSH MP, Ste. 200 281-538-4842 [Phone]
 Galveston, TX 77550 409-766-2950 [FAX]

Filing Company Information

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Texas
 One Moody Plaza, SSH MP, Ste. 200 Group Code: 408 Company Type: Health Insurance
 Galveston, TX 77550 Group Name: State ID Number:
 (281) 538-4842 ext. [Phone] FEIN Number: 73-0994234

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$100.00	12/01/2011	54168462

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/08/2011	12/08/2011

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Disposition

Disposition Date: 12/08/2011

Implementation Date: 01/09/2012

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Standard Life and Accident Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form	Policy Application	Approved	Yes
Form	Policy Application	Approved	Yes
Rate	CRITICAL ILLNESS POLICY AND RIDER RATES	Approved	Yes

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Form Schedule

Lead Form Number: SLA-CI11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/08/2011	SL- CIINDAR3	Application/ Policy Enrollment Form	Application Enrollment Form	Revised	Replaced Form #: SL-CIINDAR2 Previous Filing #: ANTX-127031871	50.100	AR SL-CIINDAR3 APPLICATION.pdf
Approved 12/08/2011	SL- CIINDSIAR3	Application/ Policy Enrollment Form	Application Enrollment Form	Revised	Replaced Form #: SL-CIINDSIAR2 Previous Filing #: ANTX-127031871	50.100	AR SL-CIINDSIAR3 APPLICATION.pdf



CRITICAL ILLNESS INSURANCE APPLICATION Please Print — Use Black Ink New Policy Reinstatement

SECTION A

1. Applicant _____ Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____
 Home Address _____ City _____ State _____ Zip _____
 Phone (____) _____ Best time to call _____ a.m. p.m. Email _____
 Social Security Number _____ Occupation _____
 Billing Address (if different) _____ City _____ State _____ Zip _____

2. Please print the full name of all other Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)	Occupation
	Spouse						

3. BENEFIT AND PREMIUM DATA

Applicant Benefit Amount: \$ _____	Billable Premium	Billing Mode
Ages 65–70: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000	\$ _____	<input type="checkbox"/> Annual
Ages 71–74: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	\$ _____	<input type="checkbox"/> Semi-Annual
Spouse: \$ _____ <small>(cannot be greater than the Applicant)</small>	\$ _____	<input type="checkbox"/> Quarterly
Child: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$30,000 <small>(cannot be greater than the Applicant)</small>	\$ _____	<input type="checkbox"/> Monthly PAC
Mortgage Protection Rider: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <small>(Applicant only—not available after age 65)</small>	\$ _____	<input type="checkbox"/> List Bill
Total Billable Premium: _____	\$ _____	

4. Will any Critical Illness insurance be replaced with this policy? Yes No
 If Yes, which company? _____ Policy Number _____

SECTION B

5. Has the Applicant or any Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer or stroke? .. Yes No
 If Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death.

	Applicant		Spouse/Other Proposed Insured	
	Age if Living	Age at Death/Cause or Age at Diagnosis/Cause	Age if Living	Age at Death/Cause or Age at Diagnosis/Cause
Father				
Mother				
Sibling				

6. a. Has the Applicant used any form of tobacco within the past 12 months? Yes No
 b. Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months?..... Yes No
7. Has the Applicant or any Proposed Insured had a weight gain or loss of 10 pounds or more within the past 12 months? Yes No
 If Yes, provide name of Applicant or any Proposed Insured and details of weight change. Gain Loss
 Name of Applicant or any Proposed Insured _____ Cause of Weight Gain/Loss _____
8. Does the Applicant or any Proposed Insured use a cane, walker, motorized vehicle, wheelchair or require mobility assistance by another person?..... Yes No
 If Yes, provide details: _____
9. Has the Applicant or any Proposed Insured within the past 5 years been charged with a driving while impaired violation (alcohol, drugs, other), had driver's license revoked or suspended, or within the last 24 months received 3 or more citations for moving violations?..... Yes No
 If Yes, provide driver's license number and state of issue: _____
10. Does the Applicant or any Proposed Insured intend to travel or reside outside the U.S. for more than 3 months during the next 12 months?..... Yes No
11. Within the past 5 years has the Applicant or any Proposed Insured:
 a. had an application for insurance declined, rated or postponed?..... Yes No
 b. flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so? Yes No
 c. engaged in boxing, scuba diving, parachuting, racing or any other hazardous sport or have intentions to do so? Yes No
 d. sought or received advice, counseling, or treatment by a physician for the use of alcohol or drugs including prescription drugs?..... Yes No
 e. used cocaine or marijuana or any other drug except as legally prescribed by a physician? Yes No

SECTION B (Continued)

Please provide details for questions 10 and 11a through 11e.

Question	Name	Details

12. Has the Applicant or any Proposed Insured ever received treatment for, been diagnosed with, been advised to have diagnostic tests for, or is now being treated for any of the following:
- a. abnormal blood pressure, chest pain, coronary artery disease, abnormal ECG, elevated cholesterol, stroke, transient ischemic attack (TIA), peripheral vascular disease or any other disorder or disease of the heart, blood vessels or of the cerebrovascular system? Yes No
 - b. cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles, or lesions, dysplastic nevi, malignant melanoma, abnormal PAP Smear, abnormal PSA test, abnormal mammogram, fibrocystic breast disease with history of breast biopsy, recurrent tumors or unexplained tumors or growth? Yes No
 - c. diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder? Yes No
 - d. any ear, nose, throat, lung, or any other respiratory disorder? Yes No
 - e. any disorder of the stomach, intestines, rectum, liver or pancreas? Yes No
 - f. any injury to or disease of the bones, muscles, joints, eyes, or skin? Yes No
 - g. epilepsy, seizures, brain disorder, tremor, multiple sclerosis, paralysis, Parkinson's, Alzheimer's or any other disease or disorder of the nervous system? Yes No
 - h. anxiety, depression, or an emotional, behavioral, mental or nervous disorder? Yes No
 - i. any disease or disorder of the kidney, bladder, or genital organs or system? Yes No
 - j. AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex), positive HIV (Human Immunodeficiency Virus) test, or any other immunological disorder? Yes No
13. Other than as stated above, has the Applicant or any Proposed Insured, within the past 5 years:
- a. consulted, received treatment or advice from, been prescribed medication by any other physician? Yes No
 - b. had any abnormal diagnostic or screening tests? Yes No
 - c. been aware of any symptoms for which a physician has not yet been consulted or been advised to have any diagnostic/screening or tests or procedures which have not yet been performed? Yes No
14. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each Applicant or any Proposed Insured including details for each Yes answer to questions 12 and 13.

Name of Applicant or any Proposed Insured	Condition	Medication	Date(s) of Treatment	Results	Name/Address of Physician

SECTION C

ATTENTION — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I/we have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare. I/We have also received an outline of coverage if required in my/our state.

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned has completed this application and represents that the answers and statements in Sections A and B on this application are true, complete, and correctly recorded to the best of my/our knowledge and belief; and agree they will be used to determine each Proposed Insured's eligibility for coverage applied for hereby. I/We understand and agree that: **1.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **2.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **3.** no insurance shall take effect unless a policy is issued (or if this application is made to change or reinstate an existing policy, unless the request is approved by the Company) and actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Proposed Insureds. I/We will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the policy issued. If this application is taken over the phone, I/we agree that my/our electronic signature(s) serve(s) as my/our original signature(s).

I/We understand and agree that: **1.** eligibility for the Plan does not constitute initial coverage under the Plan; and **2.** initial coverage under the Plan is subject to the Company's criteria.

This is a Limited Benefit Policy. Please review the policy carefully.

_____ Date

_____ Dated at City, State

_____ Applicant's Signature

_____ Spouse's Signature (if coverage is requested)



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I/We hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant or any Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I/We understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I/We understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I/We may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I/We, or my/our authorized representative, am/are entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I/We understand I/we may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I/We may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I/we agree that my/our electronic signature serves as my/our original signature.

_____ Date

_____ Dated at City, State

_____ Applicant's Signature

_____ Spouse's Signature (if coverage is requested)

_____ Witness

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____.

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

- Checking**
- Savings**

Bank Information

_____ Name

_____ City _____ State _____ Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

_____ Date Signed _____ Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number _____

Routing Number _____



AGENT STATEMENT

- As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? Yes No
 If Yes, was a replacement form completed and a copy left with the Applicant?..... Yes No
- As Agent, have you complied with state replacement regulations? Yes No
- I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. Yes No

I have inquired about and have personal knowledge of the medical history of the Applicant and each Proposed Insured.

Agent's Name (please print)

Agent's Signature

Agent's Writing Number

Date Signed

Phone (____) _____

Fax (____) _____

Email _____

Premium Quoted: \$ _____

Premium collected with Application.

Initial premium is to be drafted.

Mail Policy to: Insured Agent

Special Request: _____



CRITICAL ILLNESS INSURANCE APPLICATION Please Print — Use Black Ink New Policy Reinstatement

SECTION A

1. Applicant _____ Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____
 Home Address _____ City _____ State _____ Zip _____
 Phone (____) _____ Best time to call _____ a.m. p.m. Email _____
 Social Security Number _____ Occupation _____
 Billing Address (if different) _____ City _____ State _____ Zip _____

2. Please print the full name of all other Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)	Occupation
	Spouse						

3. BENEFIT AND PREMIUM DATA						Billable Premium	Billing Mode
Applicant Benefit Amount:	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> Annual
	<input type="checkbox"/> \$35,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$45,000	<input type="checkbox"/> \$50,000	\$ _____	<input type="checkbox"/> Semi-Annual	
Ages 65–70:	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000			\$ _____	<input type="checkbox"/> Quarterly
Ages 71–74:	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000				\$ _____	<input type="checkbox"/> Monthly PAC
Spouse: (cannot be greater than the Applicant)	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> List Bill
	<input type="checkbox"/> \$35,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$45,000	<input type="checkbox"/> \$50,000	\$ _____		
Child: (cannot be greater than the Applicant)	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$30,000	
Mortgage Protection Rider: (Applicant only—not available after age 65)	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500			\$ _____	
Total Billable Premium:						\$ _____	

4. Will any Critical Illness insurance be replaced with this policy? Yes No
 If Yes, which company? _____ Policy Number _____

SECTION B (This plan cannot be issued to any person who answers Yes to questions 7, 8 or 9.)

5. Has the Applicant or any Proposed Insured had two or more biological parents and/or siblings, either living or deceased, diagnosed with or die from one of the same conditions listed below? If Yes, check all that apply and list name of Proposed Insured:

a. Prior to age 60 <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> Stroke _____
b. Prior to age 75 <input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Colorectal Cancer _____	<input type="checkbox"/> Senile Dementia _____

6. a. Has the Applicant used any form of tobacco within the past 12 months? Yes No
 b. Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months? Yes No

7. In the past 2 years, has the Applicant or any Proposed Insured been informed by a physician of any abnormal test results or been advised to have any diagnostic/screening tests or procedures which have not yet been performed? Yes No
 If Yes, list name of Applicant or Proposed Insured: _____

8. Does the Applicant or any Proposed Insured use a cane, walker, motorized vehicle, wheelchair or require mobility assistance by another person? Yes No
 If Yes, list name of Applicant or Proposed Insured: _____

SECTION B (Continued)

9. Has the Applicant or Proposed Insured ever been diagnosed with, advised by a physician to have diagnostic tests for, been treated for in the past or is currently being treated for any of the following? Yes No

If Yes, check all that apply and list name of Applicant or Proposed Insured:

<input type="checkbox"/> Alcohol or Drug Abuse _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Leukemia _____
<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> End Stage Renal Disease _____	<input type="checkbox"/> Liver Cirrhosis _____
<input type="checkbox"/> Angioplasty _____	<input type="checkbox"/> Heart Attack _____	<input type="checkbox"/> Major Organ Failure or Transplant _____
<input type="checkbox"/> Aortic Surgery _____	<input type="checkbox"/> Heart Valve Surgery _____	<input type="checkbox"/> Multiple Sclerosis _____
<input type="checkbox"/> Bone Marrow Transplant _____	<input type="checkbox"/> Hepatitis B, C or Carrier _____	<input type="checkbox"/> Senile Dementia _____
<input type="checkbox"/> Cancer (excluding non-invasive, non-melanoma Skin Cancer) _____	<input type="checkbox"/> Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Coronary Artery Bypass Surgery _____		<input type="checkbox"/> Transient Ischemic Attack (TIA) _____

10. In the past 5 years, has the Applicant or any Proposed Insured been diagnosed with or treated for any of the following conditions? Yes No

If Yes, check all that apply:

<input type="checkbox"/> Abnormal Mammogram	<input type="checkbox"/> Dysplastic Nevi	<input type="checkbox"/> Pancreas Disorder
<input type="checkbox"/> Abnormal Moles or Lesions	<input type="checkbox"/> Fibrocystic Breast Disease (with history of biopsy)	<input type="checkbox"/> Polyps
<input type="checkbox"/> Abnormal Pap Smear	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pre-cancerous Lesions/ Tumors
<input type="checkbox"/> Abnormal Prostate-Specific Antigen (PSA)	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Recurrent Breast Tumors
<input type="checkbox"/> Basal or Squamous Cell Carcinoma	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Recurrent Human Papilloma Virus (HPV)
<input type="checkbox"/> Crohn's Disease (except irritable bowel disease or mucus colitis)	<input type="checkbox"/> Kidney Disease (except non-chronic kidney stones or infection)	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Disease or disorder of the heart or blood vessels	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Disease of the nervous system (except non-chronic shingles)	<input type="checkbox"/> Lung Disease (except asthma that has never required hospitalization and non-chronic bronchitis)	<input type="checkbox"/> Unexplained Tumors/ Growth

Complete the following for each condition checked in question 10.

Name of Applicant or Proposed Insured	Condition	Medication	Date(s) of Treatment	Results	Name/Address of Physician

SECTION C

ATTENTION — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I/we have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare. I/We have also received an outline of coverage if required in my/our state.

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned has completed this application and represents that the answers and statements in Sections A and B on this application are true, complete, and correctly recorded to the best of my/our knowledge and belief; and agree they will be used to determine each Proposed Insured's eligibility for coverage applied for hereby. I/We understand and agree that: **1.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **2.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **3.** no insurance shall take effect unless a policy is issued (or if this application is made to change or reinstate an existing policy, unless the request is approved by the Company) and actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Proposed Insureds. I/We will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the policy issued. If this application is taken over the phone, I/we agree that my/our electronic signature(s) serve(s) as my/our original signature(s).

I/We understand and agree that: **1.** eligibility for the Plan does not constitute initial coverage under the Plan; and **2.** initial coverage under the Plan is subject to the Company's criteria.

This is a Limited Benefit Policy. Please review the policy carefully.

Date

Dated at City, State

Applicant's Signature

Spouse's Signature (if coverage is requested)



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I/We hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant or any Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I/We understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I/We understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I/We may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I/We, or my/our authorized representative, am/are entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I/We understand I/we may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I/We may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I/we agree that my/our electronic signature serves as my/our original signature.

_____ Date

_____ Dated at City, State

_____ Applicant's Signature

_____ Spouse's Signature (if coverage is requested)

_____ Witness

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____.

AUTHORIZATION TO MY BANK

Bank Information

**PREAUTHORIZED
CHECK
AUTHORIZATION**

**Attach Voided Check
or Deposit Ticket Here
and Sign Authorization**

- Checking**
- Savings**

_____ Name

_____ City State Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

_____ Date Signed

✓ _____ Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number _____

Routing Number _____



AGENT STATEMENT

- As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? Yes No
 If Yes, was a replacement form completed and a copy left with the Applicant?..... Yes No
- As Agent, have you complied with state replacement regulations? Yes No
- I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. Yes No

I have inquired about and have personal knowledge of the medical history of the Applicant and each Proposed Insured.

Agent's Name (please print)

Agent's Signature

Agent's Writing Number

Date Signed

Phone (____) _____

Fax (____) _____

Email _____

Premium Quoted: \$ _____

Premium collected with Application.

Initial premium is to be drafted.

Mail Policy to: Insured Agent

Special Request: _____

SERFF Tracking Number: ANTX-127661114 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 50377
 Company Tracking Number:
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.001 Critical Illness
 Product Name: CRIT ILL REPLACEMENTS
 Project Name/Number: CRIT ILL REPLACEMENTS/CRIT ILL REPLACEMENTS

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision: 12/01/2011
Filing Method of Last Filing: SERFF

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Standard Life and Accident Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: ANTX-127661114 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 50377
 Company Tracking Number:
 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
 Limited Benefit
 Product Name: CRIT ILL REPLACEMENTS
 Project Name/Number: CRIT ILL REPLACEMENTS/CRIT ILL REPLACEMENTS

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 12/08/2011	CRITICAL ILLNESS POLICY AND RIDER RATES	SLA-CI11 AND SLA-CIMP11	Revised	Previous State Filing Number: Percent Rate Change Request:	ANTX- 1270318 71 RATES AA 55 10-27-2011.pdf RATES IA 55 10-27-2011.pdf

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Monthly Premium Rates per 1000 of Initial benefit Amount

Policy Form SLA-CI11

Attained Age Rates

Attained Age	Initial Benefit Amount 5-50,000 (Simplified Underwriting)				Initial Benefit Amount 51-500,000 (Fully Underwritten)				Attained Age
	MNS	MSM	FNS	FSM	MNS	MSM	FNS	FSM	
18 - 24	0.11	0.16	0.16	0.32	0.10	0.15	0.14	0.29	18 - 24
25 - 29	0.14	0.21	0.20	0.40	0.12	0.18	0.17	0.36	25 - 29
30 - 34	0.18	0.32	0.29	0.54	0.16	0.28	0.25	0.47	30 - 34
35 - 39	0.29	0.49	0.46	0.74	0.25	0.43	0.39	0.64	35 - 39
40 - 44	0.46	0.81	0.68	1.01	0.39	0.70	0.56	0.86	40 - 44
45 - 49	0.75	1.35	0.95	1.37	0.64	1.15	0.80	1.16	45 - 49
50 - 54	1.22	2.21	1.19	1.86	1.03	1.88	1.00	1.57	50 - 54
55 - 59	2.00	3.28	1.74	2.67	1.69	2.77	1.50	2.25	55 - 59
60 - 64	3.08	4.44	2.27	3.67	2.62	3.86	2.03	3.12	60 - 64
65 - 69	3.66	6.02	2.92	4.87	3.18	5.26	2.81	4.40	65 - 69
70 - 74	4.58	7.82	3.60	6.74	4.10	7.75	3.68	7.09	70 - 74
75 - 79	5.86	11.15	4.55	9.62	5.04	10.82	4.42	9.74	75 - 79
80-84	7.27	14.24	6.06	12.56	6.71	14.14	5.89	12.73	80 - 84
85-89	10.71	20.09	9.42	17.33	9.39	17.55	8.24	15.80	85 - 89
90-94	15.31	26.48	13.47	23.36	13.42	23.13	11.79	21.30	90 - 94
95-100	20.13	37.80	17.71	32.61	17.65	33.03	15.50	29.73	95 - 100
Rate for all children:				0.27					

A \$2 monthly policy fee is to be added to the final calculated rate

Modal Factors

Quarterly	=	Monthly x 3
Semi-Annual	=	Monthly x 6
Annual	=	Monthly x 12

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Monthly Premium Rates per 1000 of Monthly benefit Amount

Mortgage Protection Rider SLA-CIMP11

Attained Age Rates

Attained Age	Amounts of 5-50,000 (Simplified Underwriting)				Amounts of 51-500,000 (Fully Underwritten)				Attained Age
	MNS	MSM	FNS	FSM	MNS	MSM	FNS	FSM	
18 - 24	0.50	0.65	0.53	0.92	0.44	0.58	0.46	0.80	18 - 24
25 - 29	0.60	0.81	0.69	1.22	0.51	0.70	0.58	1.06	25 - 29
30 - 34	0.77	1.24	1.02	1.70	0.67	1.08	0.86	1.47	30 - 34
35 - 39	1.23	1.97	1.68	2.46	1.03	1.67	1.39	2.08	35 - 39
40 - 44	1.99	3.30	2.57	3.49	1.66	2.77	2.09	2.91	40 - 44
45 - 49	3.29	5.65	3.77	4.93	2.74	4.71	3.14	4.09	45 - 49
50 - 54	5.43	9.55	5.10	7.08	4.51	7.93	4.22	5.85	50 - 54
55 - 59	9.10	14.20	7.77	10.50	7.54	11.71	6.59	8.63	55 - 59
60 - 64	14.10	18.90	10.41	14.68	11.75	15.96	9.15	12.09	60 - 64
65 - 69	16.28	24.45	12.89	18.96	13.82	20.73	12.10	16.50	65 - 69
70 - 74	19.03	29.16	14.61	24.45	16.68	28.03	14.56	24.79	70 - 74
75 - 79	23.63	39.82	17.96	33.88	19.92	37.52	17.06	33.12	75 - 79
80-84	29.15	50.75	22.69	42.31	26.35	48.77	21.58	41.40	80 - 84
85-89	42.06	70.48	34.24	57.25	36.16	59.66	29.34	50.49	85 - 89
90-94	60.14	92.90	48.96	77.16	51.71	78.63	41.96	68.06	90 - 94
95-100	79.07	132.63	64.37	107.72	67.99	112.27	55.17	95.02	95 - 100

Modal Factors

Quarterly = Monthly x 3
 Semi-Annual = Monthly x 6
 Annual = Monthly x 12

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Monthly Premium Rates per 1000 of Initial benefit Amount
 Policy Form SLA-CI11
 Issue Age Rates

Issue Age	Initial Benefit Amount 5-50,000 (Simplified Underwriting)				Initial Benefit Amount 51-500,000 (Fully Underwritten)				Issue Age
	MNS	MSM	FNS	FSM	MNS	MSM	FNS	FSM	
18	0.31	0.45	0.41	0.61	0.29	0.42	0.38	0.57	18
19	0.31	0.45	0.41	0.61	0.29	0.42	0.38	0.57	19
20	0.31	0.45	0.41	0.61	0.29	0.42	0.38	0.57	20
21	0.31	0.45	0.41	0.61	0.29	0.42	0.38	0.57	21
22	0.31	0.45	0.41	0.61	0.29	0.42	0.38	0.57	22
23	0.33	0.48	0.43	0.64	0.31	0.46	0.40	0.59	23
24	0.36	0.52	0.45	0.67	0.33	0.49	0.41	0.62	24
25	0.38	0.56	0.47	0.69	0.35	0.52	0.43	0.64	25
26	0.40	0.60	0.49	0.72	0.37	0.56	0.45	0.66	26
27	0.43	0.64	0.51	0.75	0.39	0.59	0.47	0.69	27
28	0.46	0.69	0.54	0.79	0.42	0.64	0.50	0.73	28
29	0.50	0.74	0.58	0.84	0.45	0.69	0.53	0.77	29
30	0.53	0.80	0.61	0.88	0.49	0.74	0.55	0.81	30
31	0.57	0.85	0.64	0.92	0.52	0.78	0.58	0.85	31
32	0.60	0.90	0.67	0.97	0.55	0.83	0.61	0.89	32
33	0.65	0.98	0.71	1.03	0.59	0.90	0.65	0.94	33
34	0.70	1.06	0.76	1.10	0.64	0.97	0.68	0.99	34
35	0.76	1.14	0.80	1.16	0.68	1.03	0.72	1.05	35
36	0.81	1.21	0.84	1.22	0.73	1.10	0.75	1.10	36
37	0.86	1.29	0.89	1.29	0.77	1.17	0.79	1.15	37
38	0.93	1.39	0.93	1.36	0.83	1.25	0.83	1.22	38
39	0.99	1.49	0.97	1.43	0.89	1.34	0.86	1.28	39
40	1.06	1.59	1.02	1.50	0.94	1.42	0.90	1.34	40
41	1.13	1.69	1.06	1.58	1.00	1.51	0.94	1.40	41
42	1.19	1.79	1.11	1.65	1.06	1.60	0.97	1.46	42
43	1.28	1.92	1.16	1.76	1.13	1.71	1.02	1.55	43
44	1.37	2.05	1.22	1.86	1.21	1.83	1.07	1.65	44
45	1.46	2.18	1.28	1.97	1.29	1.94	1.12	1.74	45
46	1.55	2.32	1.34	2.08	1.37	2.06	1.17	1.84	46
47	1.64	2.45	1.39	2.19	1.45	2.18	1.22	1.93	47
48	1.74	2.60	1.46	2.32	1.54	2.31	1.28	2.04	48
49	1.85	2.76	1.53	2.45	1.63	2.45	1.34	2.16	49
50	1.95	2.91	1.59	2.58	1.72	2.58	1.39	2.27	50
51	2.06	3.06	1.66	2.71	1.81	2.71	1.45	2.39	51
52	2.16	3.22	1.73	2.84	1.91	2.85	1.51	2.50	52
53	2.27	3.38	1.81	2.99	1.99	2.99	1.57	2.63	53
54	2.37	3.54	1.88	3.14	2.08	3.13	1.64	2.76	54
55	2.47	3.70	1.96	3.28	2.17	3.26	1.70	2.89	55
56	2.57	3.86	2.03	3.43	2.26	3.40	1.77	3.02	56
57	2.67	4.02	2.11	3.58	2.34	3.54	1.83	3.15	57
58	2.77	4.20	2.18	3.78	2.44	3.72	1.91	3.30	58
59	2.87	4.38	2.25	3.98	2.55	3.89	1.99	3.46	59
60	2.97	4.56	2.32	4.18	2.65	4.07	2.07	3.61	60
61	3.07	4.74	2.39	4.37	2.75	4.25	2.14	3.77	61
62	3.17	4.92	2.46	4.57	2.85	4.42	2.22	3.93	62
63	3.30	5.25	2.62	4.78	3.05	4.90	2.45	4.33	63
64	3.44	5.57	2.79	5.00	3.25	5.38	2.67	4.73	64
65	3.58	5.89	2.95	5.21	3.46	5.85	2.90	5.13	65
66	3.71	6.21	3.12	5.42					66
67	3.85	6.54	3.28	5.63					67
68	4.09	6.96	3.45	6.05					68
69	4.34	7.38	3.61	6.46					69
70	4.58	7.81	3.78	6.88					70
71	4.83	8.23	3.94	7.29					71
72	5.07	8.66	4.11	7.71					72
73	5.33	9.33	4.32	8.25					73
74	5.59	10.00	4.54	8.80					74
75	5.86	10.68	4.75	9.35					75
Rate for all children:				0.27					

A \$2 monthly policy fee is to be added to the final calculated rate

Modal Factors
 Quarterly = Monthly x 3
 Semi-Annual = Monthly x 6
 Annual = Monthly x 12

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Monthly Premium Rates per 1000 of Monthly benefit Amount
Mortgage Protection Rider SLA-CIMP11
Issue Age Rates

Issue Age	Amounts of 5-50,000 (Simplified Underwriting)				Amounts of 51-500,000 (Fully Underwritten)				Issue Age
	MNS	MSM	FNS	FSM	MNS	MSM	FNS	FSM	
18	1.35	1.77	1.37	1.74	1.24	1.65	1.27	1.60	18
19	1.35	1.77	1.37	1.74	1.24	1.65	1.27	1.60	19
20	1.35	1.77	1.37	1.74	1.24	1.65	1.27	1.60	20
21	1.35	1.77	1.37	1.74	1.24	1.65	1.27	1.60	21
22	1.35	1.77	1.37	1.74	1.24	1.65	1.27	1.60	22
23	1.45	1.92	1.45	1.84	1.32	1.77	1.33	1.69	23
24	1.55	2.07	1.53	1.95	1.41	1.90	1.40	1.77	24
25	1.65	2.21	1.61	2.06	1.49	2.02	1.47	1.86	25
26	1.75	2.36	1.69	2.16	1.58	2.15	1.54	1.95	26
27	1.85	2.50	1.78	2.27	1.67	2.27	1.61	2.04	27
28	1.99	2.71	1.90	2.43	1.80	2.46	1.71	2.19	28
29	2.14	2.91	2.01	2.59	1.93	2.64	1.82	2.33	29
30	2.28	3.12	2.13	2.75	2.06	2.82	1.92	2.48	30
31	2.42	3.33	2.25	2.91	2.18	3.01	2.03	2.62	31
32	2.56	3.53	2.37	3.07	2.31	3.19	2.14	2.77	32
33	2.79	3.86	2.54	3.31	2.50	3.46	2.27	2.96	33
34	3.01	4.18	2.71	3.55	2.69	3.74	2.41	3.16	34
35	3.23	4.51	2.87	3.79	2.87	4.01	2.55	3.36	35
36	3.45	4.83	3.04	4.03	3.06	4.28	2.69	3.56	36
37	3.68	5.15	3.21	4.28	3.24	4.55	2.83	3.76	37
38	3.97	5.58	3.40	4.56	3.49	4.91	2.99	4.00	38
39	4.26	6.00	3.60	4.85	3.73	5.27	3.15	4.24	39
40	4.55	6.43	3.79	5.13	3.98	5.63	3.30	4.47	40
41	4.84	6.85	3.98	5.42	4.22	5.99	3.46	4.71	41
42	5.13	7.28	4.17	5.70	4.46	6.34	3.62	4.95	42
43	5.53	7.87	4.45	6.14	4.81	6.85	3.86	5.32	43
44	5.94	8.47	4.72	6.57	5.16	7.36	4.09	5.69	44
45	6.34	9.07	5.00	7.00	5.51	7.88	4.33	6.06	45
46	6.75	9.66	5.27	7.43	5.85	8.39	4.57	6.43	46
47	7.16	10.26	5.55	7.87	6.20	8.90	4.80	6.79	47
48	7.66	10.98	5.91	8.45	6.63	9.52	5.11	7.29	48
49	8.16	11.70	6.28	9.04	7.06	10.13	5.42	7.79	49
50	8.67	12.43	6.65	9.62	7.50	10.75	5.74	8.29	50
51	9.17	13.15	7.01	10.21	7.93	11.37	6.05	8.78	51
52	9.67	13.88	7.38	10.79	8.36	11.98	6.36	9.28	52
53	10.16	14.59	7.78	11.45	8.78	12.58	6.70	9.83	53
54	10.66	15.30	8.19	12.11	9.20	13.18	7.04	10.39	54
55	11.15	16.01	8.59	12.77	9.63	13.77	7.38	10.94	55
56	11.65	16.72	9.00	13.43	10.05	14.37	7.72	11.49	56
57	12.14	17.43	9.40	14.08	10.47	14.97	8.06	12.05	57
58	12.62	18.14	9.78	14.93	10.93	15.64	8.45	12.68	58
59	13.09	18.84	10.15	15.77	11.39	16.30	8.83	13.32	59
60	13.56	19.55	10.52	16.61	11.85	16.97	9.22	13.95	60
61	14.03	20.25	10.90	17.46	12.31	17.64	9.60	14.59	61
62	14.51	20.95	11.27	18.30	12.77	18.31	9.99	15.23	62
63	15.03	22.07	11.92	19.02	13.53	19.89	10.83	16.57	63
64	15.56	23.19	12.57	19.75	14.29	21.47	11.66	17.92	64
65	16.08	24.31	13.21	20.47	15.05	23.05	12.50	19.27	65
66	16.60	25.42	13.86	21.20					66
67	17.13	26.54	14.51	21.92					67
68	17.92	27.69	14.94	23.12					68
69	18.71	28.85	15.37	24.33					69
70	19.50	30.00	15.80	25.53					70
71	20.29	31.15	16.23	26.73					71
72	21.08	32.30	16.66	27.93					72
73	22.01	34.43	17.42	29.70					73
74	22.94	36.56	18.17	31.47					74
75	23.87	38.68	18.92	33.24					75

Modal Factors

Quarterly = Monthly x 3
Semi-Annual = Monthly x 6
Annual = Monthly x 12

SERFF Tracking Number: ANTX-127661114 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 50377
 Company Tracking Number:
 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
 Limited Benefit
 Product Name: CRIT ILL REPLACEMENTS
 Project Name/Number: CRIT ILL REPLACEMENTS/CRIT ILL REPLACEMENTS

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved	12/08/2011
Comments:		
Attachment: Readability Certification SL 11-18-2011.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved	12/08/2011
Comments: SL-CIINDAR2 APPROVED 5/5/2011 SL-CIINDSIAR2 APPROVED 5/5/2011		

ANTX-127031871

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved	12/08/2011
Comments:		
Attachments: ACTUARIAL MEMORANDUM AA IA 55 10-27-2011.pdf EXHIBIT 1 10-27-2011.pdf EXHIBIT II IA AA 10-27-2011.pdf EXHIBIT III 10-27-2011.pdf		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved	12/08/2011
Bypass Reason: Previously approved under ANTX-127031871		
Comments:		

SERFF Tracking Number: ANTX-127661114 State: Arkansas
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 50377
Company Tracking Number:
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit
Product Name: CRIT ILL REPLACEMENTS
Project Name/Number: CRIT ILL REPLACEMENTS/CRIT ILL REPLACEMENTS

	Item Status:	Status
Satisfied - Item: Statement of Variability	Approved	Date: 12/08/2011
Comments:		
Attachment: STATEMENT OF VARIABILITY.pdf		



READABILITY CERTIFICATION

We hereby certify that the following forms have achieved a Flesch scale readability score which meets the minimum reading ease score as required by your state:

SL-CIINDSI3
SL-CIIND3

**William
J. Hogan**

Digitally signed by William J. Hogan
DN: cn=William J. Hogan, c=US,
o=Standard Life and Accident
Insurance Company, ou=Assistant
Vice President, Health Compliance,
email=william.hogan@anico.com
Date: 2011.11.18 17:44:16 -0600

William J. Hogan
Asst. Vice President, Health Compliance

11/18/2011

Date of Signature

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

STATEMENT OF VARIABILITY

FORM NUMBERS:

SLA-CI11-ID
SLA-CIMP11-ID

SLA-CI11-ID

Page 1:

No variables

Page 2 – Table of Contents

Page numbers may vary and will be inserted appropriately.

Page 3 and 4 – Schedule of Benefits:

Certain variables represent the insured's specific information.

The statement: "**BENEFITS OTHERWISE PAYABLE ARE REDUCED 50% ON THE LATER OF A COVERED PERSON'S AGE 70 OR HIS/HER 5TH POLICY ANNIVERSARY.**", will be initially included in all policies sold. If in the future, we decide the experience for over age 70 is equitable, we may remove this statement and not reduce benefits for ages over 70.

The benefit amounts shown in variables are the minimum and maximums that we may offer under this policy. Amounts offered will be chosen by the insured in the application. The minimum we anticipate offering is \$5,000 and the maximum is \$500,000.

The Category 1 reference to [30 or 90] days is the Reduced Benefit Period timeframe. This is the amount of time from the effective date of coverage until the first diagnosis relating to cancer is made. If cancer is diagnosed before 30 or 90 days of coverage, benefits will be reduced as stated in the Schedule Page. If cancer is diagnosed after 30 or 90 days from the coverage effective date, benefits will not be reduced and will be payable in the amount stated in the Schedule Page. We initially anticipate using a 90 day reduction period but may lessen this to 30 days at a later date.

The optional rider information will be included in amounts chosen by the insured

Page 5, 6, 7:

No Variables

Page 8:

The Reduced Benefit Period reference of [30 or 90] days is the Reduced Benefit Period timeframe. This is the amount of time from the effective date of coverage until the first diagnosis relating to cancer is made. If cancer is diagnosed before 30 or 90 days of coverage, benefits will be reduced as stated. If cancer is diagnosed after 30 or 90 days from the coverage effective date, benefits will not be reduced and will be in the amount stated. We initially anticipate using a 90 day reduction period but may lessen this to 30 days at a later date.

The exceptions and limitations statement: **“BENEFITS OTHERWISE PAYABLE ARE REDUCED 50% ON THE LATER OF A COVERED PERSON’S AGE 70 OR HIS/HER 5TH POLICY ANNIVERSARY.”**, will be initially included in all policies sold. If in the future, we decide the experience for over age 70 is equitable, we may remove this statement and not reduce benefits for ages over 70.

Page 9, 10 and 11:

No Variables

Page 12:

The Premiums section will vary in that we may apply rates on either an issue age basis or an attained age basis. If the issue age basis is used, the variable statements relating to attained age will not be used. If attained age is used, we will include these statements.

Page 13, 14, 15, 16:

No Variables

FORM SLA-CIMP11-ID

No Variables.