

SERFF Tracking Number: AFDL-127094427 State: Arkansas
Filing Company: American Public Life Insurance Company State Tracking Number: 48324
Company Tracking Number: AMD4103
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: AMD4103 Hospital Indemnity Limited Benefit Rider
Project Name/Number: APL Group HI Rider/AMD4103

Filing at a Glance

Company: American Public Life Insurance Company

Product Name: AMD4103 Hospital Indemnity Limited Benefit Rider SERFF Tr Num: AFDL-127094427 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved-Closed State Tr Num: 48324

Sub-TOI: H11G.002 Short Term Co Tr Num: AMD4103 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Author: Joelle Harbour Disposition Date: 03/28/2011
Date Submitted: 03/23/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: APL Group HI Rider

Project Number: AMD4103

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association, Trust

Filing Status Changed: 03/28/2011

State Status Changed: 03/28/2011

Created By: Joelle Harbour

Corresponding Filing Tracking Number: AMD4103

Filing Description:

Based on the enclosed authorization, American Fidelity Assurance Company is submitting this form filing on behalf of American Public Life Insurance Company.

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/07/2011

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Joelle Harbour

Submitted for your review is amendment rider AMD4103, Hospital Indemnity Limited Benefit Rider. This optional rider will be used with all approved group disability income policies. Domiciliary state approval was granted on March 7, 2011.

Amendment rider AMD4103 pays a limited daily benefit if the insured is confined to a hospital as an inpatient. The benefit is paid directly to the insured.

SERFF Tracking Number: AFDL-127094427 State: Arkansas
 Filing Company: American Public Life Insurance Company State Tracking Number: 48324
 Company Tracking Number: AMD4103
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: AMD4103 Hospital Indemnity Limited Benefit Rider
 Project Name/Number: APL Group HI Rider/AMD4103

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of the state of Arkansas and such forms contain no provisions previously disapproved by the Department. The Flesch score is 50.

Thank you for your assistance in this matter. If you have any questions, please contact me at 1-800-654-8489, extension 5997.

Company and Contact

Filing Contact Information

Joelle Harbour, Compliance Analyst I joelle.harbour@af-group.com
 2000 N Classen Blvd 405-523-5997 [Phone]
 Oklahoma City, OK 73106

Filing Company Information

American Public Life Insurance Company CoCode: 60801 State of Domicile: Oklahoma
 2305 Lakeland Drive Group Code: 330 Company Type: LAH
 Flowood, MS 39232 Group Name: State ID Number:
 (601) 936-2157 ext. [Phone] FEIN Number: 64-0349942

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: AMD4103-\$50
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Public Life Insurance Company	\$50.00	03/23/2011	45907789

SERFF Tracking Number: AFDL-127094427 State: Arkansas
Filing Company: American Public Life Insurance Company State Tracking Number: 48324
Company Tracking Number: AMD4103
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: AMD4103 Hospital Indemnity Limited Benefit Rider
Project Name/Number: APL Group HI Rider/AMD4103

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/28/2011	03/28/2011

SERFF Tracking Number: *AFDL-127094427* *State:* *Arkansas*
Filing Company: *American Public Life Insurance Company* *State Tracking Number:* *48324*
Company Tracking Number: *AMD4103*
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.002 Short Term*
Product Name: *AMD4103 Hospital Indemnity Limited Benefit Rider*
Project Name/Number: *APL Group HI Rider/AMD4103*

Disposition

Disposition Date: 03/28/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AFDL-127094427 State: Arkansas
 Filing Company: American Public Life Insurance Company State Tracking Number: 48324
 Company Tracking Number: AMD4103
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: AMD4103 Hospital Indemnity Limited Benefit Rider
 Project Name/Number: APL Group HI Rider/AMD4103

Form Schedule

Lead Form Number: AMD4103

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/28/2011	AMD4103	Certificate	Hospital Indemnity Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.000	AMD4103.pdf



American Public Life Insurance Company

A member of the American Fidelity Group.

2305 Lakeland Drive

Flowood, Mississippi 39232

Effective Date: _____
(If different from the Policy or Certificate)

HOSPITAL INDEMNITY LIMITED BENEFIT RIDER

The Policy or Certificate to which this Rider is attached is hereby amended as follows:

You or **Your** as used throughout shall mean the Insured or the Insured's. **We, Us, Our** shall mean the Company.

RIDER SCHEDULE

- Daily Hospital Confinement Benefit:** [\$100, \$150, \$200, \$250] per day, per confinement
- Maximum Hospital Confinement Period:** 90 days per confinement
- Reduction in Benefits at Age 70:** 50% of the Daily Hospital Confinement Benefit

If You are confined to a Hospital as an Inpatient due to a covered Injury or Sickness, the Daily Hospital Confinement Benefit listed in the Rider Schedule will be paid to You for the number of days You are hospital confined and are charged for room and board facilities, up to the Maximum Hospital Confinement Period.

Successive Hospital stays will be considered as one confinement if they are separated by less than 90 days of confinement to a Hospital.

Inpatient means You are admitted as a resident patient to a Hospital for at least 18 continuous hours and are being charged for room and board facilities.

The Hospital Confinement Benefit will not be payable for an Injury or Sickness incurred in the first 12 months of coverage if the Injury or Sickness is caused by or resulting from a Pre-Existing Condition as defined in the Policy.

EXCLUSIONS

In addition to the Exclusions listed in the Policy, no benefits will be payable under this Rider for any Hospital Confinement that is caused by or resulting from Mental Illness or Drug or Alcohol Abuse.

TERMINATION

Your coverage under this Rider will end on the earliest of:

- (a) the end of the last period for which premium payment has been made to Us; or
- (b) the date You notify Us in writing to terminate coverage; or
- (c) the date this Rider is discontinued; or
- (d) the date the Policy is discontinued.

This Rider is subject to all the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.

William F. Weems
Vice President and C.A.O

SERFF Tracking Number: AFDL-127094427 State: Arkansas
 Filing Company: American Public Life Insurance Company State Tracking Number: 48324
 Company Tracking Number: AMD4103
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: AMD4103 Hospital Indemnity Limited Benefit Rider
 Project Name/Number: APL Group HI Rider/AMD4103

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR_Compliance_Certification.pdf	Approved-Closed	03/28/2011

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Attachments: A1269.pdf AGM107.pdf	Approved-Closed	03/28/2011

	Item Status:	Status Date:
Satisfied - Item: Letter of Authorization Comments: Attachment: APL_Authorization11.pdf	Approved-Closed	03/28/2011



2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125

COMPLIANCE CERTIFICATION

ARKANSAS

This is to certify that the attached forms comply with the requirements of:

Arkansas Rule & Regulation 19

Arkansas Rule & Regulation 49

ACA 23-80-206

ACA-23-79-138


Signature

John Lanier, Vice President
Name and Title

3/23/2011
Date



A member of the American Fidelity Group.

2305 Lakeland Drive Flowood, MS 39232
Phone: (800) 256-8606 FAX: (877) 807-0911

FOR AGENT USE ONLY:

Requested Effective Date: _____

Bill Location: _____

GROUP DISABILITY INCOME APPLICATION

1. PROPOSED INSURED INFORMATION
Last Name First Name Full Middle Name Suffix
Age Date of Birth Sex Soc Sec Number Date of Employment
Residence Address: Number & Street (Not a P.O. Box) City State Zip
Home Phone # Work Phone # Country of Citizenship
Mailing Address (if different than Residence) City State Zip
Employer Name Salary: \$ Occupation
Are you currently able to perform the duties of your occupation? Yes No

Applicant's E-mail Address

2. BENEFITS APPLIED FOR

Table with 8 columns: Product, New, Change, Benefit Amount, Employee, Employer, Frequency, Total. Rows include [STD] and [Rider] with checkboxes and dollar amounts.

3. BENEFICIARY

First Name Middle Name Last Name Relationship to Insured Country of Citizenship

4. ELECTION I hereby enroll, add or change, as checked above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my premiums, if any, from my pay.

5. ACKNOWLEDGMENT I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
If applying for disability income coverage, OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.
"Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any.

BROCHURE(S) # HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S). (Applicant Initials):

6. FRAUD NOTICE Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)

APPLICANT SIGNATURE _____ Date _____

AGENT SIGNATURE (where required by law) _____ Agent # _____

AMERICAN PUBLIC LIFE INSURANCE COMPANY

2305 Lakeland Drive, Flowood, MS 39232

GROUP DISABILITY INCOME APPLICATION

PROPOSED INSURED'S NAME _____

HEALTH HISTORY

7. Within the **past 5 years**, have you received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following:

Cancer (other than basal or squamous cell skin cancer), heart and/or circulatory disorder, peripheral vascular disease (PVD), stroke or transient ischemic attack, liver or kidney disorder/disease (excluding stones), pulmonary disease, diabetes requiring insulin, rheumatoid arthritis, epilepsy, ulcerative colitis, Crohn's disease, organ transplant, systemic lupus erythematosus, disorder of blood cells or blood clotting disorder, seizures, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV), Chronic Fatigue Syndrome (CFS), fibromyalgia, alcohol or drug addiction or abuse, or neurological disorder (excluding headaches or migraines).

Yes No

8. Within the **past 12 months**, have you:

Received advice from a medical provider, taken medication, incurred an expense, undergone tests, or received treatment (including, but not limited to, spinal manipulation, physical therapy, or counseling) for a condition related to: (a) your back, neck or spine; (b) a mental or nervous condition; or (c) had surgery recommended that has not yet been performed or received a referral for surgery consultation?

Yes No

9. Are you currently pregnant?

Yes No

10. I hereby certify that I have read the above statements and all of the medical conditions or they have been read to me. I also understand that additional investigation could occur at time of claim and any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.

Applicant's Initials: _____ Date: _____

 **American Public Life Insurance Company**

A member of the American Fidelity Group

Contract Number: _____

2305 Lakeland Drive • Flowood, MS • 39232 • Phone: (800) 256-8606 • Fax: (877) 807-0911

Application for **Group Disability Income Insurance** is hereby made to American Public Life Insurance Company based on the following:

- 1. Full Legal Name of Policyholder: _____
- 2. Mailing Address: _____
- 3. Physical Address (if different): _____
- 4. Group Type: Association Corporation Sole Proprietorship or Partnership Education Other
- 5. Nature of Organization: _____ Tax ID Number: _____
- 6. Designation of Class or Classes Eligible for Coverage (attach an additional page if necessary): _____

- 7. Current employees are eligible: Immediately After _____ days employment As determined by each firm
- 8. New employees are eligible after _____ days employment.
- 9. Minimum Standards: Before this Policy or the insurance of additional persons or a change in class takes effect, the following applicable minimum standards must be met. Where the Policyholder is a/an: Employer Trust Association, the participation requirements are as follows: _____

If these standards are not met, it is agreed that the Company may:

- (1) ask for satisfactory evidence of insurability before an eligible person's coverage takes effect; or
- (2) terminate the Policy or Subscribing Unit.

To issue coverage and maintain eligibility: _____

- 10. Initial Premium rate is as follows: _____
The premium is due on the _____ of each month.
- 11. Effective Date: _____ Original Policy Effective Date: _____ Policy Amended Effective: _____
If this application is approved by the Company, it is desired that the Policy takes effect at 12:01 AM at the place where the Policy is delivered. It is agreed that the coverage of an eligible person will not take effect until the first premium has been paid for or by such person.
- 12. The Policyholder declares that to the best of his knowledge and belief the statements and answers shown above are true and complete. The Policyholder understands and agrees that: (a) the application will form a part of any policy issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company unless it appears in writing on this application; (c) no waiver or modification will bind the Company unless it is in writing and is signed by an Executive Officer of the Company; and (d) only those persons eligible under the terms of the policy or policies issued will be covered.
- 13. I hereby request American Public Life Insurance Company to issue and deliver the Group Certificates of Insurance for the coverage applied. I agree to make payroll deductions for the Employee portion of any premium.
- 14. Non-ERISA Group
 ERISA Acknowledgment: The Employer named below acknowledges that the Employee Retirement Income Security Act of 1974 (ERISA), as amended or other laws, if applicable, may require that the Employer be responsible for certain duties or obligations with respect to the Employer or Employer's Employees and dependents under any certificate under such group policy or policies.

Dated at _____ on the _____ day of _____ 20____

Authorized Signature: _____ Official Position: _____

Agent: _____ Agent Number: _____

FRAUD WARNING: Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)



American Public Life Insurance Company

A member of the American Fidelity Group.

January 2, 2011

NAIC Number: 60801
FEIN Number: 64-0349942

To Whom It May Concern:

American Fidelity Assurance Company, located at 2000 N. Classen Boulevard, Oklahoma City, Oklahoma, 73125, is hereby authorized to submit forms for approval to the Department of Insurance on behalf of American Public Life Insurance Company. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Sincerely,

Alex M. Bagby, ASA, MAAA
Vice President & Chief Risk Officer