

SERFF Tracking Number: AFDL-127094435 State: Arkansas  
Filing Company: American Public Life Insurance Company State Tracking Number: 48325  
Company Tracking Number: AMD4104  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: AMD4104 Critical Illness Limited Benefit Rider  
Project Name/Number: APL Group CI Rider/AMD4104

## Filing at a Glance

Company: American Public Life Insurance Company

Product Name: AMD4104 Critical Illness SERFF Tr Num: AFDL-127094435 State: Arkansas  
Limited Benefit Rider

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 48325  
Closed

Sub-TOI: H11G.002 Short Term Co Tr Num: AMD4104 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

Implementation Date:

State Filing Description:

## General Information

Project Name: APL Group CI Rider

Project Number: AMD4104

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: AMD4104

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 AMD4104, Critical Illness 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 AMD4104 will provide a one time benefit if, following the waiting period, the insured is diagnosed with one of the critical illnesses defined in the rider. The benefit is paid directly to the insured.

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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	

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: AMD4104-\$50  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Public Life Insurance Company	\$50.00	03/23/2011	45907823

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## Correspondence Summary

### Dispositions

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

*SERFF Tracking Number:*      *AFDL-127094435*                      *State:*                      *Arkansas*  
*Filing Company:*              *American Public Life Insurance Company*      *State Tracking Number:*      *48325*  
*Company Tracking Number:*      *AMD4104*  
*TOI:*                      *H11G Group Health - Disability Income*      *Sub-TOI:*                      *H11G.002 Short Term*  
*Product Name:*              *AMD4104 Critical Illness Limited Benefit Rider*  
*Project Name/Number:*      *APL Group CI Rider/AMD4104*

## **Disposition**

Disposition Date: 03/28/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Letter of Authorization	Approved-Closed	Yes
<b>Form</b>	Group Critical Illness Limited Benefit Rider	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number: AMD4104**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/28/2011	AMD4104	Application/Group Enrollment Form	Critical Illness Limited Benefit Rider	Initial		50.000	AMD4104.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)

## CRITICAL ILLNESS 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

<b>MAXIMUM CRITICAL ILLNESS BENEFIT:</b>	[\$10,000, \$15,000, \$20,000, \$25,000]
<b>CRITICAL ILLNESS WAITING PERIOD:</b>	[30, 60, 90] days
<b>CRITICAL ILLNESS:</b>	Heart Attack Kidney Failure Major Organ Failure Paralysis Stroke
<b>REDUCTION IN BENEFITS AT AGE 70:</b>	50% of the Maximum Critical Illness Benefit

### DEFINITIONS

**Critical Illness** means any of the Critical Illnesses listed in the Rider Schedule and defined in this Rider.

**Critical Illness Waiting Period** means the number of days shown in the Rider Schedule following the Effective Date of this Rider. No benefits will be paid for a Critical Illness when the Date of Diagnosis occurs during the Critical Illness Waiting Period.

**Date of Diagnosis** means the first date a Physician establishes the diagnosis of a Critical Illness through the use of objective clinical evidence.

**Heart Attack** means an acute myocardial infarction resulting in the sudden death of the heart muscle resulting from a blockage of one or more coronary arteries. A Physician must make the diagnosis and treatment must occur within 72 hours of the onset of symptoms. The diagnosis must be based on an event, which consists of all of the following:

- (a) the sudden onset of symptoms consistent with a Heart Attack; and
- (b) elevation of cardiac (heart) biomarkers consistent with a Heart Attack; and
- (c) Electrocardiographic changes consistent with a Heart Attack.

The definition of Heart Attack does not include acute or chronic congestive heart failure, atherosclerotic heart disease, angina, including unstable angina, coronary disease or any other dysfunction of the cardiovascular system.

**Kidney Failure (Renal Failure)** means the diagnosis by a Physician of the irreversible failure of both kidneys from any cause that necessitates treatment by renal dialysis or kidney transplantation.

**Major Organ Failure** means diagnosis of organ failure of the liver, both lungs, pancreas, or heart resulting in You being placed on the UNOS (United Network for Organ Sharing) list for transplantation. If You are on the UNOS list for transplantation for more than one organ transplant only a single benefit will be paid.

**Paralysis** means that You have experienced the complete loss of use of two or more limbs for at least 180 consecutive days as a result of a neurological injury. Paralysis must be expected to be permanent and must be diagnosed by a Physician board certified in Neurology. Limb is defined as a complete arm or leg. Paralysis as a result of Stroke is excluded.

**Stroke** means a sudden neurological impairment of sensory and/or motor functions due to aneurysm rupture, acute cerebral occlusion, or acute cerebral hemorrhage from a cerebral artery, which results in permanent damage to the nervous system. Stroke must be diagnosed by a Physician based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic study and presence of neurological deficits persisting for a period of 30 days or greater. Stroke does not mean head injury, subdural hematoma, transient ischemic attack, multi-infarct dementia, or chronic cerebrovascular insufficiency.

### **BENEFITS**

We will pay You the Maximum Critical Illness Benefit shown on the Rider Schedule if You are diagnosed with one of the Critical Illnesses defined in this Rider and:

- (a) the Date of Diagnosis is after the [30, 60, 90] day Critical Illness Waiting Period;
- (b) the Date of Diagnosis occurs while this Rider is in force; and
- (c) the Critical Illness is not excluded by name or specific description in this Rider.

This benefit will be paid only once during Your lifetime regardless of the number of Critical Illnesses diagnosed. Proof of diagnosis must be submitted before benefits are paid.

At age 70 the Maximum Critical Illness Benefit will reduce by 50%.

If You are eligible to receive the Critical Illness Benefit, but die before the benefit amount is paid, the benefit will be paid to Your designated beneficiary or, if none, the benefit will be paid to Your estate.

### **EXCLUSIONS**

In addition to the Exclusions listed in the Certificate to which this Rider is attached, no benefits will be paid for any loss caused by or resulting from:

- (a) a Critical Illness when the Date of Diagnosis occurs during the Waiting Period;
- (b) a Critical Illness diagnosed outside of the United States; or
- (c) a Sickness or Injury not specifically defined in this Rider.

### **PRE-EXISTING CONDITION EXCLUSION**

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Date of Diagnosis occurs before You have been continuously covered under this Rider for 12 consecutive months.

This exclusion will not apply to a Critical Illness caused by or resulting from a Pre-Existing Condition when the Critical Illness Date of Diagnosis occurs after You have been continuously covered under this Rider for 12 consecutive months.

**Pre-Existing Condition** means a disease, Injury, Sickness, physical condition or mental illness for which You have experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Effective Date of this Rider. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness.

### **TERMINATION**

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

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

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## Supporting Document Schedules

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

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

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



2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125

**COMPLIANCE CERTIFICATION**

**ARKANSAS**

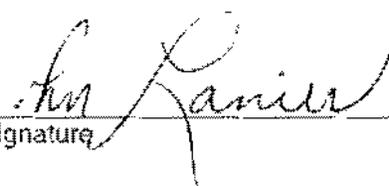
This is to certify that the attached forms comply with the requirements of:

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 Last Name First Name Full Middle Name Suffix

INFORMATION

Age Date of Birth Sex Soc Sec Number Date of Employment
Mo Day Yr M F Mo Day Yr

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
Annual Monthly

Are you currently able to perform the duties of your occupation? Yes No

Applicant's E-mail Address

2. BENEFITS APPLIED FOR

PREMIUM

Table with 8 columns: Product, New, Change, Benefit Amount, Employee, Employer, Frequency, Total. Rows include [STD], [Rider], and a TOTAL row.

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**

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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

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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

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9. Are you currently pregnant?

Yes  No

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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