

SERFF Tracking Number: CCGN-127092608 State: Arkansas
Filing Company: Life Insurance Company of North America State Tracking Number: 48624
Company Tracking Number: 11-3002
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
Product Name: Blanket Accident Insurance
Project Name/Number: Claim Provisions and General Provisions/11-3002

Filing at a Glance

Company: Life Insurance Company of North America

Product Name: Blanket Accident Insurance SERFF Tr Num: CCGN-127092608 State: Arkansas

TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed-Approved- State Tr Num: 48624
Closed

Sub-TOI: H04.000 Health - Blanket Accident/Sickness Co Tr Num: 11-3002 State Status: Approved-Closed

Filing Type: Form

Author: Terri Jones

Date Submitted: 04/29/2011

Reviewer(s): Rosalind Minor

Disposition Date: 05/04/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Claim Provisions and General Provisions

Project Number: 11-3002

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association, Blanket, Trust, Other

Overall Rate Impact:

Deemer Date:

Submitted By: Terri Jones

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

We submit forms BA-01-1540.00 and BA-01-1710.00 for your review and approval. These forms have not been filed with our state of domicile since Pennsylvania does not require the filing of forms intended for delivery outside their state pursuant to PA Notices 96-1 and/or 96-13.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Filing not required in domicile state of PA

Market Type: Group

Group Market Size: Small and Large

Explanation for Other Group Market Type: All eligible groups defined in your law

Filing Status Changed: 05/04/2011

State Status Changed: 05/04/2011

Created By: Terri Jones

Corresponding Filing Tracking Number:

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 Product Name: Blanket Accident Insurance
 Project Name/Number: Claim Provisions and General Provisions/11-3002

These forms are new and not intended to replace any forms currently on file. They are intended for use with Group Policy form BA-01-1000.00 et al which was previously approved by your Department.

A Description of Variability is enclosed. The forms themselves, as well as the Description of Variability, note when certain provisions within these forms may be included, deleted or modified, as applicable to a particular policy. Variable material indicated by hard brackets ([]) indicate text that may be included or excluded. Material indicated by soft brackets ({ }) may be modified as requested by the Policyholder or participating Subscriber. Variable material will never be more restrictive than permitted by law.

Company and Contact

Filing Contact Information

Terri Jones, Compliance Sr. Specialist Terri.Jones@CIGNA.com
 1601 Chestnut St -Two Liberty 215-761-3941 [Phone]
 Philadelphia, PA 19192 215-761-5609 [FAX]

Filing Company Information

Life Insurance Company of North America CoCode: 65498 State of Domicile: Pennsylvania
 1601 Chestnut Street Group Code: 901 Company Type:
 TL16D Group Name: State ID Number:
 Philadelphia, PA 19192 FEIN Number: 23-1503749
 (215) 761-8442 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 2 forms. \$50.00 per form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Life Insurance Company of North America	\$100.00	04/29/2011	47077319

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/04/2011	05/04/2011

SERFF Tracking Number: CCGN-127092608 *State:* Arkansas
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Disposition

Disposition Date: 05/04/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CCGN-127092608 State: Arkansas
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 Product Name: Blanket Accident Insurance
 Project Name/Number: Claim Provisions and General Provisions/11-3002

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Description of Variability	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Claim Provisions	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes

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Form Schedule

Lead Form Number: BA-01-1540.00

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/04/2011	BA-01-1540.00	Policy/Cont ract/Fratern al	Policy/Cont Claim Provisions Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		45.400	BA-01-1540.00 Claim Provisions_P olicy.pdf
Approved-Closed 05/04/2011	BA-01-1710.00	Policy/Cont ract/Fratern al	Policy/Cont General Provisions Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		45.200	BA-01-1710.00 General Provisions.pdf

CLAIM PROVISIONS

Beneficiary

[Any beneficiary designations made under a prior policy/plan which was not provided by Us and which is replaced through coverage under this Policy shall be null and void.]

[The {Policyholder, Insurance Company} shall solicit and maintain all beneficiary designations made under the Policy.]

[If the {Policyholder, Subscriber} elects, after the Effective Date of the Policy, to have Us solicit and maintain beneficiary designations under the Policy, then all beneficiary designations made under the Policy prior to the date of the start of the Solicitation Period by Us shall be null and void as of the day immediately following the last date of that Solicitation Period.

If the {Policyholder, Subscriber} elects, after the Effective Date of the Policy, to discontinue having Us maintain beneficiary designations under the Policy, then all beneficiary designations made under the Policy prior to the date of the start of the Solicitation Period by the {Policyholder, Subscriber} shall be null and void as of the day immediately following the last date of that Solicitation Period.

Solicitation Period shall mean that {30/60/90} day period of time immediately preceding the effective date of the {Policyholder's, Subscriber's} election that is provided to {Employees, Members} insured under the Policy to designate a beneficiary.]

[All beneficiaries designated as to any coverages under this Policy shall be null and void as of the effective date of cancellation of the Policy, except as to those {Employees, Members} for whom coverage remains in effect after Policy cancellation.]

The beneficiary is the person or persons {the Covered Person} names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and {the Policyholder, Subscriber}. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary [, or to make any assignment of rights or benefits permitted by this Policy].

[The {Employee, Member} may change the beneficiary at any time by giving written notice to {the Employer or the Insurance Company}.] A beneficiary designation or change will become effective on the date {the Covered Person} executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless {the Covered Person} has specified otherwise. The share of any beneficiary who does not survive {the Covered Person} will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if {the Covered Person} dies while benefits are payable to him, We may make direct payment to [the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. parents;
4. siblings;
5. estate of {the Covered Person}.]

Or

[the estate of {the Covered Person}.]

Claim Forms

We send forms for filing proof of loss when We receive the notice of claim. If claim forms are not sent within {15 days} after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written {or authorized electronic} proof of the nature and extent of the loss for which claim is made.

[Conditional Claim Payment]

If {the Covered Person} incurs expenses for Injuries received in a Covered Accident and in Our opinion a third party may be liable, We will pay benefits if:

1. {the Covered Person} first agrees in writing to refund the lesser of:
 - a. the amount We actually paid for such expenses; and
 - b. the amount actually received from the third party regardless of whether the amount is for such expenses; and
2. the third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, if the third party's liability is satisfied in an amount less than the benefits paid under this Policy, We will pay the difference.]

Legal Actions

No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of the applicable statute of limitations from the time proof of loss is required to be furnished.

Notice of Claim

Written {or authorized electronic/telephonic} notice must be given to Us or Our agent within 31 days after a {Covered Accident} occurs or the loss begins or as soon as reasonably possible, but in no case any longer than 15 months after the date of loss. If written {or authorized electronic/telephonic} notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written {or authorized electronic/telephonic} notice was given as soon as was reasonably possible. Notice can be given at Our home office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include {the Policyholder's; Subscriber's} name and policy number and {the Covered Person's} name and address.

Payment of Claims

All benefits will be paid in United States currency. Benefits for loss of life will be payable [to {the Employee's, Member's} beneficiary named under this Policy, if any.] *or* [in accordance with the Beneficiary provision and these Claim Provisions.] [All other proceeds payable under this Policy, unless otherwise stated, will be payable to {the covered Employee, Member} or to his estate.] If any payee of benefits is a minor or otherwise legally incompetent, we will pay benefits to the person designated as his legal guardian or conservator.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay {variable; e.g., \$1,000 to \$5,000} to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability.

[Payment of Claims to Foreign Employees]

{The Policyholder, Subscriber} may, in a fiduciary capacity, receive and hold any benefits payable to {Covered Persons} whose place of employment is other than:

- {1. the United States of America;}
- {2. Puerto Rico; or}
- {3. the Dominion of Canada}.

We will not be responsible for the application or disposition by {the Policyholder, Subscriber} of any such benefits paid. Our payments to {the Policyholder, Subscriber} will constitute a full discharge of Our liability for those payments under this Policy.]

Physical Examination [and Autopsy]

We, at Our own expense, have the right and opportunity to examine {the Covered Person} when and as often as We may reasonably require while a claim is pending [and to make an autopsy in case of death where it is not forbidden by law].

Proof of Loss

Written {or authorized electronic} proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within {90 days} after the termination of each period for which We are liable. If written {or authorized electronic} notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written {or authorized electronic} proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when {the Covered Person} dies, We may recover the overpayment from {the Covered Person's} estate.

Time of Payment

We will pay benefits due under this Policy for any loss, other than a loss for which this Policy provides any periodic payment, immediately upon receipt of due written {or authorized electronic} proof of such loss. Subject to due written {or authorized electronic} proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us, unless otherwise shown in the *Benefits* sections of this Policy.

GENERAL PROVISIONS

Addition of New {Employees /Members}	All {Employees/Members} added to the Classes of Covered Classes in the <i>Schedule of Benefits</i> are eligible for insurance under this Blanket Policy.
Assignment	<p><i>Option 1: Include if no rights and benefits are assignable:</i> [The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.]</p> <p><i>Option 2: Include when no assignment other than benefits that have become payable is permitted:</i> [The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.]</p> <p><i>Option 3: Include if assignment is permissible:</i> [We will be bound by an assignment of {the Covered Person's} insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by {the Covered Person} and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy for {the Covered Person} remains in force.]</p> <p>This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.</p>
[Certificates	Where required by law, We will provide a certificate of insurance for delivery to {the Covered Person}. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.]
[[{30 Day} Right To Examine Certificate	<p><i>(Included when the Covered Person pays any part of the premium)</i> If {the Covered Person} does not like the Certificate for any reason, it may be returned to Us within {30 days} after receipt. We will return any premium that has been paid. In that case the Certificate will be void as if it had never been issued.]</p>
Clerical Error	A person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.
Conformity with Statutes	Any provision in this policy that is in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.
Entire Contract	<p>This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.</p> <p>If an enrollment form of any {Covered Person} is required, it may also be made a part of this Policy at Our option.</p>
Examination of the Policy	This Policy will be available for inspection at {the Policyholder's; Subscriber's} office during regular business hours.
Incontestability	<p>[1.] Of This Policy or Participation Under This Policy All statements made by {the Policyholder} to obtain this Policy {or by the Subscriber to participate under this Policy} are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to</p>

deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to {the Policyholder, Subscriber.}

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

[2. Of {The Covered Person's} Insurance

All statements made by {the Covered Person} are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from {the Covered Person's} effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.]

Misstatement of Fact

If {the Policyholder; Subscriber} has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Noncompliance with Policy Requirements

Any express or implied waiver by Us of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by Us to enforce any policy provision will not be a waiver or amendment of that provision.

Policy Changes

No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. We may agree with {the Policyholder; Subscriber} to modify a plan of benefits without {the Covered Person's} consent.

Records

{The Policyholder; Subscriber} or its authorized Administrator will maintain the records of {the Covered Person's} insurance under this Policy. We will be permitted to examine {the Policyholder's; Subscriber's} records relating to the insurance under this Policy at any reasonable time. {The Policyholder; Subscriber} is acting as an agent of {the Covered Person} for transactions relating to this insurance. The actions of {the Policyholder; Subscriber} will not be considered the actions of the Insurance Company.

[Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.]

[Reporting Requirements

The {Policyholder; Subscriber} or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. additional information required by Us.]

[We, at Our sole discretion, may waive reporting of any information specified above.]

[Subscriber Participation Under This Policy

An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by Us.]

Workers' Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

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 Product Name: Blanket Accident Insurance
 Project Name/Number: Claim Provisions and General Provisions/11-3002

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/04/2011
Comments:		
Attachment: LINA Flesch Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	05/04/2011
Comments: Application form TL-007141 was previously approved by your Department on August 17, 1998.		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	05/04/2011
Bypass Reason: This is not a PPACA filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Description of Variability	Approved-Closed	05/04/2011
Comments:		
Attachment: LINA DOV.pdf		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	05/04/2011
Comments:		
Attachment:		

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Cover Letter.pdf

**Life Insurance Company of North America
1601 Chestnut Street
P.O. Box 7716
Philadelphia, PA 19192-2235**

READABILITY CERTIFICATION

We, the Life Insurance Company of North America, certify that we have carefully scored the forms listed below, using the Flesch Readability Test, in accordance with applicable readability standards. These forms were scored separately and in their entirety.

Form Number	Description of Form	Score
BA-01-1540.00	Claim Provisions	45.4
BA-01-1710.00	General Provisions	45.2



Signature: _____

Name: Edward J. Skowronek

Title: Assistant Secretary

Date: 3/17/2011

**LIFE INSURANCE COMPANY OF NORTH AMERICA (LINA)
DESCRIPTION OF VARIABILITY
BLANKET ACCIDENT POLICY**

FORMS: BA-01-1540.00 and BA-01-1710.00

The above-captioned forms are additional forms for use with previous approved policy forms BA-01-1000.00 et al.

General Notes on Variability

This policy form is designed to provide blanket accident insurance that can be issued directly to an employer group or other eligible group. References to “Policyholder”, “Employer” and “Subscriber” may be selected as applicable.

The forms themselves, as well as the Description of Variability, note when certain provisions within these forms may be included, deleted or modified, as applicable to a particular policy. Text enclosed within hard brackets ([]) indicate material that may be included or deleted as requested by a Policyholder. Variable material is indicated by soft brackets ({ }). Variations may result from negotiations between us and the Policyholder. However, variable material will never be more restrictive than permitted by law.

Certain terms, such as Employee or Covered Person, may be varied if requested by a Policyholder. For example, an employer may request that his employees be referred to as associates, and an association may request use of a term such as insured member. Language indicating, for example, that a benefit or provision applies to a specific class, may be added as applicable.

Certain specific information on variability appears within the text of the forms as prepared for this submission. Generally, information on variability that will not be part of an issued policy will appear in italics or may be noted as identifying information that is optional.

Specific Notes on Variability

Listed below is a description of variable text for the forms submitted.

Claim Provisions (BA-01-1540.00)

- Beneficiary Provisions – The solicitation period for designating a beneficiary may be 30, 60 or 90 days.
- Claim Forms – The time period for sending claim forms will range from 15-20 days.
- References to electronic or telephonic Notice of Claim or for Proof of Loss may be modified or deleted based on plan specifications.
- Payment of Claims Provision – The dollar amount may range from \$1,000 to \$5,000.
- Payment of Claims of Foreign Employees Provision – The listing of geographic areas may be modified to reflect the location(s) selected by the Policyholder.
- Proof of Loss – Time period shown may range from 90 to 120 days.

General Provisions (BA-01-1710.00)

- Right to Examine Certificate – The time limit shown may range from 30 to 60 days.

Terri M. Jones
Compliance Specialist
Regulatory & State Government Affairs



CIGNA Group Insurance
Life • Accident • Disability

April 29, 2011

TL16D
1601 Chestnut Street
Philadelphia, PA 19192
Telephone 215-761-3941
Facsimile 215-761-5609
terri.jones@cigna.com

Jay Bradford - Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Life Insurance Company of North America

NAIC #: 0901 – 65498
FEI Number: 23-1503749
Company ID#: 11-3002

Blanket Accident Insurance

Claim Provisions – Form BA-01-1540.00
General Provisions – Form BA-01-1710.00

Dear Commissioner Bradford:

Attached please find the above captioned forms for your review and approval. These forms have not been filed with our state of domicile since Pennsylvania does not require the filing of forms intended for delivery outside their state pursuant to PA Notices 96-1 and/or 96-13.

These forms are new and not intended to replace any forms currently on file. They are intended for use with Group Policy form BA-01-1000.00 et al which was previously approved by your Department.

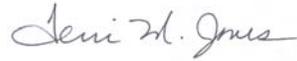
A Description of Variability is enclosed. The forms themselves, as well as the Description of Variability, note when certain provisions within these forms may be included, deleted or modified, as applicable to a particular policy. Variable material indicated by hard brackets ([]) indicate text that may be included or excluded. Material indicated by soft brackets ({ }) may be modified as requested by the Policyholder or participating Subscriber. Variable material will never be more restrictive than permitted by law.

The referenced forms have been written in readable language and are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, positioning and format. However, printing standards will never be less than that required under your law.

April 29, 2011
Page 2

We appreciate you taking the time to review these forms and trust that you will find everything in order. If you should have any questions or require additional information, please do not hesitate to e-mail me at terri.jones@cigna.com or call me collect at 215.761.3941.

Very truly yours,

A handwritten signature in cursive script that reads "Terri M. Jones".

Terri M. Jones