

SERFF Tracking Number: CMBD-127191465 State: Arkansas
 Filing Company: Combined Insurance Company of America State Tracking Number: 48939
 Company Tracking Number: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: 164019-AR - Application for Accident and Health Insurance
 Project Name/Number: 164019-AR - Application for Accident and Health Insurance/164019-AR - Application for Accident and Health Insurance

Filing at a Glance

Company: Combined Insurance Company of America

Product Name: 164019-AR - Application for Accident and Health Insurance SERFF Tr Num: CMBD-127191465 State: Arkansas

TOI: H02I Individual Health - Accident Only SERFF Status: Closed-Approved-Closed State Tr Num: 48939

Sub-TOI: H02I.000 Health - Accident Only Co Tr Num: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor
 Author: Deborah Shortridge Disposition Date: 06/15/2011
 Date Submitted: 05/31/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
 State Filing Description:

Implementation Date:

General Information

Project Name: 164019-AR - Application for Accident and Health Insurance

Status of Filing in Domicile: Pending

Project Number: 164019-AR - Application for Accident and Health Insurance

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: A similar form was filed with our domicile state, Illinois, on May 26, 2011.

Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:

Market Type: Individual
 Individual Market Type:
 Filing Status Changed: 06/15/2011
 State Status Changed: 06/15/2011

Deemer Date:
 Submitted By: Deborah Shortridge
 Filing Description:

Created By: Deborah Shortridge
 Corresponding Filing Tracking Number:

Combined Insurance Company of America
 FEIN Number: 36-2136262
 NAIC Number: 626-62146

SERFF Tracking Number: CMBD-127191465 State: Arkansas
Filing Company: Combined Insurance Company of America State Tracking Number: 48939
Company Tracking Number: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: 164019-AR - Application for Accident and Health Insurance
Project Name/Number: 164019-AR - Application for Accident and Health Insurance/164019-AR - Application for Accident and Health Insurance
Form Nos. 164019-AR - Application for Accident and Health Insurance / 164019-1H - Conditional Receipt

This is a new filing. Form No. 164019-AR is a new application which will not replace any existing application.

Application 164019-AR will be used with our previously approved accident and health forms (listed below). Form No. 164019-1H is the conditional receipt. The forms are being filed as variable to allow them to be used with any future policy form filings. These forms are solicited on a face-to-face basis by our Insurance Producers or by direct market for telephone and mail solicitation.

Form No. Description Approval Date SERFF Tracking #

14028-AR Accident Only Policy August 25, 2005 USPH-6FHQKB441
12400-AR Sickness Only Rider April 13, 2006 USPH-6NMR9Q500
16075-AR Cancer Only Policy December 31, 1987
16521-AR Specified Critical Condition Policy February 27, 2002
16522-AR Specified Critical Condition Policy February 27, 2002

Please consider the arrangement of the information on the application as variable. The information may be rearranged to accommodate data processing or marketing needs but the information will remain the same. The variable bracketed areas are all inclusive; however, we may delete boxes, if necessary, based on our marketing decisions for the policy plans. A variable memorandum is attached.

We appreciate your time in reviewing this filing. Please call me at our toll free number (888-449-3623 ext. 31534) or email me (deborah.shortridge@combined.com) if you have further questions or need additional information.

Company and Contact

Filing Contact Information

Deborah Shortridge, Senior Policy Analyst Deborah.Shortridge@combined.com
1000 Milwaukee Avenue 847-953-1534 [Phone]
Glenview, IL 60025 847-953-1557 [FAX]

Filing Company Information

Combined Insurance Company of America CoCode: 62146 State of Domicile: Illinois
1000 Milwaukee Avenue Group Code: 626 Company Type:
Glenview, IL 60025 Group Name: State ID Number:
(847) 953-1531 ext. [Phone] FEIN Number: 36-2136262

SERFF Tracking Number: CMBD-127191465 State: Arkansas
Filing Company: Combined Insurance Company of America State Tracking Number: 48939
Company Tracking Number: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: 164019-AR - Application for Accident and Health Insurance
Project Name/Number: 164019-AR - Application for Accident and Health Insurance/164019-AR - Application for Accident and Health Insurance

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Combined Insurance Company of America	\$100.00	05/31/2011	48191330

SERFF Tracking Number: CMBD-127191465 State: Arkansas
Filing Company: Combined Insurance Company of America State Tracking Number: 48939
Company Tracking Number: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: 164019-AR - Application for Accident and Health Insurance
Project Name/Number: 164019-AR - Application for Accident and Health Insurance/164019-AR - Application for Accident and Health Insurance

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/15/2011	06/15/2011

SERFF Tracking Number: CMBD-127191465 *State:* Arkansas
Filing Company: Combined Insurance Company of America *State Tracking Number:* 48939
Company Tracking Number: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE
TOI: H02I Individual Health - Accident Only *Sub-TOI:* H02I.000 Health - Accident Only
Product Name: 164019-AR - Application for Accident and Health Insurance
Project Name/Number: 164019-AR - Application for Accident and Health Insurance/164019-AR - Application for Accident and Health Insurance

Disposition

Disposition Date: 06/15/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CMBD-127191465 State: Arkansas
 Filing Company: Combined Insurance Company of America State Tracking Number: 48939
 Company Tracking Number: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: 164019-AR - Application for Accident and Health Insurance
 Project Name/Number: 164019-AR - Application for Accident and Health Insurance/164019-AR - Application for Accident and Health Insurance

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Variability Memorandum	Approved-Closed	Yes
Form	Application for Accident and Health Insurance	Approved-Closed	Yes
Form	Conditional Receipt	Approved-Closed	Yes

SERFF Tracking Number: CMBD-127191465 State: Arkansas
 Filing Company: Combined Insurance Company of America State Tracking Number: 48939
 Company Tracking Number: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: 164019-AR - Application for Accident and Health Insurance
 Project Name/Number: 164019-AR - Application for Accident and Health Insurance/164019-AR - Application for Accident and Health Insurance

Form Schedule

Lead Form Number: 164019 - Application for Accident and Health Insurance

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/15/2011	164019-AR	Application/Enrollment Form	Application for Accident and Health Insurance	Initial		50.000	164019-AR.pdf
Approved-Closed 06/15/2011	164019-1H	Other	Conditional Receipt	Initial			164019-1H.pdf



[5101164019]

1) PERSONAL INFORMATION (Required for all products)

LANGUAGE PREFERENCE E S F

SEX M F INSURED'S FIRST NAME

MIDDLE INITIAL LAST NAME

INSURED'S RESIDENCE ADDRESS

CITY STATE ZIP CODE

PLACE OF BIRTH (COUNTRY) IMMIGRATION STATUS

U.S. Citizen Green Card - U.S. Resident for [3] years or more Green Card - U.S. Resident for less than [3] years

Do you have a [mobile phone]? YES NO PHONE NUMBER SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

Do you have a [landline phone]? YES NO PHONE NUMBER INSURED'S HEIGHT INSURED'S WEIGHT FT. IN. LBS.

INSURED'S DATE OF BIRTH INSURED'S AGE EMAIL MM DD YYYY

MAILING ADDRESS FOR COMPANY CORRESPONDENCE (ONLY IF DIFFERENT FROM RESIDENCE ADDRESS)

CITY STATE ZIP CODE

May we contact you by email for marketing purposes? YES NO

INSURED'S EMPLOYER NAME EMPLOYER PHONE NUMBER

INSURED'S EMPLOYER ADDRESS

CITY STATE ZIP

Please provide any other Combined Policy Number

Please indicate where the Insured would like to receive annual notices, policy contract, or related documents. Email Residence Mailing Address Business

Please indicate where the Insured would like to be contacted by an Agent. Residence Business

Required for all products

Is any person applying for coverage on Medicaid? YES NO If "Yes" whom: Insured Spouse [/Domestic Partner/Civil Union]

Child(ren) Names of Child(ren): _____

(Any person who is currently a Medicaid Recipient is not eligible for coverage under the policy being applied for.)

Will this policy replace any existing policies? YES NO Combined Insurance Policy No. _____ Other _____ Company Name and Policy No. _____

[(If "Yes" please complete Form 030921)]



[5102164019]

2) DEPENDENT INFORMATION (Required for Dependent Coverage under Accident Protector, Accident & Sickness Protector, or Cancer Care Protector).

SEX M F SPOUSE'S [DOMESTIC PARTNER/CIVIL UNION] FIRST NAME MIDDLE INITIAL LAST NAME SOCIAL SECURITY NUMBER (LAST 4 DIGITS) SPOUSE'S [DOMESTIC PARTNER/CIVIL UNION] DATE OF BIRTH HEIGHT FT. IN. WEIGHT LBS.

CHILD'S NAME (FIRST NAME, LAST NAME) (ADDITIONAL CHILDREN INCLUDE SEPARATE PAGE) BIRTHDATE: MO/DAY/YR RELATIONSHIP TO INSURED

(1) SOCIAL SECURITY NUMBER (LAST 4 DIGITS) Answer the qualification question shown below for the policy being applied for: * Qualification Question 1 Yes No

(For additional children include separate page.)

3) PLAN SELECTION

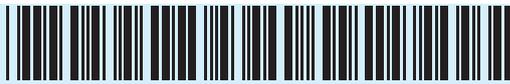
Accident Protector FORM NUMBER 1 4 0 2 8 PLAN CODE A S P Individual Single Parent [X] Individual/Spouse [X] Family [X] Silver (Plan I) Gold (Plan II)

Accident & Sickness Protector FORM NUMBER 1 4 0 2 8 PLAN CODE A S P with Sickness Rider 1 2 4 0 0 Individual Silver (Plan I) [X] Individual/Spouse [X] Gold (Plan II) [X] Single Parent [X] Family

Accident and Sickness Protector Qualification Questions - Read Carefully: (1) To the best of your knowledge and belief, has the Insured or any eligible dependent had any advice or treatment for cancer, stroke, heart attack, or other heart condition, Paraplegia, Congenital Deformity, Muscular Dystrophy, Cystic Fibrosis, or Multiple Sclerosis within the last five (5) years or been diagnosed with insulin dependent diabetes (at any age) or non-insulin dependent diabetes prior to the age of 40? Insured: [X] Yes [X] No Spouse [Domestic Partner/Civil Union]: [X] Yes [X] No

Cancer Care Protector FORM NUMBER 1 6 0 7 5 PLAN CODE C A P Individual Plan Silver (Plan I) [X] Family Plan Gold (Plan II) [X] Platinum (Plan III)

(1) Cancer Care Protector Qualification Question - Read Carefully: To the best of your knowledge and belief, has the Insured or any eligible dependent had any advice or treatment for Cancer, Leukemia, Hodgkin's Disease, AIDS (Acquired Immune Deficiency Syndrome) or skin cancer within the last ten (10) years? Insured: [X] Yes [X] No Spouse [Domestic Partner/Civil Union]: [X] Yes [X] No *Answer Qualification Question for each child listed above.



[5103164019]

4) ADDITIONAL UNDERWRITING INFORMATION (Required for Critical Care Protector only)

Yes No

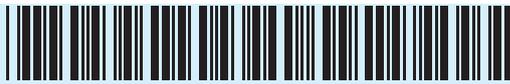
Has the Insured used tobacco products in any form in the last 12 months?

- 1. Has the Insured received any medical ADVICE or TREATMENT from a member of the medical profession, or taken any prescription MEDICINE within the past 5 years for:
 - a. Angina, stroke, heart attack, atrial fibrillation, congestive heart failure, or a heart valve replacement?
 - b. Liver or kidney disorder, cirrhosis of the liver, Hepatitis C, or organ transplant?
 - c. Cancer, melanoma, brain tumor, Hodgkin's disease or leukemia?
 - d. Alzheimer's disease, dementia, Parkinson's disease, Multiple Sclerosis?
 - e. Chronic Obstructive Lung/Pulmonary disease, Emphysema or other lung disease requiring oxygen?
 - f. Manic depression, schizophrenia, alcoholism or drug addiction?
- 2. Is the Insured listed on this application for insurance an insulin dependent diabetic?
- 3. Has the Insured listed been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)?
- 4. Is the Insured currently Disabled (including that from workers' compensation, Social Security but excluding Military Disability)?
- 5. Is the Insured currently pregnant? *(not applicable if male.)*
- 6. Have 2 or more of the Insured's parents, brothers, or sisters been diagnosed with cancer or any malignant growths while they were under the age of 60?
- 7. Have 2 or more of the Insured's parents, brothers, or sisters been diagnosed with heart disease while they were under the age of 60?

If any of the above questions are answered "Yes", the proposed Insured is not eligible for coverage.

- 8. Has the Insured applied for or received Disability Benefits (including that from workers' compensation, Social Security or Military Disability) within the last 12 months?
 - 9. Is the Insured listed on the application for insurance a non-insulin dependent diabetic taking oral medication and/or treated by diet?
 - 10. Within the past 5 years, has the Insured been convicted of: (1) two or more moving violations; (2) driving under the influence of alcohol or drugs, or (3) had a driver's license suspended or revoked?
 - 11. Within the past 10 years, has the Insured been convicted of a felony?
 - 12. In the past 12 months, has a member of the medical profession diagnosed the Insured with or treated the Insured for an injury, disease or disorder of the back, neck, spine, or joint?
 - 13. Within the past 5 years has the Insured had any medical advice (including referrals to other physicians for diagnostic tests and surgery), or treatment from a member of the medical profession, been hospitalized, or taken any prescription medications?
- (If "Yes" is answered to question 9, 10, 11, 12 or 13 explain in the boxes below.) In any case, please provide information on the Insured's physician.**

Health Condition	Date of Diagnosis	Medication/Dosage/Treatment Received	Dates	Physician(s) Name: Address (Street, City, State, Zip) & Phone
			From: To:	
			From: To:	
			From: To:	



[5105164019]

APPLICATION NUMBER

[5 1 0 5]

6) DECLARATIONS – This section must be read, signed, and dated by Insured.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.

In applying for this coverage, I represent and affirm the following:

- 1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
- 2. I received the Outline of Coverage and Notice of Information Practices and if applicable, the Medical Information Bureau (MIB) Disclosure Statement and the notice under the Fair Credit Reporting Act.
- 3. If applying for an Accident Only policy, I understand that the policy does not provide benefits for loss from sickness.
- 4. If applying for Critical Care Protector, I understand that the policy: 1) is NOT major medical and NOT meant to replace medical expense insurance; and 2) is NOT life insurance; and I am not covered by any Title XIX program (Medicaid or any similar name.).
- 5. If applying for the Cancer Care Protector or the Senior Cancer Protector Policy, I understand that the policy is cancer only and does not pay benefits for loss from any other sickness or from accidents. FOR PERSONS ELIGIBLE FOR MEDICARE: I acknowledge receipt of the "Guide to Health Insurance" and duplication notice.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from any of the following: Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically related facilities; Government Agency; Medical Information Bureau, Inc., (MIB); Consumer Reporting Agency; Combined's own records. Combined Insurance Company of America will acquire through a personal phone interview or another means from the above any needed information on the Insured, his/her dependents including but not limited to copies of records, concerning advice, care or treatment, on past or present health, the use of drugs or alcohol, and information relating to mental illness. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance. Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules.

This authorization shall remain valid for a period of two years from the date of application. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to the Company. You may revoke this authorization anytime by writing Combined; however, such revocation may affect coverage. Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

Any person who knowingly presents a 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.

I authorize Combined to show my name, firm name, occupation, city, and years with CICA as a policyholder to prospective insureds. YES NO

X Signature of Insured Date of Application: MM DD YYYY

City (where signed): State:

I, the authorized agent/producer, have on the Date of Application recorded the information as given to me. I have delivered the Notice of Information Practices and Outline of Coverage. I have no knowledge of any unfavorable medical history not recorded on this Application. I certify that I have inspected this application for completeness and according to our field underwriting guidelines it may be submitted to the Home Office for further underwriting review.

Licensed Agent/Producer (print) Agent's/Producer's Signature Code #

Sales Manager (print) Manager's Signature Code #

Date MM DD YYYY

Primary Agent/Producer contact information

Agent's/Producer's phone

Agent's/Producer's e-mail address

Agent's/Producer's cell phone

Home Office use only

Complete this area when splitting commissions.

Primary	Secondary
Agent/Producer Name <input type="text"/>	Agent/Producer Name <input type="text"/>
Code # <input type="text"/>	Code # <input type="text"/>
Percentage <input type="text"/>	Percentage <input type="text"/>
Agent's/Producer's Signature <input type="text"/>	Agent's/Producer's Signature <input type="text"/>



[5106164019]

APPLICATION NUMBER

[5 1 0 6]

AUTOMATIC PREMIUM COLLECTION (Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: _____ City: _____ State: _____

BANK ROUTING NUMBER

BANK ACCOUNT NUMBER

Complete if adding policies from another application

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Charge my Checking Savings Initial Premium Collected \$ _____ Policy Type (L = Life, H = Health) _____

Credit Card Preferred Billing Date (1-28 only) _____ Amount Charged _____

NAME OF CARDHOLDER

CARDHOLDER ZIP CODE

ACCOUNT NUMBER

MONTH

YEAR

CARD TYPE

VISA

MC

EXPIRES

AUTHORIZATION FOR ELECTRONIC DEBIT: I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking, savings, or credit card account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule. I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

X _____ Date: MM DD YYYY

PAYOR'S PHONE NUMBER

Mobile Landline

Signature of Payor/Cardholder (Signature must be the same as on file at the bank/financial institution or represent an authorized signee for a business account.)

**COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601
www.combinedinsurance.com]**

Application No. _____

Amount of Insurance \$ _____

CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY

I have applied for insurance from Combined Insurance Company of America (Combined Insurance).

With my insurance application I, or the payor, have submitted a check, money order, cash or credit card in the amount of: \$ _____

This receipt shall be void and no coverage applied for will take effect if any instrument given in payment of the first premium is not honored.

I understand that this payment will be held by Combined Insurance and, if my application is approved and a policy is issued to me, Combined Insurance will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that the policy(ies) I applied for will NOT become effective unless my initial premium has been paid, the application is approved in writing by Combined Insurance and the applicable policy is delivered to me. I understand that if Combined Insurance approves my application, I will have coverage beginning on the date of such approval by Combined Insurance. If my application is not approved by Combined Insurance, the above premium will be immediately refunded to me.

I understand that in no event will I have coverage for the period between the date of this receipt and the date on which Combined Insurance disapproves or approves my application and issues my policy(ies). The application shall be deemed declined if the policy(ies) is (are) not issued within 60 days after the date of application.

Proposed Insured's Signature _____

Sales Representative's Signature _____

Code # _____

Date MM DD YYYY

SERFF Tracking Number: CMBD-127191465 State: Arkansas
 Filing Company: Combined Insurance Company of America State Tracking Number: 48939
 Company Tracking Number: 164019-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: 164019-AR - Application for Accident and Health Insurance
 Project Name/Number: 164019-AR - Application for Accident and Health Insurance/164019-AR - Application for Accident and Health Insurance

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/15/2011
Comments:		
Attachment: Readability Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	06/15/2011
Bypass Reason: This is an application filing. Please see general information tab.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	06/15/2011
Bypass Reason: Not applicable to this filing.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	06/15/2011
Bypass Reason: Not applicable to this filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Variability Memorandum	Approved-Closed	06/15/2011
Comments:		
Attachment: Variability Memorandum.pdf		



READABILITY CERTIFICATION

RE: Form No. 164019-AR – Application for Accident & Health Insurance Coverage

We hereby certify that the above captioned form has a Flesch Index Score of 50 and meets the reading ease requirements.

A handwritten signature in black ink that reads "Michael J. Hollar".

Michael J. Hollar
Assistant Secretary / Manager



Variable List for Form No. 164019-AR

Variable	Options
Page 1	
1) Personal Information	
Home Office	Bracketed address to alleviate a future filing if the company's address changes.
Website address	Bracketed to alleviate a future filing if the website address changes.
Language Preference Area	The entire line will be removed if only using English version. The individual check boxes maybe removed depending on Company decision regarding languages being offered.
Immigration Status – Green Card	0-3 years
Question “Do you have a [mobile phone] [landline phone]?”	Bracketed to alleviate a future filing if the terminology or phone terminology changes.
Social Security Number	<p>Bracketed to allow for removal of social security section or to obtain just the last four digits.</p> <p>(1) Company executively gives directive not to obtain the SSN# or just obtain the last four digits.</p> <p>(2) A potential client may have a company directive not allowing third party vendors to obtain employee SSN#.</p>
Mailing Address	Bracketed to allow for Company decision to remove in its entirety if not needed for business operations.
Statement regarding receiving notices etc.	Bracketed Email and Mailing Address to allow for company decision to remove in its entirety if not needed for business operations.
(If “Yes” please complete Form 030921)	Bracketed to allow removal if Company decides not to allow for policy form replacements.

Page 2

2) Dependent Information

Social Security Number

Bracketed to allow for removal of social security section or to obtain just the last four digits.

- (1) Company executively gives directive not to obtain the SSN# or just obtain the last four digits.
- (2) A potential client may have a company directive not allowing third party vendors to obtain employee SSN#.

3) Plan Selection

Form Number

Bracketed to allow for a future change in the policy form number.

Plan Code: ASP/CAP

Bracketed to allow for a change to this internally used plan code.

Coverage and Plan Options

Bracketed to allow for us to remove or add to options without having to refile this application.

Page 4

4) Plan Selection (continued)

Form Number

Bracketed to allow for a future change in the policy form number.

Plan Code: CCP/CFO

Bracketed to allow for a change to this internally used plan code.

Page 4

5) Premium & Billing Information

Renewal Modes

Bracketed to allow for removal of a particular mode option.

Premium & Billing Information

Bracketed to allow for flexibility as to what account the applicant prefers renewal premium to be automatically withdrawn from.

Form of Initial Premium Collected

Bracketed to allow line to be removed if information not needed.

Required if Payor (different from Insured)

Bracketed to allow us to delete in its entirety if such name and address not needed.

Statement "Check the most convenient phone number and time to call:"

Bracketed to alleviate a future filing if disclosure not needed.

Required for all products

Bracketed to alleviate a future filing if the terminology or phone terminology changes.

Page 5

6) Declarations

Please read carefully items 3, 4 & 5

3. If applying for an Accident Only policy...

May be deleted if we stop selling the indicated policy.

4. If applying for Critical Care Protector...

5. If applying for the Cancer Care Protector Policy...

Agent Information

Bracketed to allow for removal when application used via direct response.

Home Office use only

All inclusive. May be deleted if Company decision is to not offer split commission.

Variable List for Form No. 164019-1H

Automatic Premium Collection

May be deleted if it is decided to have Automatic Premium Collection as a separate document.

Change my Checking, Savings Credit Card

Bracketed to allow for changes or additions to these options.

Preferred Billing

Bracketed to allow for removal of this line if not needed.

Name of Cardholder

Bracketed to allow for removal if Company decides not to accept renewal premium by credit card.