

SERFF Tracking Number: PERR-127211620 State: Arkansas  
 Filing Company: AXIS Insurance Company State Tracking Number: 49071  
 Company Tracking Number: AXIS-AH-CIR-AR-11-01-F  
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
 Limited Benefit  
 Product Name: Critical Illness Rider  
 Project Name/Number: AXIS-AH-CIR-AR-11-01-F/AXIS-AH-CIR-AR-11-01-F

## Filing at a Glance

Company: AXIS Insurance Company  
 Product Name: Critical Illness Rider SERFF Tr Num: PERR-127211620 State: Arkansas  
 TOI: H07G Group Health - Specified Disease - SERFF Status: Closed-Approved- State Tr Num: 49071  
 Limited Benefit Closed  
 Sub-TOI: H07G.001 Critical Illness Co Tr Num: AXIS-AH-CIR-AR-11- State Status: Approved-Closed  
 01-F  
 Filing Type: Form Reviewer(s): Rosalind Minor  
 Authors: Lana Begunova, Sandra Disposition Date: 06/28/2011  
 Sedano, Addy Anggelico  
 Date Submitted: 06/16/2011 Disposition Status: Approved-  
 Closed  
 Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: AXIS-AH-CIR-AR-11-01-F Status of Filing in Domicile: Pending  
 Project Number: AXIS-AH-CIR-AR-11-01-F Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments: Submitted  
 concurrently.  
 Explanation for Combination/Other: Market Type: Group  
 Submission Type: New Submission Group Market Size: Small and Large  
 Group Market Type: Employer, Association, Blanket, Discretionary, Overall Rate Impact:  
 Trust  
 Filing Status Changed: 06/28/2011 Deemer Date:  
 State Status Changed: 06/28/2011 Submitted By: Addy Anggelico  
 Created By: Lana Begunova  
 Corresponding Filing Tracking Number:  
 Filing Description:  
 On behalf of AXIS Insurance Company (the "Company" or "AXIS"), we are filing the captioned Critical Illness Rider for  
 your review and approval:  
 • Critical Illness Rider - CI-R-0111-AR

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The Rider submitted in this filing will be attached to and become part of the underlying policies. Your Department recently approved the following policy filings:

Policy Form Number: BACC-001-0909-AR  
Department Filing number: PERR-126309547  
Approval Date: 11/4/2009

Policy Form Number: GADD-001-1009-AR  
Department Filing number: AXSS-126405981  
Approval Date: 12/15/2009

The Critical Illness Benefits pay for first diagnosis for certain diseases as elected by the Policyholder as well as an optional Specified Disease and Health Screening Benefit.

Any bracketed material is being filed as variable. Please note, variable information will never be less favorable to an insured than the minimum statutory and regulatory requirements of the state where the policy is issued. Any numeric variables will vary to ranges shown and will comply with minimum statutory/regulatory requirements. A Statement of Variable Language is included to provide you with an explanation of how these forms may vary to accommodate different policyholders, plan designs, or specific clients/cases.

Enclosed is authorization for Perr&Knight to submit this filing on behalf of the Company. All correspondence related to this filing should be directed to Perr&Knight. If there are any requests for additional information related to items prepared by the Company, we will forward the request immediately to the Company contact. The Company's response will be submitted to your attention as soon as we receive it.

## Company and Contact

### Filing Contact Information

Lana Begunova, State Filings Analyst doi@perrknight.com  
881 Alma Real Dr., Suite 205 888-201-5123 [Phone] 151 [Ext]  
Pacific Palisades, CA 90272 310-230-8529 [FAX]

### Filing Company Information

(This filing was made by a third party - perrandknightactuaryconsultants)

AXIS Insurance Company CoCode: 37273 State of Domicile: Illinois  
11680 Great Oaks Way Group Code: 3416 Company Type:  
Ste. 500 Group Name: AXIS Specialty State ID Number:  
Limited



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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/28/2011	06/28/2011



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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Letter of Authority	Approved-Closed	Yes
Supporting Document	Statement of Variability, Actuarial Memorandum	Approved-Closed	Yes
Form	Critical Illness Rider	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number: BACC-001-0909-AR, GADD-001-1009-AR**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/28/2011	CI-R-0111	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Critical Illness Rider	Initial		41.000	CI-R-0111-AR.pdf

**[LOGO]**

Underwritten by:  
AXIS INSURANCE COMPANY  
[303 West Madison, Suite 500  
Chicago, Illinois 60606]  
(A Stock Company)

Administrative Office:  
[1 University Square Drive  
Suite 200  
Princeton, NJ 08540]

[Policyholder/Subscriber]: [ABC Incorporated]  
Policy Number: [XXXXXX]  
Effective Date [of this Rider]: [January 1, 2006]  
[Insured: \_\_\_\_\_ [John R. Smith] \_\_\_\_\_]

This Rider is attached to and made part of the Policy as of the Effective Date shown above. It is subject to all of the provisions, limitations and exclusions of the Policy except as specifically modified herein.

**THIS IS LIMITED BENEFIT COVERAGE.**  
**[FOR CRITICAL ILLNESS BENEFITS TO BE PAYABLE. THE [INSURED PERSON] MUST SURVIVE**  
**FOR 30 DAYS AFTER DIAGNOSIS OF THE CRITICAL ILLNESS.]**  
**[THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

**RIDER SCHEDULE**

**[HEALTH SCREENING BENEFIT . . .**

Per Test Amount ..... [\$50 – \$500]  
[Test Frequency Maximum ..... [1 to 6 [per Insured] per calendar year]]  
[Waiting Period ..... [0 to 90 days]]

**CRITICAL ILLNESS BENEFITS . . .**

**Face Amount**

[Insured Person] [Employee/- Member] ..... [\$1000-500,000]

[Insured Spouse [and/or Domestic Partner]..... [\$1000-\$500,000]  
[2% to 100% of Employee/Member Amount]]

[Insured Dependent Child (ren)..... [\$1000-\$100,000]  
[2% to 50% of the Employee/Member Amount]]

**Critical Illness**

**Benefit Amount**

**[Advanced Alzheimer Disease**

First Diagnosis Benefit..... [2% to 100% of Face Amount]  
[Recurrence Benefit.....None]]

**[Aortic Surgery**

First Diagnosis Benefit..... [2% to 100% of Face Amount  
[Recurrence Benefit.....None]]

**[ADL Deficit [Loss of Independent Living]**

First Diagnosis Benefit ..... [2% to 100% of Face Amount]  
[Recurrence Benefit.....None]]

**[Benign Brain Tumor**

First Diagnosis Benefit..... [2% to 100% of Face Amount]  
Recurrence Benefit.....None]]

**[Coma**

First Diagnosis Benefit ..... [2% to 100% of Face Amount]  
[Recurrence Benefit.....None]]

**[Coronary Bypass Surgery**

First Diagnosis Benefit..... [2 to 100% of Face Amount]  
[Recurrence Benefit..... [2% to 100% of First Diagnosis Benefit][None]]

**[Heart Attack**

First Diagnosis Benefit ..... [2 to 100% of Face Amount]  
[Recurrence Benefit ..... [2% to 100% of First Diagnosis Benefit] [None]]

**[Heart Valve Replacement**

First Diagnosis Benefit..... [2% to 100% of Face Amount]  
[Recurrence Benefit.....None]]

**[Invasive Cancer**

First Diagnosis Benefit ..... [2% to 100% of Face Amount]  
[Recurrence Benefit ..... [2% to 100% of First Diagnosis Benefit] [None]]

**[In-Situ Cancer**

First Diagnosis Benefit ..... [2% to 100% of Face Amount]  
[Recurrence Benefit ..... [2% to 100% of First Diagnosis Benefit] [None]]

**[Kidney (Renal) Failure**

First Diagnosis Benefit ..... [2 to 100% of Face Amount]  
[Recurrence Benefit ..... [2% to 100% of First Diagnosis Benefit] [None]]

**[Loss of Sight, Speech or Hearing**

First Diagnosis Benefit ..... [2% to 100% of Face Amount]  
[Recurrence Benefit.....None]]

**[Multiple Sclerosis**

First Diagnosis Benefit ..... [2% to 100% of Face Amount]  
[Recurrence Benefit.....None]]

**[Organ Transplant**

First Diagnosis Benefit ..... [2% to 100% of Face Amount]

[Recurrence Benefit.....None]

**[Paralysis**

First Diagnosis Benefit

[Quadriplegia .....[25%, 50%, 75% 100% of Face Amount]]

[Paraplegia.....[25%, 50%, 75% 100% of Face Amount]]

[Hemiplegia .....[25%, 50%, 75% 100% of Face Amount]]

[Uniplegia .....[25%, 50%, 75% 100% of Face Amount]]

[Recurrence Benefit.....None]

**[Severe Burn**

First Diagnosis Benefit

[Second Degree Burn.....[2% to 100% of Face Amount]]

[Third Degree Burn.....[2% to 100% of Face Amount]]

[Recurrence Benefit.....None]

**[Stroke**

First Diagnosis Benefit ..... [2% to 100% of Face Amount]

[Recurrence Benefit .....[2% to 100% of First Diagnosis Benefit] [None]]

**[Specified Disease Benefit**

[Initial Hospitalization Benefit ..... [\$100-\$10,000 per Confinement]

[Hospital Confinement Benefit..... [\$50-\$5000 per day up to [15-365 days]  
[\$100-\$10,000 a day for every additional day  
beyond [15 -365 days]]

[Benefit Lifetime Maximum..... [1 to 6 Specified Disease Benefits]]

**Note: Definitions will vary to ranges displayed within brackets and will be included or omitted depending on coverages selected.**

**[Activities of Daily Living (ADLs)** mean the following activities:

Bathing - the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment;

Dressing - the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;

Toileting - the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;

Transferring - the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment;

Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment; and

Continence - the ability to voluntarily maintain control of bowel and/or bladder function or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.]

**ADL Deficit** means the inability to perform without assistance [1-6] [or more] of the Activities of Daily Living (ADLs).

**Critical Illness** – means any of the following illnesses: [Advanced Alzheimer Disease, Aortic Surgery, ADL Deficit [Loss of Independent Living], Benign Brain Tumor, Coma, Coronary Bypass Surgery, Heart Attack, Heart Valve Replacement, Invasive Cancer, In-Situ Cancer, Kidney (Renal) Failure, Loss of Sight, Speech or Hearing, Multiple Sclerosis, Organ Transplant, Paralysis, Severe Burn, Stroke, Specified Disease] as each is defined in this Rider.

**Diagnosed/Diagnosis** – means a definitive and unequivocal diagnosis made by a Physician who specializes in the condition for which benefits are being claimed:: (1) based upon the use of clinical and/or laboratory investigations as supported by the [Insured Person's] medical records; and (2) meeting any Diagnostic Requirements set forth in this Rider for the particular Critical Illness being diagnosed.

**Eligible Class** means the classification(s) of Eligible Persons as shown in the Schedule of Benefits.

**Rider Schedule** means the schedule found in the beginning of this Rider.

**Schedule of Benefits** means the schedule provided in the Policy.

**Sickness** means an illness or disease which requires treatment by a Physician.

Other definitions that apply to this Rider are in the *General Definitions* section of the Policy.

## [EFFECTIVE AND TERMINATION DATES

### **Option 1**

**[[Insured Person's] Effective Date.** Coverage for a person in an Eligible Class as shown in the Schedule of Benefits will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. [the first day of the month following] the date the person becomes a member on an Eligible Class;
3. the date for which the first premium for the person's coverage is paid;
4. the Effective Date of this Rider as shown above;
5. [the first day of the month following] the date the person's Individual Application is approved by the Company.]

**[Insured Spouse's Effective Date.** An eligible Spouse's coverage will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. the [Insured Person's] effective date of insurance;
3. the date for which the first premium for spouse coverage is paid;
4. [the first day of the month following ]the date the [Insured Person] elects spouse coverage under the Policy;
5. the Effective Date of this Rider as shown above;
6. [the first day of the month following] the date the Company approves the [Insured Person's] Individual Application for spouse coverage.]]

**[Insured Dependent's Effective Date.** An eligible Dependent's coverage will become effective on the latest of the following dates:

7. the Policy Effective Date;
8. the [Insured Person's] effective date of insurance;
9. the date for which the first premium for dependent coverage is paid;
10. [the first day of the month following ]the date the [Insured Person] elects dependent coverage under the Policy;
11. the Effective Date of this Rider as shown above;
12. [the first day of the month following] the date the Company approves the [Insured Person's] Individual Application for dependent coverage.]]

### **Option 2**

**[Insured Person's] Effective Date.** Coverage for a person in an Eligible Class as shown in the Schedule of Benefits will become effective as follows.

*[(If Non-Contributory)*

No enrollment is required if a person is not required to contribute towards the cost of coverage. Such person's coverage will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. [the first day of the month following] the date the person becomes a member of an Eligible Class;
3. the date for which the first premium for the person's coverage is paid;
4. the Effective Date of this Rider as shown above.]

*[(If Contributory)*

A person is required to enroll for coverage for which he or she is required to contribute towards the cost of coverage. Such person's coverage will become effective on the latest of the following dates:

1. [the first day of the month following] the date the person's enrollment form is received by the Company [and any required evidence of insurability] [, if such date is within 31 days of the date he or she becomes a member of an Eligible Class];
2. the date for which the first premium for the person's coverage is paid;
3. the Effective Date of this Rider as shown above;
4. the Policy Effective Date.]

**[Insured Spouse's Effective Date.** An eligible Spouse's coverage will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. the [Insured Person's] effective date of insurance;
3. the date for which the first premium for spouse coverage is paid;
4. [the first day of the month following] the date the [Insured Person] elects spouse coverage under the Policy];
5. [the first day of the month following] the date the Company receives the enrollment for insurance [and any required evidence of insurability,] [if application is made more than 31 days after the spouse's eligibility date.]]

**[Insured Dependent's Effective Date.** An eligible Dependent's coverage will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. the [Insured Person's] effective date of insurance;
3. the date for which the first premium for dependent coverage is paid;
4. [the first day of the month following] the date the [Insured Person] elects dependent coverage under the Policy [;
5. [the first day of the month following] the date the Company receives the enrollment for insurance [and any required evidence of insurability,] [if application is made more than 31 days after the dependent's eligibility date.]]

***Use with either Option 1 or 2***

Newborn children are automatically covered from the moment of birth, and adopted children are covered from the earlier of the date of placement or final decree of adoption. If an [Insured Person] is not enrolled for Dependent Child coverage and such [Insured Person] desires uninterrupted coverage for a newborn or adopted child, the [Insured Person] must notify the Company within 31 days of the child's birth or the earlier of the date of placement or final decree of adoption. Upon notification, the Company will convert coverage under the Policy to include Dependent Child coverage and advise the [Insured Person] of the additional premium due. If Dependent Child coverage is in force, it is not necessary to notify the Company of the birth or adoption of a child and an additional premium payment is not required.

[If a husband and wife are eligible to be covered as [Insured Persons], one but not both, is eligible for Dependent Child coverage for their eligible Dependent Children. The other spouse may elect single coverage only.]

**[Late Entrants**

[If a person does not enroll within 31 days after becoming a member of an Eligible Class as shown in the Schedule of Benefits, he or she must meet the Evidence of Insurability Requirement.] [If a person does not enroll within 31 days after becoming a member of an Eligible Classes shown in the Schedule of Benefits,

he or she may only apply for coverage during the *open enrollment period* or within 31 days of a change in family status. The date that insurance takes effect will be the first of the month following the *open enrollment period* or *change in family status*. Evidence of insurability may be required.]]

#### **[Evidence of Insurability Requirement**

Evidence of insurability is required for:

- [a person who enrolls for insurance more than 31 days after the date he or she becomes a member of an Eligible Class as shown in the Schedule of Benefits;]
- an [Insured Person] who voluntarily canceled insurance and who is reapplying;
- a person who is applying after coverage ended due to non-payment.]

#### **[Change in Family Status**

A Change in Family Status means:

1. marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
2. death of or divorce from a Spouse [or Domestic Partner];
3. death of or emancipation of a child;
4. Spouse's loss of employment which results in a loss of group insurance;
5. [change in the [Insured Person's] classification from part-time to full-time or from full-time to part-time.]]

**[Open Enrollment.** The open enrollment period is a period of time agreed upon by the [Policyholder/Subscriber] and the Company, during which: (a) members of an Eligible Class may apply for insurance; and (b) [Insured Persons] may elect to make changes in their amount of insurance or apply for additional insurance.]

**[Effective Date of Changes.** Any change in coverage will take effect on the [[first day of the month following the] date of such change] [Policy Anniversary Date immediately following the date of such change]:

[If the [Insured Person] is not actively at work on the last scheduled work day coincident with or preceding the date that an increase in his or her coverage is to take effect, such increase will be effective on [the first day of the month following ]the date the [Insured Person] returns to active work. [If an Insured Dependent is unable to engage in the activities of a person in good health of like age and sex on the date any increase in his or her insurance would otherwise become effective, such increase will not be effective until the [first day of the month following the] date such Insured Dependent is able to engage in normal activities of a person in good health of like age and sex.]]

**[[Insured Person's] Termination Date.** An [Insured Person's] coverage ends on the earliest of: (1) the date the Policy is terminated; (2) the end of the Grace Period if premiums are not paid when due; (3) attainment of age [65, 70, 75]; (5) the date the [Insured Person] requests, in writing, that his or her coverage be terminated; (4) the date the [Insured Person] ceases to be a member of an Eligible Class.

Termination of coverage will not affect a claim for a Critical Illness benefit or Covered Loss that occurred while the Insured's coverage was in force under the Policy.

If an [Insured Person's] coverage under the Policy ends for any reason, except nonpayment of premium, while the [Insured Person] is hospitalized, coverage shall continue for a period of ten consecutive days during a single period of continuous hospitalization.]

**[Insured Spouse's Termination Date.** An Insured Spouse's coverage ends on the earliest of: (1) the date the [Insured Person's] coverage ends; (2) the end of the Grace Period if premiums for the Insured Spouse are not paid when due; (3) attainment of age [65, 70, 75]; (4) the date the [Insured Person] requests, in writing, that coverage for the Insured Spouse be terminated; (5) the date the Insured Spouse ceases to be an eligible Insured Spouse.

Termination of coverage will not affect a claim for a Critical Illness benefit or Covered Loss which is incurred while the Insured Spouse's coverage was in force under the Policy.

If an Insured Spouse's coverage under the Policy ends for any reason, except nonpayment of premium, while the Insured Spouse is hospitalized, then coverage shall continue for a period of ten consecutive days during a single period of continuous hospitalization.]

**[Insured Dependent's Termination Date.** An Insured Dependent's coverage ends on the earliest of: (1) the date the [Insured Person's] coverage ends; (2) the end of the Grace Period if premiums for the Insured Dependent are not paid when due; (3) attainment of age [65, 70, 75]; (4) the date the [Insured Person] requests, in writing, that coverage for the Insured Dependent be terminated; (5) the date the Insured Dependent ceases to be an eligible Insured Dependent.

Termination of coverage will not affect a claim for a Critical Illness benefit or Covered Loss which is incurred while the Insured Dependent's coverage was in force under the Policy.

If an Insured Dependent's coverage under the Policy ends for any reason, except nonpayment of premium, while the Insured Dependent is hospitalized, then coverage shall continue for a period of ten consecutive days during a single period of continuous hospitalization.]

## DESCRIPTION OF BENEFITS

### HEALTH SCREENING BENEFIT

The Company will pay the Per Test Amount under Health Screening Benefit shown in the Rider Schedule when an [Insured Person] undergoes routine testing [more than [0-90] days] after the Effective Date [of this Rider],.. Services covered are: blood test for triglycerides; breast ultrasound; chest x-ray; colonoscopy; electrocardiogram; fasting blood glucose test; flexible sigmoidoscopy; hem cult stool analysis; mammography; Pap test; PSA (blood test for prostate cancer); serum cholesterol test to determine level of HDL and LDL; serum protein electrophoresis (blood test for myeloma); bone marrow; CA 125 blood test; CA 15-3 blood test for breast cancer; CEA blood test for colon cancer and cervical cancer screening, [breast biopsy,] [or] [any cancer biopsy,] dental cancer screening, stress test (bicycle or treadmill). Service must be ordered or prescribed by a Physician, received while the [Insured Person]'s coverage under the Policy is in force [and a charge must be incurred]. No benefit is payable for any tests in excess of the Test Frequency Maximum shown in the Rider Schedule.]

### CRITICAL ILLNESS DIAGNOSIS BENEFITS

If, while coverage under the Policy is in force, an [Insured Person] is Diagnosed with a Critical Illness by a Physician, the Company will pay the Benefit Amount shown in the Rider Schedule, subject to the Diagnostic Requirements, [Reduction Schedule] and Benefit Payment Conditions listed below.

[Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an [Insured Person] for that Critical Illness, no benefits are payable for that Insured Person with respect to the Diagnosis of any other Critical Illness.]<sup>1</sup>

[Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an [Insured Person] for that Critical Illness, a First Diagnosis Benefit for a separate and subsequently Diagnosed Critical Illness will not be payable unless that subsequently Diagnosed Critical Illness is medically unrelated to the previously Diagnosed Critical Illness.]<sup>2</sup>

[Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an [Insured Person] for that Critical Illness, a Recurrence Benefit may become payable for a recurrence of that same Critical Illness but no benefits are payable for that [Insured Person] with respect to the Diagnosis of any other Critical Illness.]<sup>3</sup>

[Once a Critical Illness has been Diagnosed and a First Diagnosis Benefit has become payable to an [Insured Person] for that Critical Illness, a Recurrence Benefit may become payable for a recurrence of that same Critical Illness, but a First Diagnosis Benefit for a separate and subsequently Diagnosed Critical Illness will not be payable unless that subsequently Diagnosed Critical Illness is medically unrelated to the previously Diagnosed Critical Illness.]<sup>4</sup>

### Benefit Payment Conditions

Payment of benefits upon the first Diagnosis of the Critical Illnesses listed below are subject to the following:

1. [the Diagnosis is made within the United States, it territories or possessions;]
2. the Diagnosis is made while the [Insured Person's] coverage is in force under the Policy;
3. payment is not precluded by any general or specific exclusion or limitation set forth in this Rider or any failure to meet any condition precedent set out below; [
4. the [Insured Person] survives for at least 30 days after the date the Critical Illness is Diagnosed.]

## Diagnostic requirements

- **All Critical Illnesses** – The Company reserves the right to have any Critical Illness Diagnosis reviewed by a Physician of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to request an examination of either the [Insured Person] or the evidence used in arriving at such Diagnosis by an independently acknowledged expert selected by the Company in the applicable field of medicine.

The opinion of such expert as to such Diagnosis shall be binding on both the [Insured Person] and the Company.

## [Advanced Alzheimer Disease]

**First Diagnosis** If an [Insured Person] is first Diagnosed with Advanced Alzheimer Disease [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Advanced Alzheimer Disease shown in the Rider Schedule.

**Definitions** For purposes of this benefit:

**Advanced Alzheimer's Disease** means a degenerative disorder of brain nerve cells manifested by memory loss, confusion and disorientation; usually begins in middle or late life with gradual progression.

## Diagnostic requirements

The [Insured Person] must exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. It must result in significant reduction in mental and social functioning such that the [Insured Person] requires substantial assistance in performing at least [1-6] of the Activities of Daily Living. The Diagnosis of Advanced Alzheimer's Disease must be made by a legally qualified, board certified neurologist. ]

## [Aortic Surgery]

**First Diagnosis** If an [Insured Person] is first Diagnosed and receives Aortic Surgery [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Aortic Surgery shown in the Rider Schedule.

**Definitions** For purposes of this benefit:

**Aortic Surgery** means undergoing surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches. The definition does not include surgical procedure (for example the insertion of stents) or endovascular repair and surgery following traumatic injury to the aorta.]

## [Activities of Daily Living (ADL) Deficit [Loss of Independent Living]]

**First Diagnosis** If an [Insured Person] is first Diagnosed as having an ADL Deficit [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for ADL Deficit shown in the Rider Schedule of Benefits.

## Diagnostic requirements

The Diagnosis must indicate that the condition is expected to be permanent. The [Insured Person] must continue to be under the regular and appropriate care of a Physician.]

### **[Benign Brain Tumor**

**First Diagnosis** If an [Insured Person] is first Diagnosed as having a Benign Brain Tumor [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Benign Brain Tumor shown in the Rider Schedule.

[The Benign Brain Tumor benefit is paid in lieu of the ADL Deficit benefit.]

**Definitions** For purposes of this benefit:

**Benign Brain Tumor** means a non cancerous tumor in the brain that either requires surgical excision or causes permanent neurological impairment persisting for at least [3-12] consecutive months.

**Benign Brain Tumor** does not include:

1. Cysts, granulomas, malformation in, or of, the arteries or veins of the brain; or
2. Hematomas and /or tumors of the pituitary gland or spine.

### **Diagnostic requirements**

The Diagnosis shall be based on objective clinical findings and laboratory data that confirm the presence of a non cancerous tumor of the brain and demonstrate evidence of permanent neurological impairment. The permanent neurological impairment must result in the [Insured Person's] inability to perform without assistance at least [2-6] of the Activities of Daily Living. The Diagnosis must be confirmed by a Physician who is a neurologist.]

### **[Coma**

**First Diagnosis** If an [Insured Person] is first Diagnosed as being Comatose [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Coma shown in the Rider Schedule.

**Definitions** For purposes of this benefit:

**Coma** or Comatose means a profound state of unconsciousness from which the [Insured Person] is not likely to be aroused through powerful stimulation. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment, illness or injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of illness or injuries.

### **Diagnostic requirements**

The Coma must continue for [30-180 consecutive days] and must be Diagnosed and treated regularly by a Physician. ]

### **[Coronary Artery Bypass**

**First Diagnosis.** If an [Insured Person] is first Diagnosed with a condition that necessitates a Coronary Artery Bypass and receives the Coronary Artery Bypass [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Coronary Artery Bypass shown in the Rider Schedule.

**[Recurrence** If a First Diagnosis Benefit for Coronary Artery Bypass has been paid and more than [3-24] months following the first Diagnosis, such Insured Person is Diagnosed with a subsequent condition that

necessitates a Coronary Artery Bypass and receives the Coronary Artery Bypass, the Company will pay the Recurrence Benefit Amount for Coronary Artery Bypass shown in the Rider Schedule.]

**Definitions** For purposes of this benefit:

**Coronary Artery Bypass** – means the use of non-coronary blood vessel or blood vessels (either artery or vein) to surgically bypass obstructions in a native coronary artery or arteries.

**Diagnostic requirements**

The Diagnosis of the condition that necessitates the need for a Coronary Artery Bypass must be made by a cardiologist and based on angiographic evidence of the underlying disease.]

**[Heart Attack**

**First Diagnosis** If an [Insured Person] is Diagnosed as having suffered a Heart Attack [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount shown for Heart Attack in the Rider Schedule.

**[Recurrence** If a First Diagnosis Benefit for Heart Attack has been paid and more than [3–24] months following the first Diagnosis, such Insured Person is Diagnosed as having had a subsequent Heart Attack, the Company will pay the Recurrence Benefit Amount for Heart Attack shown in the Rider Schedule.]

**Definitions** For purposes of this benefit:

**Heart Attack** means the death of a portion of the heart muscle as a result of inadequate cardiac blood supply to the relevant area.

**Diagnostic requirements**

The Diagnosis of Heart Attack must be based on an event which contains all of the following criteria: (1) associated new electrocardiographic (EKG) changes which support the Diagnosis; (2) concurrent diagnostic elevation of cardiac enzymes above normal levels; and (3) confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.]

**[Heart Valve Replacement**

**First Diagnosis.** If an [Insured Person] is Diagnosed with a condition that necessitates a Heart Valve Replacement and receives the Heart Valve Replacement [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount shown for Heart Valve Replacement in the Rider Schedule.

**Definitions** For purposes of this benefit:

**Heart Valve replacement** means surgery requiring median sternotomy (surgery through the breastbone) on the advice of a Cardiologist to repair one or more heart valves.]

**[Invasive Cancer**

**First Diagnosis** If an [Insured Person] is first Diagnosed with Invasive Cancer [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Invasive Cancer shown in the Rider Schedule.

**[Recurrence** If a First Diagnosis Benefit for Invasive Cancer has been paid and more than [3–24] months following the first Diagnosis, such Insured Person is Diagnosed as having had a subsequent occurrence of Invasive Cancer, the Company will pay the Recurrence Benefit Amount for Invasive Cancer shown in the Rider Schedule.]

**Definitions** For purposes of this benefit:

**Invasive Cancer** – means a disease which is manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. For the purposes of this definition, it does NOT mean the following:

1. pre-malignant lesions, benign tumors or polyps;
2. leukoplakia;
3. hyperplasia;
4. carcinoid;
5. any tumors in the presence of any human immuno-deficiency virus (HIV);
6. polycythemia;
7. stage 1 Hodgkin's disease;
8. stage A prostate cancer;
9. Duke's stage A colon cancer;
10. intraductal non-invasive breast cancer;
11. stage 0 or 1 transitional cell carcinoma of urinary bladder; and
12. any skin cancer other than malignant melanoma with a depth of 1mm or deeper or greater than Clark level 2.
13. T<sub>1</sub>N<sub>0</sub>M<sub>0</sub> (TNM Classification System) papillary carcinoma of the thyroid less than 1 cm in diameter;
14. chronic Lymphocytic Leukemia RAI stage 0;
15. In-Situ Cancer.

**In-Situ Cancer** – means carcinoma cancer that is confined to the organ where it first developed and has not spread to other parts of the body. In-Situ Cancer includes Stage 1 Hodgkin's disease

#### **Diagnostic requirements**

Invasive Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.]

#### **[In-Situ Cancer**

**First Diagnosis** If an [Insured Person] is first Diagnosed with In-Situ Cancer [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for In-Situ Cancer shown in the Rider Schedule.

**[Recurrence** If a First Diagnosis Benefit for In-Situ Cancer has been paid and more than [3–24] months following the first Diagnosis, such Insured Person is Diagnosed as having had a subsequent occurrence of In-Situ Cancer, the Company will pay the Recurrence Benefit Amount for In-Situ Cancer shown in the Schedule of Benefits.]

**Definitions** For purposes of this benefit:

**In-Situ Cancer** – means carcinoma cancer that is confined to the organ where it first developed and has not spread to other parts of the body. In-Situ Cancer includes Stage 1 Hodgkin's disease

#### **Diagnostic requirements**

In-Situ Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.]

## **[Kidney (Renal) Failure**

**First Diagnosis** If an [Insured Person] is first Diagnosed with Kidney (Renal) Failure [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Kidney (Renal) Failure shown in the Rider Schedule.

**[Recurrence** If a First Diagnosis Benefit for Kidney (Renal) Failure has been paid and more than [3–24] months following the first Diagnosis, such Insured Person is Diagnosed as having had subsequent Kidney (Renal) Failure, the Company will pay the Recurrence Benefit Amount for Kidney (Renal) Failure shown in the Schedule of Benefits.]

**Definitions** For purposes of this benefit:

**Kidney (Renal) Failure** means end stage failure which: (1) presents as a chronic irreversible failure of at least one of the kidneys to function; and (2) necessitates treatment by regular renal dialysis or kidney transplant.

### **Diagnostic requirements**

The Diagnosis of Kidney (Renal) Failure must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.]

## **[Loss of Sight, Speech or Hearing**

**First Diagnosis** If an [Insured Person] is first Diagnosed as having suffered Loss of Sight, Speech or Hearing [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Loss of Sight, Speech or Hearing shown in the Rider Schedule.

**Definitions** For purposes of this benefit:

**Loss of Sight, Speech, or Hearing** means the irreversible loss of sight in both eyes, the irreversible loss of the ability to speak, or the irreversible loss of hearing for all sounds in both ears.

### **Diagnostic requirements**

The Diagnosis of Loss of Sight, Speech, or Hearing must be made by a licensed professional or specialist in the applicable field of medicine. The Diagnosis of Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 200 degrees in both eyes. The Diagnosis of Loss of Speech must include documented evidence of the illness for the continuous 12-month period prior to the Diagnosis. The Diagnosis of Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.]

## **[Multiple Sclerosis**

**First Diagnosis** If an [Insured Person] is first Diagnosed with Multiple Sclerosis [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Multiple Sclerosis shown in the Rider Schedule.

### **Diagnostic requirements**

The Diagnosis of Multiple Sclerosis must be determined by a consultant neurologist. There must be a current clinical impairment of motor or sensory function, which has persisted for a continuous period of at least [6, 12 18] months. ]

## **[Organ Transplant**

**First Diagnosis** If an [Insured Person] is first Diagnosed as needing an Organ Transplant and such Insured Person undergoes the Organ Transplant [more than [0-90] days] after the Effective Date [of this Rider]; the Company will pay the Benefit Amount for Organ Transplant shown in the Rider Schedule.

**Definitions** For purposes of this benefit:

**Organ Transplant** means having undergone surgery as a recipient of a transplant as follows:

1. human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation; or
2. whole human organs limited to: heart, lung, liver, or pancreas because of the irreversible end stage failure of such organ.

For the purpose of this definition, Organ Transplant does **NOT** mean:

1. other stem cell transplant; or
2. part of an organ transplant.

### **Diagnostic requirements**

The Diagnosis and medical necessity for an Organ Transplant must be determined as follows:

- For a heart transplant: by a Physician who is a transplant cardiologist and supported by objective clinical findings and laboratory data.
- For a liver transplant: by a Physician who is a gastroenterologist and supported by objective clinical findings and laboratory data. The need for a liver transplant resulting either directly or indirectly from drug overdose or excessive alcohol ingestion is not covered under this Benefit
- For a lung transplant: by a Physician who is a pulmonologist and supported by objective clinical findings and laboratory data including
  - Pulmonary function test;
  - Chest X-Ray; and
  - Evidence of end stage lung disease
- For pancreas transplant: by a Physician who is an endocrinologist or gastroenterologist and supported by objective clinical findings and laboratory data including
  - Diagnosis of Type 1 diabetes; and
  - Evidence of progressive end organ dysfunction.
- For Bone Marrow Transplant: by a Physician who is an oncologist or hematologist and supported by objective clinical findings and laboratory data including pathology reports supporting the underlying Diagnosis.]

### **[Paralysis**

**First Diagnosis** If an [Insured Person] is first Diagnosed as being Paralyzed [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Paralysis shown in the Rider Schedule.

**Definitions** For purposes of this benefit:

**Paralysis/Paralyzed** – means Quadriplegia, Paraplegia, Hemiplegia or Uniplegia that is expected to last for a continuous period of 12 months or more from either the date of the injury causing Paralysis or the date of the diagnosis of the illness causing Paralysis. “Quadriplegia” means the complete and irreversible Paralysis of both upper and lower limbs. “Paraplegia” means the complete and irreversible Paralysis of both lower limbs. “Hemiplegia” means the complete and irreversible Paralysis of the upper and lower limbs of the same side of the body. “Uniplegia” means the complete and irreversible paralysis of one limb. “Limb” means entire arm or entire leg.

## **Diagnostic requirements**

The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis.]

## **[Specified Disease**

**First Diagnosis** If an [Insured Person] is first Diagnosed with a Specified disease [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Initial Hospitalization Benefit amount shown in the Rider Schedule, when an [Insured Person] is confined to a Hospital for at least 12 hours or more as a result of receiving treatment for a Specified Disease. [This benefit is payable only once per Period of Confinement][and once per calendar year]].

[The Company will pay the Hospital Confinement Benefit Amount shown in the Rider Schedule when a [Insured Person] is Confined to a Hospital for a Diagnosed Specified Disease.]

**Definitions** For purposes of this benefit:

**Specified Disease** means one of the following diseases; adrenal hypo function, Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig Disease), botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, legionnaires disease, malaria, meningitis, muscular dystrophy, polio, rabies, Reye's syndrome, scarlet fever, scleroderma, sickle cell anemia, systemic lupus, tetanus, toxic shock syndrome, tuberculosis, typhoid fever, variant Creutzfeldt-Jakob disease ( mad cow disease). The diagnosis must be made upon a tissue specimen, culture, and/or titer.

**[Hospital Confinement or Confined to a Hospital** means a stay of [24-98] [or more] consecutive hours as a registered resident bed-patient in a Hospital. Separate Hospital Confinements due to the same Specified Disease will be treated as one Hospital Stay unless separated by at least [30 days - 180 days].]

## **[Severe Burn**

**First Diagnosis** If an [Insured Person] is first Diagnosed as having suffered a Severe Burn [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Severe Burn shown in the Rider Schedule.

**Definitions** For purposes of this benefit:

**Severe Burn/Severely Burned** means cosmetic disfigurement of at least 20% of the surface of a body area that is a second degree, partial thickness burn or a third-degree, full-thickness burn, as determined by a Physician. (A second degree, partial thickness burn, is the destruction of the skin through the epidermal layers, extending into the dermis layer; a third degree, full-thickness burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).

## **[Stroke**

**First Diagnosis** If an [Insured Person] is first Diagnosed with having suffered a Stroke [more than [0-90] days] after the Effective Date [of this Rider], the Company will pay the Benefit Amount for Stroke shown in the Rider Schedule.

**[Recurrence.** If a First Diagnosis Benefit for Stroke has been paid and more than [3–24] months following the first Diagnosis, such Insured Person is Diagnosed as having had a subsequent Stroke, the Company will pay the Recurrence Benefit Amount for Stroke shown in the Rider Schedule.]

**Definitions** For purposes of this benefit:

**Stroke** – means: (1) a cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or embolization from an extra-cranial source lasting more than 24 hours; and (2) producing measurable neurological deficit persisting for at least [30] days following the occurrence of the Stroke.

The following are not considered Strokes:

1. Transient Ischemic Attacks (TIAs)
2. Vertebro-Basilar Insufficiency
3. Incidental findings on imaging studies

*Transient Ischemic Attack (TIA)* means a neurological condition or event with the signs and symptoms of a stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.]

**Diagnostic requirements**

The Diagnosis of Stroke must be made by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.]

## LIMITATIONS AND EXCLUSIONS

### [Reduction Schedule

The benefit amount payable for a Critical Illness will be reduced by [25%-50%] if an Insured Person is age [65, 70, 75] or older on the date the benefit becomes payable.

"Age" as used above refers to the age of the [Insured Person] on the [Insured Person's] most recent birthday, regardless of the actual time of birth.]

### [Pre-Existing Condition Limitation

Benefits provided by this Rider are not payable in connection with a Pre-Existing Condition for a period ending the earlier of: [(1) the end of 12 consecutive months commencing on or after the date the [Insured Person] has been enrolled for coverage under this Rider during all of which the [Insured Person] has received no medical advice or treatment in connection with the Pre-Existing Condition; and (2) the end of the 2-year period commencing on the effective date of the [Insured Person's] coverage under this Rider.] A Critical Illness resulting from a Pre-Existing Condition commencing thereafter will be covered unless otherwise excluded by this Policy.

A Pre-Existing Condition means a disease or physical condition for which medical advice or treatment was received by the [Insured Person] during the [6, 12, 18] months immediately preceding the Effective Date [of this Rider].]

### Exclusions

#### Exclusions

This Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

- (a) the Insured Person's suicide, or intentional self inflicted Injury or Sickness, while sane or insane.
- (b) the Insured Person's being under the influence of an excitant, depressant, hallucinogen, narcotic, other drug; or intoxicant including those taken as prescribed by a Physician.
- (c) the Insured Person's commission of or attempt to commit an assault or felony.
- (d) the Insured Person's engaging in an illegal activity or occupation.
- (e) the Insured Person's voluntary participation in a riot.
- (f) any illness, loss or condition specifically excluded from the definition of any Critical Illness.
- (g) war, whether declared or not, however this does not include loss due to terrorism.
- [(h) balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedure].
- [(i) any Injury or Sickness covered under any state or federal Worker's Compensation, Employer's Liability law or similar law.]<sup>3</sup>

The President and Secretary witness this Rider:

[



] 6

CI-R-0111-AR

[



] 7

18

Secretary

President

SERFF Tracking Number: PERR-127211620 State: Arkansas  
 Filing Company: AXIS Insurance Company State Tracking Number: 49071  
 Company Tracking Number: AXIS-AH-CIR-AR-11-01-F  
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
 Limited Benefit  
 Product Name: Critical Illness Rider  
 Project Name/Number: AXIS-AH-CIR-AR-11-01-F/AXIS-AH-CIR-AR-11-01-F

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	06/28/2011
<b>Comments:</b>		
<b>Attachment:</b> Readability41 x NC, NY.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	06/28/2011
<b>Comments:</b>		
The applications have been approved under State Tracking Numbers: PERR-126309547 and AXSS-126405981.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Letter of Authority	Approved-Closed	06/28/2011
<b>Comments:</b>		
<b>Attachment:</b> PKAuthorization.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability, Actuarial Memorandum	Approved-Closed	06/28/2011
<b>Comments:</b>		
<b>Attachments:</b> Blanket Statement of Variability-CI Rider.pdf AXIS Insurance Company Actuarial Memorandum Critical Illness Rider CI-R-0111.pdf		





May 2, 2011

Re: Axis Insurance Company - NAIC#: 3416 37273 / FEIN#: 39-1338397

Critical Illness Rider

To Whom It May Concern:

Perr & Knight is hereby authorized to submit rate, rule, and form filings on behalf of Axis insurance Company. This authorization includes providing additional information and responding to questions regarding the filings on our behalf as necessary. This authorization is deemed to be in effect until rescinded in writing.

Please direct all correspondences and inquiries related to this filing to Perr & Knight at the following address:

State Filings Department

Perr&Knight

881 Alma Real Drive, Suite 205

Pacific Palisades, CA 90272

Phone: (310) 230-9339

Fax: (310) 230-1061

Please contact me if you have any questions regarding this authorization.

Sincerely,

A handwritten signature in black ink that reads "Megan K. Morehead". The signature is written in a cursive style and is positioned above the printed name.

Megan K. Morehead

Assistant VP Compliance

megan.morehead@axiscapital.com



**AXIS Insurance Company**  
**STATEMENT OF VARIABLE LANGUAGE for**  
**Critical Illness Rider – CI-R-0111**

Language that is bracketed in the form is intended to be variable. Below is an explanation of those variables.

<b>FORM</b>	<b>Variable</b>	<b>Description of Variable</b>
General Variable Items		<p>Any bracketed material is being filed as variable. Please note variable information will never be less favorable to an insured than the minimum statutory and regulatory requirements of the state where the policy is issued. Any numeric variables will vary to ranges shown and will comply with minimum statutory/regulatory requirements.</p> <p>Brackets around numbers or alphas in listing, and punctuation/words such as “and/or” in a listing, will be included or deleted as needed in order to make the statement or provision read correctly.</p> <p>Reference to Insured Person may vary to reflect group type. E.g., when underlying Policyholder is an Employer, the term may be change to “Employee.” When underlying Policyholder is a School, the term may be changed to “Student.”</p> <p>Reference to Spouse may also include a Same Sex Spouse where same sex marriage is recognized or Domestic Partner where said coverage is allowed by state law. Reference to Domestic Partner may vary to reflect the proper designation allowed by state law, e.g., Partner to a Civil Union.</p> <p>The format may vary according to plan design or policyholder preference; however the relative prominence of provisions will not change. Subject to state readability laws, the print size, style, page size and layout may be modified to reflect various formats including 8.5 x 11 pages, booklets or brochure styles.</p>
	1	Logo
	2	Company address may change
	3	<ul style="list-style-type: none"> <li>• Policyholder – John Doe information</li> <li>• Policy Number - John Doe information</li> <li>• Policy Effective Date - John Doe information ; Effective Date may be date Policy Effective Date, or if Rider is issued after Policy Effective Date, Rider will take effect on Rider Effective Date</li> <li>• Insured – John Doe information; name of individual Insured may or may not be included on Rider</li> </ul>
	5	This sentence will be included when a survival period is included in the Critical Illness benefits.
Rider Schedule		<p>Benefits shown will be included or omitted according to plan design. Benefit amounts will vary to range shown.</p> <p>The Schedule is variable in its entirety and will reflect plan design. The appropriate language will always appear but the arrangement and formatting may vary. Any language required by statute or regulation will always appear and not be excluded or limited.</p>
Health Screening Benefit		<p>This benefit may be included or omitted according to plan design. When this benefit is included:</p> <ul style="list-style-type: none"> <li>• The test frequency maximum may be included or omitted according to plan design. When included it will vary from 1 to 6</li> </ul>

		<p>tests and may apply per Insured or per year for all insureds.</p> <ul style="list-style-type: none"> <li>The waiting period may be included or omitted according to plan design. When included it will vary to range shown.</li> </ul>
Critical Illness Benefits		<p>Face Amount for an Insured Person will be a lump sum payment where amount varies to the range shown.</p> <p>Dependents and/or Spouses may be covered depending on plan design and policyholder preference. When covered, the benefit may be provided as a lump sum payment or as a percentage of the Insured Person's face amount.</p> <ul style="list-style-type: none"> <li>Benefits may be included or omitted according to plan design.</li> <li>Benefits will be paid as a percentage of the face amount; percentage will vary to range shown.</li> <li>The reference to recurrence benefit may be included or omitted according to plan design.</li> </ul>
Advanced Alzheimer Disease		
Aortic Surgery		
ADL Deficit [Loss of Independent Living]		The benefit may also be called "Loss of Independent Living"
Benign Brain Tumor		
Coma		
Coronary Bypass Surgery		A recurrence benefit may be included or omitted according to plan design. When included it will be a percentage of the First Diagnosis benefit and will vary to the percentage shown.
Heart Attack		A recurrence benefit may be included or omitted according to plan design. When included it will be a percentage of the First Diagnosis benefit and will vary to the percentage shown.
Heart Valve Replacement		
Invasive Cancer		A recurrence benefit may be included or omitted according to plan design. When included it will be a percentage of the First Diagnosis benefit and will vary to the percentage shown.
In-Situ Cancer		A recurrence benefit may be included or omitted according to plan design. When included it will be a percentage of the First Diagnosis benefit and will vary to the percentage shown.
Kidney (Renal) Failure		A recurrence benefit may be included or omitted according to plan design. When included it will be a percentage of the First Diagnosis benefit and will vary to the percentage shown.
Loss of Sight, Speech or Hearing		
Multiple Sclerosis		
Organ Transplant		
Paralysis		A First Diagnosis Benefit may be paid for: Quadriplegia, Paraplegia, Hemiplegia, and/or Uniplegia. The benefit(s) will be paid as one of the percentages of the Face Amount shown.
Severe Burn		A First Diagnosis Benefit may be paid for: 2 <sup>nd</sup> degree burn and/or 3 <sup>rd</sup> degree burn.
Stroke		A recurrence benefit may be included or omitted according to plan design. When included it will be a percentage of the First Diagnosis benefit and will vary to the percentage shown.
Specified Disease Benefit		The benefit may be paid for an initial hospitalization and/or for hospital confinement. The Lifetime benefit maximum may be included or omitted according to plan design.
Definitions		Definitions shown as variables are included or omitted according to plan design.
Effective Date and Termination Dates		This section may be included or omitted. When the rider has the same

	<p>effective/termination dates as the underlying policy, this section will be omitted.</p> <p>References to Dependent and/or Spouse provisions may be included or omitted depending on whether Dependent and/or Spouse coverage is offered or selected.</p> <p>Insured Person's Effective Date provision, number 5, contains reference to an Individual Application. At this time, there is no application developed for this coverage, thus this bullet will be omitted from this provision. In the near future, the Company does plan on developing an Individual Application for this coverage (will include simplified underwriting questions). The company will file this Application with your Department prior to use of the application.</p> <p>The provisions which may be used when coverage is offered on a contributory basis (Insured Person's/Spouse's/Dependent's Effective Date) have a reference to evidence of insurability. Again, until the Individual Application is developed, this reference will be omitted from these provisions.</p> <p>The following provisions will be included or omitted according to plan design and policyholder preference:</p> <ul style="list-style-type: none"> <li>• Late Entrants</li> <li>• Evidence of Insurability</li> <li>• Change in Family Status</li> <li>• Open Enrollment</li> </ul> <p>Effective Date of changes may occur on: the first day of the month following the date of the change; the date of the change; or the Anniversary date following the date of the change.</p> <p>The Actively at work provision may be included or omitted.</p>
Description of Benefits	<p>As described in Rider Schedule, benefits shown will be included or omitted according to plan design.</p> <p>Waiting Periods will be included or omitted according to plan design.</p>
Critical Illness Diagnosis Benefit	<p>Reference to Reduction Schedule will be included or omitted depending on plan design.</p> <ol style="list-style-type: none"> <li>1. This provision will be included when Insureds are entitled to one First Diagnosis benefit for one Critical Illness. (One benefit paid for one Critical Illness only.)</li> <li>2. This provision will be included when Insureds are entitled to one First Diagnosis benefit per Critical Illness, but Critical Illnesses must be medically unrelated.</li> <li>3. This provision will be included when Insureds are entitled to one First Diagnosis benefit and one Recurrence benefit for one Critical Illness. (Benefits paid for one Critical Illness only.)</li> <li>4. This provision will be included when Insureds are entitled to one First Diagnosis benefit and one Recurrence benefit for one Critical Illness, but another First Diagnosis benefit may be payable for another Critical Illness. Critical Illnesses must be medically unrelated.</li> </ol> <p>Benefit Payment Conditions:</p> <ul style="list-style-type: none"> <li>• Requirement that diagnosis be made in the US may be included or omitted;</li> </ul>

		<ul style="list-style-type: none"> <li>Survival Period may be included or omitted.</li> </ul>
Limitations and Exclusions		<p>Reduction Schedule may be included or omitted according to plan design. When included percentages and ages will vary as shown.</p> <p>Pre-Existing Condition Limitation may be included or omitted according to plan design.</p>
	6	Secretary – current Company Secretary appears; name may be revised should corporate officer be removed/replaced
	7	President – current Company President appears; name may be revised should corporate officer be removed/replaced

**AXIS INSURANCE COMPANY  
ACTUARIAL MEMORANDUM**

**CRITICAL ILLNESS Rider  
Form Number CI-R-0111**

**December, 2010**

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**AXIS INSURANCE COMPANY  
ACTUARIAL MEMORANDUM**

**CRITICAL ILLNESS Rider  
Form Number CI-R-0111**

**1. Summary**

- Scope and Purpose

The purpose of this memorandum is to certify that the premiums for this Rider Form satisfy the rate filing requirements of your State. This is a new filing. This memorandum should not be used for any other purpose.

- Product Descriptions

This Rider provides benefits on diagnosis of Critical Illnesses as defined in the Rider and subject to all provisions, limitations and exclusions of the Base Policy unless specifically modified by this Rider contract.

If, while coverage under the Policy is in force, an Insured Person is diagnosed with a Critical Illness by a Physician, the Company will pay the Benefit Amount shown in the Rider Schedule, subject to the Diagnostic Requirements, and Benefit Payment Conditions described in the rider contract.

Critical Illness – means any of the following illnesses:

- Advanced Alzheimer Disease
- Aortic Surgery
- ADL Deficit
- Benign Brain Tumor
- Coma
- Coronary Bypass Surgery
- Heart Attack
- Heart Valve Replacement
- Invasive Cancer
- In-Situ Cancer
- Kidney/Renal Failure
- Loss of Sight, Speech or Hearing
- Multiple Sclerosis
- Organ Transplant
- Paralysis
- Severe Burn
- Stroke
- Specified Disease.

- General Marketing Method

This Critical Illness Rider will be attached to and made part of the Blanket Accident Policy BACC-001-0909 and the Group Accident Policy GADD-001-1009. Both the Blanket Accident policy and the Group Accident policy provide a lump sum upon Accidental Death and/or Accidental Dismemberment arising out of a covered Accident.

They also provide for the optional extension of coverage for additional premiums to include Additional Benefits as well as to include legal family members of the Primary Insured with additional premiums. Legal Family members and rates for all optional benefits are defined in the Base Policy. All Base Policy Rates and benefits are as defined in the Base Policy.

## **2. Description of Rider Benefits**

### **1) Health Screening Benefit**

This Coverage Pays a fixed amount per test as shown and listed in the Rider Schedule subject to the limits shown therein, in the event that the Insured undergoes routine testing as ordered or prescribed by a Physician. No benefit is payable for any tests in excess of the Test Frequency Maximum shown in the Rider Schedule.

### **2) Advanced Alzheimer's Disease**

If an Insured Person is first Diagnosed with Advanced Alzheimer Disease as defined in the Rider Contract, the Company will pay the Alzheimer's disease Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

### **3) Aortic Surgery**

If an Insured Person is first Diagnosed and receives Aortic Surgery, as defined in the Rider Contract, the Company will pay the Aortic Surgery Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

### **4) Activities of Daily Living (ADL) Deficit**

If an Insured Person is first Diagnosed as having ADL deficit as defined in the Rider Contract and the condition is expected to be permanent, the Company will pay the ADL Deficit Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

### **5) Benign Tumor**

If an Insured Person is first Diagnosed as having a Benign Tumor, as defined in the Rider Contract, the Company will pay the Benign Tumor Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

### **6) Coma**

If an Insured Person is first Diagnosed as being comatose as defined in the Rider Contract, the Company will pay the Coma Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

### **7) Coronary Artery Bypass**

If an Insured Person is diagnosed with a condition that necessitates Coronary Artery Bypass Surgery as defined in the Rider Contract and receives Coronary Artery Bypass Surgery, the Company will pay the Coronary Artery Bypass Surgery First Diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been

previously paid, and Recurrence is covered, then the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

8) Heart Attack

If an Insured Person is first diagnosed as having a Heart Attack, as defined in the Rider Contract, the Company will pay the Heart Attack First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

9) Heart Valve Replacement

If an Insured Person is first Diagnosed with a condition that necessitates Heart Valve Replacement as defined in the Rider Contract and receives Heart Valve Replacement, the Company will pay the Heart Valve Replacement Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

10) Invasive Cancer

If an Insured Person is first diagnosed with Invasive Cancer, as defined in the Rider Contract, the Company will pay the Invasive Cancer First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

11) In-Situ Cancer

If an Insured Person is first diagnosed with In-Situ Cancer, as defined in the Rider Contract, the Company will pay the In-Situ Cancer First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

12) Kidney/Renal Failure

If an Insured Person is first diagnosed with Kidney/Renal Failure, as defined in the Rider Contract, the Company will pay the Kidney/Renal Failure First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

13) Loss of Sight, Speech or Hearing

If an Insured Person is first Diagnosed as suffered Loss of Sight, Speech or Hearing as defined in the Rider Contract, the Company will pay the Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

14) Multiple Sclerosis

If an Insured Person is first Diagnosed with Multiple Sclerosis as defined in the Rider Contract, the Company will pay the Multiple Sclerosis Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

15) Organ Transplant

If an Insured Person is first Diagnosed as needing an Organ Transplant as defined in the Rider Contract and undergoes the Organ Transplant, the Company will pay the Organ Transplant Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

16) Paralysis

If an Insured Person is first Diagnosed as being paralyzed as defined in the Rider Contract, the Company will pay the Paralysis Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

17) Severe Burn

If an Insured Person is first Diagnosed as having suffered Severe Burn as defined in the Rider Contract, the Company will pay the Severe Burn Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

18) Stroke

If an Insured Person is first diagnosed as having suffered a Stroke, as defined in the Rider Contract, the Company will pay the Stroke First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

19) Specified Disease Hospitalization

If an Insured Person is first Diagnosed as having one of the listed Specified Diseases and is confined to a hospital as defined in the Rider Contract, the Company will pay the Specified Disease Hospitalization Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

**3. Actuarial Basis of Rates by Benefit.**

This rider provides coverage to Primary Insureds or other valid groups. Net Claims Cost Rates were developed separately for the various benefits. **Rates are annually renewable and are not guaranteed. All Benefits are reduced by 50% on attaining age 65 and above. Coverage ends at age 70.**

- Rider Benefits

1) Health Screening Benefit

This Coverage Pays a fixed amount per test as shown and listed in the Rider Schedule subject to the limits shown therein, in the event that the Insured undergoes routine testing as ordered or prescribed by a Physician. No benefit is payable for any tests in excess of the Test Frequency Maximum shown in the Rider Schedule.

The Net Claims Costs were developed from the following Sources:

- a) Milliman's Health Cost Guidelines<sup>TM</sup>
- b) Data was trended to July 1, 2011.

Monthly Net Claims Cost for \$100 Benefit Per Test							
Female		Maximum Tests Per Person Per Year					
Begin Age	End Age	1	2	3	4	5	6
18	24	\$3.63	\$7.01	\$10.15	\$13.07	\$15.80	\$18.38
25	39	\$3.88	\$7.51	\$10.89	\$14.04	\$17.00	\$19.79
40	49	\$4.29	\$8.27	\$11.95	\$15.38	\$18.59	\$21.61
50	64	\$5.25	\$10.19	\$14.78	\$19.10	\$23.17	\$27.02

Monthly Net Claims Cost for \$100 Benefit Per Test							
Male		Maximum Tests Per Person Per Year					
Begin Age	End Age	1	2	3	4	5	6
18	24	\$3.06	\$5.76	\$8.16	\$10.33	\$12.30	\$14.10
25	39	\$3.23	\$6.11	\$8.69	\$11.04	\$13.19	\$15.18
40	49	\$3.77	\$7.20	\$10.35	\$13.25	\$15.94	\$18.45
50	64	\$5.17	\$10.01	\$14.51	\$18.72	\$22.68	\$26.43

Monthly Net Claims Cost for \$100 Benefit Per Test							
		Maximum Tests Per Person Per Year					
		1	2	3	4	5	6
Ages 18-64		\$4.28	\$8.24	\$11.90	\$15.30	\$18.48	\$21.46

2) Advanced Alzheimer's Disease

This Coverage pays a fixed amount, in the event that the Insured Person is first Diagnosed with Advanced Alzheimer Disease as defined in the Rider Contract.

The incidence of Advanced Alzheimer's Disease in the US Population was obtained from the National Institute of Health "2000 Progress Report on Alzheimer's Disease" <http://www.nia.nih.gov/NR/rdonlyres/EC84A6F4-4E81-449A-BA0C-0E90E9E385EC/0/2000PR.pdf>.

This report shows that in 2000, there were 360,000 new cases of Alzheimer's disease of which 61,200 were severe. Using this data, the Advanced Alzheimer's Disease incidence rate per 1,000 US Population was .23862. From this data, the resulting Net Claims Cost Per 1,000 of first diagnosis Advanced Alzheimer's Disease Benefit is .2386.

3) Aortic Surgery

This benefit pays a fixed amount as shown in the Rider Schedule subject the conditions in the Rider Contract, on an Insured Person's first diagnosis of needing and receiving Aortic Surgery.

The data for the incidence rate was obtained from the American Heart Association Report, "Heart and stroke Statistics – 2010 Update, Table 7.3". The incidence rate obtained was .0112 resulting in a Net Claims cost per 1000 of Aortic Surgery Benefit of .0112.

4) ADL Deficit

This benefit pays a fixed amount if an Insured Person is first Diagnosed as having ADL deficit as defined in the Rider Contract and the condition is expected to be permanent, the Company will pay the ADL Deficit Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The data for the incidence rate was obtained from the CDC Report "Limitations in Activities of Daily living and Instrumental Activities of Daily Living, 2003-3007". Table 1 of this report shows incidence rates per 1,000 of US population by Number of ADL and IADL. Using this data, the Net Claims Cost per 1000 of ADL Deficit Benefits is as follows:

ADL Annual Net Claims Cost Rates Per 1000 of ADL Benefit by # of ADLs			
# of ADL Deficits	At Least 1	2 or More	3 or More
Annual Net Claims Cost per 1000	0.0209	.0163	.0116

5) Benign Brain Tumor

This Benefit pays fixed amount(s) as shown in the Rider Schedule if the Insured Person is first Diagnosed as having a Benign Tumor, as defined in the Rider Contract, the Company will pay the Benign Tumor Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

Incidence rates were developed from the following data sources:  
 CDC, NPCR 2006 Brain Cancers by Tumor type,  
<http://apps.nccd.cdc.gov/uscs/braincancersbytumortype.aspx>

The derived Annual Claims Cost per 1,000 of Benign Brain Tumor benefit is .0683.

6) Coma

This Coverage pays fixed amount(s) as shown in the Rider Schedule if an Insured Person is first Diagnosed as being comatose as defined in the Rider Contract, the Company will pay the Coma Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The CDC National Health Statistics Table 1 (Number of People with Care for Selected Conditions by Type of Service: United States, 2006) shows an Incidence for 2006 of .1267 per 1000 of US Population for Coma & Brain Death. Adjusting for Base Policy exclusions and for insured population, results in an incidence rate for this benefit of .0532 per 1000. The Annual Net Claims Cost per \$1,000 of Coma benefit for Coma lasting at least 90 days is therefore .0532. To adjust for Coma lasting a different number of days, multiply the Net Claims cost by the following factors.

Factors for Coma Continuation Period		
30 Days	60 Days	90 Days
1.03	1.02	1.00

7) Coronary Bypass Surgery

If an Insured Person is diagnosed with a condition that necessitates Coronary Artery Bypass Surgery as defined in the Rider Contract and receives Coronary Artery Bypass Surgery, the Company will pay the Coronary Artery Bypass Surgery First Diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, then the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The Net Claims Cost per 1000 for this benefit was derived from the CDC : "Table 29. Number and rate of discharges from short-stay hospitals with a coronary artery bypass graft and number and rate of procedures by sex, age, and geographic region: United States, 2005". <http://www.cdc.gov/nchs/data/nhsr/nhsr029.pdf>

From this data, the derived incidence rate per 1,000 of US population ages 0-64 is .8561 resulting in an Annual Net Claims Cost per \$1000 of First Diagnosis Coronary Artery Bypass Graft Benefit of .8561.

Recurrence was estimated using the incidence of recurrent Heart Attacks from <http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.109.192667v1>

This data shows that the recurrence rate of heart attacks as a % of first heart attack is 59.87%. From this data, the derived incidence rate per 1,000 of US population ages 0-64 is .5126 resulting in an Annual Net Claims Cost per \$1000 of Coronary Artery Bypass Graft recurrence Benefit of .5126.

8) Heart Attack

If an Insured Person is first diagnosed as having a Heart Attack, as defined in the Rider Contract, the Company will pay the Heart Attack First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The Net Claims Cost per 1000 for this benefit was derived from the following Source Data: "American Heart Association, Heart Disease and Stroke Statistics – 2010 update Heart Disease and Stroke Statistics--2010 Update.mht" <http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.109.192667v1>

The Data shows that an expected incidence of Heart Attacks of 2.541/1000 of US Population with a recurrence rate of 1.5214/1000. Annual Net Claims Cost/1000 of benefit are as follows:

Heart Attack: Annual Net Claims Cost /1000		
Age Bracket	1st Diagnosis	Recurrence
18-44	0.3532	0.2115
45-54	2.1832	1.3072
55-64	6.5989	3.951
65-70	10.0652	6.0263

To adjust rates for a minimum survival period of 30 days, multiply rates by .85.

#### 9) Heart Valve Replacement

If an Insured Person is first Diagnosed with a condition that necessitates Heart Valve Replacement as defined in the Rider Contract and receives Heart Valve Replacement, the Company will pay the Heart Valve Replacement Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The Net Claims Cost per 1000 for this benefit was derived from the following Source Data: "Table 7: CDC NCHS Advance Data – Use of selected Medical Device Implants in the United States, 1988". <http://www.cdc.gov/nchs/data/ad/ad191.pdf>

The Data shows that an incidence of Heart Valve Replacements in 1988 was .1254/1000 of US population.

The January 12, 2009 article <http://www.articlesbase.com/diseases-and-conditions-articles/aortic-stenosis-surgery-to-transform-by-2015-719421.html> predicts that the incidence of Heart valve replacements would reach .1424/1000 in 2015.

Averaging these 2 data points produces an Annual Net Claims Cost per 1000 of Heart Valve Replacement benefit is therefore .1339.

#### 10) Invasive Cancer

If an Insured Person is first diagnosed with Invasive Cancer, as defined in the Rider Contract, the Company will pay the Invasive Cancer First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

##### a) First Diagnosis

The Net Claims Cost per 1000 for this benefit was derived from the following SeerStat Source Data: "Table 3.1.1M from [All Cancer Sites Combined. Invasive Cancer Incidence Rates and 95% Confidence Intervals by Age and Race and Ethnicity, United States \(Table 3.1.1.1M\)](#)" .

<http://apps.nccd.cdc.gov/uscs/cancersbyageandrace.aspx?Gender=Male&Count=false&Population=false&DataType=Incidence&RateType=AgeadjType&CancerSite=All%20Cancer%20Sites%20Combined&Year=2006&Site=All%20Cancer%20Sites%20Combined&SurveyInstanceID=1>

The Data shows a first diagnosis incidence rate of Invasive Cancer including In-Situ Breast cancer for age 0-64 of 2.479/1000 and for all ages, 4.7802/1000. Adjusting for In-Situ Breast Cancer, the age 0-64 incidence rate is 2.3031

From this data, the derived Annual Net Claims Cost per \$1000 of First Diagnosis Invasive Cancer benefit is 2.3031 for ages 0-64. Age Banded Rates per 1000 are as follows:

Invasive Cancer	
Annual Net Claims Cost/1000	
Age Band	First Diagnosis
0-19	0.1382
20-29	0.3360
30-39	1.0648
40-49	3.2769
50-59	9.2218
60-65	16.3384

b) Recurrence benefit,

The incidence rate for recurrence after 24 months was obtained from “Table 1.B: Risk of subsequent primary cancer after any initial cancer, by calendar year at initial diagnosis and time since initial diagnosis, SEER 1973-2000”, [http://seer.cancer.gov/publications/mpmono/Ch01\\_Introduction.pdf](http://seer.cancer.gov/publications/mpmono/Ch01_Introduction.pdf).

This data shows that the risk of Invasive Cancer recurrence is .4601/1000 leading to a Recurrence Annual Net Claims Cost per \$1,000 of Recurrence Benefit of .4601. Age Banded Rates per 1000 are as follows:

Invasive Cancer	
Annual Net Claims Cost/1000	
Age Band	Recurrence
0-19	0.0322
20-29	0.0782
30-39	0.2478
40-49	0.7626
50-59	2.1460
60-65	3.8021

11) In Situ Cancer

If an Insured Person is first diagnosed with In-Situ Cancer, as defined in the Rider Contract, the Company will pay the In-Situ Cancer First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

a) First Diagnosis

The Net Claims Cost per 1000 for this benefit was derived from the following SeerStat Query <http://seer.cancer.gov/faststats/selections.php?>

This data shows that between 2000-2007, the incidence of Cancer In-Situ is .2094/1000 for ages 0-64 and .4212 for all ages combined.

From this data, the derived Annual Net Claims Cost per \$1000 of First Diagnosis In-Situ Cancer benefit is .2094 for ages 0-64.

b) Recurrence benefit.

In-Situ Cancer recurrence rate as a % of the incidence of First Diagnosis In-Situ Cancer was proxied using Invasive Cancer recurrence as a % of First Diagnosis Invasive incidence.

The derived recurrence incidence rate .0487/1000 leading to an Annual Net Claims Cost per \$1,000 of Recurrence Benefit of .0487 for ages 0-64 combined.

12) Kidney (Renal) Failure

If an Insured Person is first diagnosed with Kidney/Renal Failure, as defined in the Rider Contract, the Company will pay the Kidney/Renal Failure First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

a) First Diagnosis

The Net Claims Cost per 1000 for this benefit was derived from the following sources:

- i. <http://kidney.niddk.nih.gov/kudiseases/pubs/kustats/>
- ii. [http://www.kidney.org/news/newsroom/fs\\_new/esrdinUS.cfm](http://www.kidney.org/news/newsroom/fs_new/esrdinUS.cfm)
- iii. <http://www.usrds.org/reference.htm>

These data shows that the 2007 incidence of Kidney Failure is .3610/1000. For ages 0-64, the incidence rate/1000 is .2336

From this data, the derived Annual Net Claims Cost per \$1000 of First Diagnosis Kidney Failure for ages 0-64 is .2336.

b) Recurrence benefit,

The incidence rate for recurrence after 24 months was proxied by the recurrence rate for stroke from the following Source Data: "American Heart Association, Heart Disease and Stroke Statistics – 2010 update Heart Disease and Stroke Statistics--2010 Update.mht"  
<http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.109.192667v1>

The Data shows a recurrence rate approximately = 23.27% of the 1<sup>st</sup> diagnosis rate leading to a Recurrence Annual Net Claims Cost per \$1,000 of Recurrence Benefit of .0544 per 1000 for ages 0-64.

13) Loss of Sight Speech or Hearing

If an Insured Person is first Diagnosed as suffered Loss of Sight, Speech or Hearing as defined in the Rider Contract, the Company will pay the Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The Net Claims Cost per 1000 for this benefit was derived from the following sources:

- i. Loss of Hearing Speech: “National Institute of Deafness and other Communication Disorders,  
<http://www.nidcd.nih.gov/health/statistics/quick.htm>.
- ii. Loss of Sight: NATIONAL Eye Institute,  
[http://www.nei.nih.gov/eyedata/pbd\\_tables.asp](http://www.nei.nih.gov/eyedata/pbd_tables.asp)

These data show that the incidence of Loss of Hearing and Speech is .0345/1000 and the incidence rate for loss of sight is .0379/1000.

From this data, the derived Annual Net Claims Cost per \$1000 of Loss of Sight, Speech and Hearing Benefit is .0681.

#### 14) Multiple Sclerosis

If an Insured Person is first Diagnosed with Multiple Sclerosis as defined in the Rider Contract, the Company will pay the Multiple Sclerosis Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The Net Claims Cost per 1000 for this benefit was derived from the Multiple Sclerosis Foundation Report ” <http://www.msfacts.org/who-gets-multiple-sclerosis.aspx>”

The Data shows that an incidence of Multiple Sclerosis in 2009 of .0374/1000 of US population.

The Annual Net Claims Cost per \$1,000 of Multiple Sclerosis benefit is therefore .0374.

#### 15) Organ Transplant

If an Insured Person is first Diagnosed as needing an Organ Transplant as defined in the Rider Contract and undergoes the Organ Transplant, the Company will pay the Organ Transplant Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The Net Claims Cost per 1000 for this benefit was derived from the US Department of Health and Human Services Organ Procurement & Transplant query: ” <http://optn.transplant.hrsa.gov/latestData/step2.asp>”

The Data shows the number of Organ Transplants from 1988-2010. This data shows a 2006-2009 average incidence of Organ Transplants of .1059/1000 of US Population.

The Annual Net Claims Cost per \$1,000 of Organ Transplant benefit is therefore .1059.

#### 16) Paralysis

If an Insured Person is first Diagnosed as being paralyzed as defined in the Rider Contract, the Company will pay the Paralysis Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

This Coverage pays fixed amount(s) as shown in the Schedule of Benefits in the event that the Insured Person suffers a Covered Loss that results in Paralysis.

Incidence rates were developed from the following data sources:

- a) National Spinal Cord Injury Statistical Center – 2007 Annual Report for the Model Spinal Cord Injury Care Systems  
(<http://images.main.uab.edu/spinalcord/pdffiles/2007NSCISC2.pdf>)
- b) National Spinal Cord Injury Statistical Center – 2006 Annual Report for the Model Spinal Cord Injury Care Systems  
(<http://images.main.uab.edu/spinalcord/pdffiles/NSCIC%20Annual%2006.pdf>)
- c) Spinal Cord Injury Information Network – Facts and Figures at a Glance  
(<http://www.spinalcord.uab.edu/show.asp?durki=116979&site=1021&return=19775>)
- d) National Center for Health Statistics – National Health Survey – Prevalence of Selected Impairments – United States – 1977  
([http://www.cdc.gov/nchs/data/series/sr\\_10/sr10\\_134.pdf](http://www.cdc.gov/nchs/data/series/sr_10/sr10_134.pdf))
- e) U.S. Census Bureau – The 2009 Statistical Abstract  
(<http://www.census.gov/compendia/statab/tables/09s0007.xls>)

The age weighted 0-64 claims cost per 1000 for this are as follows:

	Quadriplegia	Paraplegia	Hemiplegia	Uniplegia	Total
Annual Claim Cost per 1000	0.0167	0.0294	0.0628	0.0159	0.1163

The Claims cost above are for loss occurring 90 days after effective date of coverage. To adjust for loss occurring after a different number of days from effective date, multiply by the factors as shown in the Table below:

<b>Factors for Days after which Loss Must Occur</b>			
<b>30 Days</b>	<b>45 Days</b>	<b>60 Days</b>	<b>90 Days</b>
0.950	0.951	0.952	0.955

#### 17) Severe Burn

If an Insured Person is first Diagnosed as having suffered Severe Burn as defined in the Rider Contract, the Company will pay the Severe Burn Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The American Burn Association 2007 Fact Sheet, Selected Statistics on Admissions to Burn Centers, 1995-2005, shows that burns exceeding 30% of Total Body Surface Area (TBSA) is 10%. Burns exceeding 20% TBSA was approximated to be 15%. 2007 data from CDC (<http://webappa.cdc.gov/cgi-bin/broker.exe>) shows the incidence rate for Unintentional Burns was .02363 per 1000. The Net Claims Cost per 1000 of Benefit for burns exceeding 20% TBSA is therefore .0036.

#### 18) Stroke

If an Insured Person is first diagnosed as having suffered a Stroke, as defined in the Rider Contract, the Company will pay the Stroke First diagnosis Benefit Amount on first occurrence or if a first diagnosis benefit had been previously paid, and Recurrence is covered, the Recurrence Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The Net Claims Cost per 1000 for this benefit was derived from the following Source Data: "American Heart Association, Heart Disease and Stroke Statistics – 2010 update Heart Disease and Stroke Statistics--2010 Update.mht"

<http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.109.192667v1>

The Data shows that an expected incidence of Stroke of 2.5731/1000 of US Population with a recurrence rate of 0.5990/1000.

The Annual Net Claims Cost per 1000 of Heart Attack benefits are as follows:

Stroke: Annual Net Claims Cost /1000		
Age Bracket	1st Diagnosis	Recurrence
18-44	0.407	0.0948
45-54	2.217	0.516
55-64	4.8945	1.139
65-70	8.4692	1.9709

To adjust rates for a minimum survival period of 30 days, multiply rates by .95.

19) Specified Disease Benefit

If an Insured Person is first Diagnosed as having one of the listed Specified Diseases and is confined to a hospital as defined in the Rider Contract, the Company will pay the Specified Disease Hospitalization Benefit Amount as shown in the Rider Schedule subject to the conditions specified in the Rider Contract.

The combined incidence rate from CDC data per 1000 of us population was .3285 with a maximum for any 1 disease of .0760.

Combing the above, produces an annual net claims cost for \$100 Initial Hospital confinement benefit of .0597.

4. Renewability Clause

The rider is renewable with the base policy renewal at the option of the policyholder or the Company. The premiums are not guaranteed, and, are subject to change upon renewal.

5. Applicability

This form will be available for new issues.

6. Morbidity and Mortality Basis

Morbidity rates were developed based upon a variety of sources as shown in the section 3 above. Mortality was not taken into account.

7. Persistency

Persistency assumptions were not used in the pricing as this is annually renewable business.

8. Target Loss Ratio

The Target Loss Ratio for this rider form is 60%. Where there are state mandated minimums that are higher than 60%, Gross Rates will be calculated to comply with such minimums.

9. Lifetime Loss Ratio

The lifetime loss ratio is assumed to be the same as the target loss ratio as this is new company with no history or business inforce.

10. Realistic Loss Ratio

Same as 9 above

11. Retention Percentage (1 – Loss Ratio)

$$\text{Gross Premium} = \frac{\text{Net Claims Cost}}{(1 - \text{Loss Ratio})}$$

$$\text{Net Claims Cost} = \sum_{j=1}^n \text{Claim}_{-} \text{Cost}_j$$

Where n = Total Number of Benefits in the Plan of Insurance

Loss Ratio is targeted at 60% (57.5% for Claims and 2.5% for Loss Adjusted Expense).

The loading of 40% of Gross Premiums (Retention Percentage) is to provide for the following:

- Commissions: 15.0%
- Premium Taxes: 2.5%
- New Business Expenses: 2.5%
- Maintenance and Administration Expenses: 10.0%
- Contingency and Risk Margins: 5.0%
- Provision for Profit: 5.0%

12. Rating Period

The effective date of use of this Rider will be upon the Department of Insurance approval.

The premium rates will be effective for one year unless there are statutory changes requiring a change in the rates or one of the events triggering a change as described in the contract occurs. Policies are annually renewable on the anniversary date but premium rates may change.

13. Effect of Law Changes

The Company may increase premium rates more frequently than annually if there is a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this rider.

14. Issue Age Range

Issue age range is subject to underwriting but does not exceed 65. Coverage ends at age 70.

15. Average Annual Premium

Excluding the Health Screening benefit, the average annual premium per \$1,000 of Critical Illness benefit is estimated to vary between \$2.00 and \$8.00 depending on plan design (i.e., number of conditions covered under the Rider Contract). For a typical sale, we will target a benefits package averaging \$120/Year.

16. Gender Adjustment Factors

Where gender specific rates are not available, unisex population weighted rates are used.

17. Premium Modalization Rules

The following table shows the Premium Mode Factors:

Premium Mode	Modal Factor
Annual	1.00
Semi-Annual	.52
Quarterly	.265
Monthly	.09
9-month Payment schedule	.117

18. Claim Liability and Reserves

Reserves will be made up of a liability for approved claims not yet paid, claims in course of processing and incurred but not reported claims. In addition, reserves will be held for unearned premiums. All reserves will be developed using standard actuarial methods as prescribed by the American Academy of Actuaries.

19. Active Life Reserves

Not applicable to this product.

20. Trend Assumption

Trend assumption was inherent in Morbidity assumptions.

21. Marketing Method

This rider will be attached to the base policy and sold through licensed insurance brokers, agents and third party administrators to eligible blanket group policyholders. In the future, it may be offered on a direct response basis.

22. Underwriting

Since this rider will be attached to the base policy and sold as group coverage to employers or other valid groups, group underwriting methods will be employed by AXIS in reviewing the institution or entity's needs, plan design, and prior overall experience data. The underwriting function is to determine if the inherent risks unique to the group are acceptable and if so collect the facts required establishing the appropriate premium rates.

23. Distribution of Business

This is a new policy form filing; consequently the distribution of business by age and gender is expected to follow that of the U.S. population.

24. Experience and Trend

This is a new product filing and we do not have any historical experience or trends. Any health coverages will reflect medical inflation and utilization trends on renewal.

25. History of Rate Adjustments

This is not applicable because this is a new product filing.

26. Coordination of Benefits

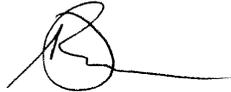
Not Applicable.

27. Number of Policyholders

This is not applicable because this is a new rider filing.

28. Actuarial Certification

To the best of my knowledge and judgment, this filing is in compliance with the applicable laws of this State and that the proposed premiums are reasonable in relation to the benefits provided.



Submitted by: Dhanasar Ramjit, FSA, MAAA

Title: Senior Vice President and Actuary

Date: Dec 20, 2010