

SERFF Tracking Number: CCGN-127302478 State: Arkansas
 Filing Company: Life Insurance Company of North America State Tracking Number: 49189
 Company Tracking Number: 11-2002
 TOI: H03G Group Health - Accidental Death & Dismemberment Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment
 Product Name: Group Accident
 Project Name/Number: Claim Provisions and General Provisions/11-2002

Filing at a Glance

Company: Life Insurance Company of North America

Product Name: Group Accident SERFF Tr Num: CCGN-127302478 State: Arkansas
 TOI: H03G Group Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved- Closed State Tr Num: 49189
 Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment Co Tr Num: 11-2002 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Author: Kathy Forno, CCP, DCP, HIA Disposition Date: 07/13/2011
 Date Submitted: 06/30/2011 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Claim Provisions and General Provisions
 Project Number: 11-2002
 Requested Filing Mode:

Explanation for Combination/Other:
 Submission Type: New Submission
 Group Market Type: Employer, Association, Trust, Other

Overall Rate Impact:

Deemer Date:
 Submitted By: Kathy Forno, CCP, DCP, HIA
 Filing Description:
 Group Accident Insurance

Status of Filing in Domicile: Not Filed
 Date Approved in Domicile:
 Domicile Status Comments: Filing not required in domicile state of PA.
 Market Type: Group
 Group Market Size: Small
 Explanation for Other Group Market Type: All eligible groups defined in your law
 Filing Status Changed: 07/13/2011
 State Status Changed: 07/13/2011
 Created By: Kathy Forno, CCP, DCP, HIA
 Corresponding Filing Tracking Number:

Claim Provisions (Policy) – Form GA-00-1640.00
 Claim Provisions (Certificate) – Form GA-00-CE1640.00

<i>SERFF Tracking Number:</i>	<i>CCGN-127302478</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Life Insurance Company of North America</i>	<i>State Tracking Number:</i>	<i>49189</i>
<i>Company Tracking Number:</i>	<i>11-2002</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death & Dismemberment</i>
<i>Product Name:</i>	<i>Group Accident</i>		
<i>Project Name/Number:</i>	<i>Claim Provisions and General Provisions/11-2002</i>		

General Provisions – Form GA-00-1825.00

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

These forms are new and not intended to replace any forms currently on file. They are intended for use with Group Policy form GA-00-1000.00 et al which was previously approved by your Department.

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

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

Company and Contact

Filing Contact Information

Kathy Forno,	Kathy.Forno@CIGNA.com
1601 Chestnut Street	215-761-8532 [Phone]
TL16D	
Philadelphia, PA 19192	

Filing Company Information

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

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Filing Fees

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? No
Fee Explanation: \$50/form x3= \$150
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Life Insurance Company of North America	\$150.00	06/30/2011	49284299

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/13/2011	07/13/2011

SERFF Tracking Number: CCGN-127302478 *State:* Arkansas
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Disposition

Disposition Date: 07/13/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CCGN-127302478 State: Arkansas
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 Dismemberment
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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	Cover letter	Approved-Closed	Yes
Supporting Document	Actuarial Cert	Approved-Closed	Yes
Supporting Document	Description of variability	Approved-Closed	Yes
Form	Policy Claim Provisions	Approved-Closed	Yes
Form	Cert Claim provisions	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GA-00-1640.00

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/13/2011	GA-00-1640.00	Policy/Cont	Policy Claim ract/Fratern Provisions al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		45.200	GA-00-1640.00_Policy Claim Provisions_.pdf
Approved-Closed 07/13/2011	GA-00-CE1640	Policy/Cont	Cert Claim provisions ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		45.500	GA-00-CE1640 _Cert Claim Provisions_.pdf
Approved-Closed 07/13/2011	GA-00-1825.00	Policy/Cont	General Provisions ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		49.200	GA-00-1825.00_General Provisions_.pdf

CLAIM PROVISIONS

Notice of Claim

Written {or authorized electronic/telephonic} notice of claim must be given to Us within {31 days} after a Covered Loss occurs or begins or as soon as reasonably possible. If written {or authorized electronic/telephonic} notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written {or authorized electronic/telephonic} notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include {the Policyholder's, Subscriber's} name and policy number and {the Covered Person's} name, address, policy and certificate number.

Claim Forms

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

[Claimant Cooperation Provision

Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.]

Proof of Loss

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

Time of Payment of Claims

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

Payment of Claims

All benefits will be paid in United States currency. Benefits for loss of life will be payable [to the {Employee's, Member's} beneficiary named under this Policy, if any.] *or* [in accordance with the Beneficiary provision and these Claim Provisions.] All other proceeds payable under this Policy, unless otherwise stated, will be payable to {the covered Employee, Member} or to his estate.

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

[Payment of Claims to Foreign Employees

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

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

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

Physical Examination [and Autopsy]

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

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written {or authorized electronic} proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Beneficiary

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

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

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

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

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

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

The beneficiary is the person or persons {the Employee, Member} names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and {the Policyholder, Subscriber}. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary [, or to make any assignment of rights or benefits permitted by this Policy.] [A separate beneficiary may be designated to receive any Accidental Death Benefit payable at the death of {the Employee's, Member's} Spouse or Dependent Child.] [Any Accidental Death Benefit payable at the death of {the Employee's, Member's} Spouse or Dependent Child will be paid to {the Employee's, Member's} estate.]

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

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

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

1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. estate of {the Covered Person}.]

Or

[the estate of {the Covered Person}.]

Recovery of Overpayment

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

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

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

CLAIM PROVISIONS

Notice of Claim

Written {or authorized electronic/telephonic} notice of claim must be given to Us within {31 days} after a Covered Loss occurs or begins or as soon as reasonably possible. If written {or authorized electronic/telephonic} notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written {or authorized electronic/telephonic} notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the {Policyholder's, Subscriber's} name and policy number and Your name, address, policy and certificate number.

Claim Forms

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

[Claimant Cooperation Provision

Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.]

Proof of Loss

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

Time of Payment of Claims

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

Payment of Claims

All benefits will be paid in United States currency. Benefits for loss of life will be payable [to the {Employee's, Member's} beneficiary named under the Policy, if any.] *or* [in accordance with the *Beneficiary* provision and these Claim Provisions.] All other proceeds payable under this Policy, unless otherwise stated, will be payable to You or to your estate.

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

Physical Examination [and Autopsy]

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

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written {or authorized electronic} proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time written proof of loss must be furnished.

Beneficiary

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

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

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

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

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

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

The beneficiary is the person or persons You name or change on a form executed by You and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary. [, or make any assignment of rights or benefits permitted by this Policy.] [A separate beneficiary may be designated to receive any Accidental Death Benefit payable at the death of Your Spouse or Dependent Child.] [Any Accidental Death Benefit payable at the death of Your Spouse or Dependent Child will be paid to Your estate.]

[You may change the beneficiary at any time by giving written notice to the {Policyholder, Subscriber, or the Insurance Company}.] A beneficiary designation or change will become effective on the date You {, Your Spouse, Dependent Child} execute it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

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

If there is no named beneficiary or surviving beneficiary, or if You die while benefits are payable to You, We may make direct payment to [the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. Your estate or the estate of Your Spouse and/or Dependent Child.]

or

[Your estate or the estate of Your Spouse and/or Dependent Child.]

Recovery of Overpayment

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

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

If there is an overpayment due when You{, Your Spouse, or Dependent Child} die, We may recover the overpayment from Your{, Your Spouse's, or Dependent Child's} estate.

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

[Subscriber Participation Under This Policy

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

Misstatement of Fact

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

Certificates

Where required by law, We will provide a certificate of insurance for delivery to {the Covered Person}. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

[{30 Day} Right To Examine Certificate

If {a Covered Person} does not like the Certificate for any reason, it may be returned to Us within {30 days} after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.]

[Multiple Certificates

[{The Covered Person} may have in force only one certificate at a time under this Policy. If at any time {the Covered Person} has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.]

[{A Covered Person} is not eligible for insurance under more than one certificate providing benefits for accident insurance under group policies issued by Us. If premium is being paid for more than one such certificate, insurance will be in effect under the certificate with the earliest effective date and premiums paid for certificates which are not in effect will be refunded.]]

Assignment

Option 1: Include if no rights and benefits are assignable:

[The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.]

Option 2: Include when no assignment other than benefits that have become payable is permitted:

[The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.]

Option 3: Include if assignment is permissible:

[We will be bound by an assignment of {a Covered Person's} insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by {the Covered Person} and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy and {the Covered Person's} certificate remains in force.]

Incontestability**1. Of This Policy or Participation Under This Policy**

All statements made by {the Policyholder, Subscriber} to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to {the Policyholder, Subscriber.}

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

2. Of {A Covered Person's} Insurance

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

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

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

[Reporting Requirements

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

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

Policy Termination

We may terminate coverage on or after the first anniversary of the policy effective date. {The Policyholder, Subscriber} may terminate coverage on any premium due date. Written {or authorized electronic} notice by certified mail must be given at least {31 days} prior to such premium due date. [Failure by {the Policyholder, Subscriber} to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.]

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

[Reinstatement

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of {the Policyholder, Subscriber} satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid [, but not to any period more than {60 days} prior to the date of reinstatement.]]

Clerical Error

{A Covered Person's} insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes

We may agree with {the Policyholder, Subscriber} to modify a plan of benefits without {the Covered Person's} consent.

Workers' Compensation Insurance

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

Examination of the Policy

This Group Policy will be available for inspection at {the Policyholder's, Subscriber's} office during regular business hours.

Examination of Records

We will be permitted to examine all of {the Policyholder's, Subscriber's} records relating to this Group Policy.

Examination may occur at any reasonable time while the Group Policy is in force; or it may occur:

1. at any time for two years after the expiration of this Group Policy; or, if later,
2. upon the final adjustment and settlement of all Group Policy claims.

{The Policyholder, Subscriber} is acting as an agent of {the Covered Person} for transactions relating to this insurance. The actions of {the Policyholder, Subscriber} will not be considered Our actions.

[Ownership of Records

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

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 Product Name: Group Accident
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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/13/2011
Comments:	Read cert attached.		
Attachment:	LINA Flesch Cert.pdf		
Bypassed - Item:	Application	Approved-Closed	07/13/2011
Bypass Reason:	n/a		
Comments:			
Satisfied - Item:	Cover letter	Approved-Closed	07/13/2011
Comments:	Cover letter attached.		
Attachment:	AR letter bene null.pdf		
Satisfied - Item:	Actuarial Cert	Approved-Closed	07/13/2011
Comments:	Cert of no impact attached.		
Attachment:	LINA Actuarial Cert.pdf		
		Item Status:	Status Date:

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TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Group Accident
Project Name/Number: Claim Provisions and General Provisions/11-2002

Satisfied - Item: Description of variability Approved-Closed **Date:** 07/13/2011
Comments:
Description of variability attached.
Attachment:
LINA DOV.pdf

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

READABILITY CERTIFICATION

We, the Life Insurance Company of North America, certify that we have carefully scored the form listed below, using the Flesch Readability Test, in accordance with applicable readability standards. This form was scored separately and in its entirety.

Form Number	Description of Form	Score
GA-00-1640.00	Claim Provisions (Policy)	45.2
GA-00-CE1640.00	Claim Provisions (Certificate)	45.5
GA-00-1825.00	General Provisions	49.2



Signature: _____

Name: Edward J. Skowronek

Title: Assistant Secretary

Date: 3/15/2011

Kathy T. Forno, CCP, DCP, HIA
Sr. Compliance Specialist
Regulatory & State Government Affairs



CIGNA Group Insurance
Life • Accident • Disability

June 30, 2011

TL16D
1601 Chestnut Street
Philadelphia, PA 19192
Telephone 215-761-8532
Facsimile 215-761-5609
Kathy.forno@cigna.com

JAY BRADFORD
Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Life Insurance Company of North America

NAIC #: 0901 – 65498
FEI Number: 23-1503749
Company ID#: 11-2002

Group Accident Insurance

Claim Provisions (Policy) – Form GA-00-1640.00
Claim Provisions (Certificate) – Form GA-00-CE1640.00
General Provisions – Form GA-00-1825.00

Dear Commissioner:

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

These forms are new and not intended to replace any forms currently on file. They are intended for use with Group Policy form GA-00-1000.00 et al which was previously approved by your Department.

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

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

We appreciate you taking the time to review these forms and trust that you will find everything in order. If you should have any questions or require additional information, please do not hesitate to e-mail me at kathy.forno@cigna.com or call me collect at 215.761.8532.

Very truly yours,

Kathy T. Forno

Kathy T. Forno, CCP, DCP, HIA
Senior Compliance Specialist
CIGNA Legal and Public Affairs
1601 Chestnut St. TL 16D
Philadelphia, PA 19192

Phone: 215.761.8532
E-mail: kathy.forno@cigna.com

LIFE INSURANCE COMPANY OF NORTH AMERICA (LINA)

Group Accident Policy Forms, GA-00-1000.00, et al

Actuarial Certification

I certify that the provisions in the forms listed below do not have an impact on the group accident rates on file.

Forms:

GA-00-1640.00	Claim Provisions (Policy)
GA-00-CE1640.00	Claim Provisions (Certificate)
GA-00-1825.00	General Provisions

Submitted by:



Kathryn Shelton, FSA, MAAA
Actuarial Director

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

FORMS: GA-00-1640.00, GA-00-CE1640.00 & GA-00-1825.00

The above-captioned forms are additional forms for use with previous approved policy forms GA-00-1000.00, et al.

General Notes on Variability

This policy form is designed to provide group accident insurance that can be issued (a) directly to an employer or other eligible group or (b) to a trust to which multiple employers or other eligible entities may subscribe. References to “Policyholder”, “Employer” and “Subscriber” may be selected as applicable.

The terms “Employee”, “Member”, “Covered Person”, etc., may be used as applicable to reflect Policy/Certificate issuance to employer/employee groups or other eligible groups under the law of your state. A term other than “Employee” or “Member” may be used if requested by a policyholder for consistency with other policies or with personnel practices. Modifications may also be made to reflect coverage provided to a specific Covered Class of insureds.

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

Specific Notes on Variability

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

Claim Provisions - Policy (GA-00-1640.00) and Claim Provisions - Certificate (GA-00-CE1640.00)

- References to electronic or telephonic Notice of Claim or for Proof of Loss may be modified or deleted based on plan specifications. Time limits shown may increase but will not be less than the minimums required by law.
- Payment of Claims Provision – The dollar amount may range from \$1,000 to \$5,000.
- Payment of Claims of Foreign Employees Provision (applicable to the Policy only) – The listing of geographic areas may be modified to reflect the location(s) selected by the Policyholder.
- Beneficiary Provision – The solicitation period for designating a beneficiary may be 30, 60 or 90 days.

General Provisions (GA-00-1825.00)

- Right to Examine Certificate – The time limit shown may range from 30 to 60 days.
- Policy Termination – The time period shown may range from 31 to 60 days.
- Reinstatement – The time period shown may range from 60 to 90 days.