

**State:** Arkansas **Filing Company:** Continental American Insurance Company  
**TOI/Sub-TOI:** H02G Group Health - Accident Only/H02G.000 Health - Accident Only  
**Product Name:** Accident  
**Project Name/Number:** Enrollment Form /

## Filing at a Glance

Company: Continental American Insurance Company  
Product Name: Accident  
State: Arkansas  
TOI: H02G Group Health - Accident Only  
Sub-TOI: H02G.000 Health - Accident Only  
Filing Type: Form  
Date Submitted: 11/05/2012  
SERFF Tr Num: CAIC-128755783  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 9097  
  
Implementation: On Approval  
Date Requested:  
Author(s): Sara McCormick  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 11/05/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** Continental American Insurance Company  
**TOI/Sub-TOI:** H02G Group Health - Accident Only/H02G.000 Health - Accident Only  
**Product Name:** Accident  
**Project Name/Number:** Enrollment Form /

## General Information

Project Name: Enrollment Form Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Group Market Type: Employer, Other Explanation for Other Group Market Type: Union  
Overall Rate Impact: Filing Status Changed: 11/05/2012  
State Status Changed: 11/05/2012  
Deemer Date: Created By: Sara McCormick  
Submitted By: Sara McCormick Corresponding Filing Tracking Number:

### Filing Description:

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130  
TOI: H02G Group Health - Accident Only  
Sub-TOI: H02G.000 Health - Accident  
Proposed Effective Date: On Approval  
Domicile State Approval: SC – Pending  
Form: C70206.1AR – Enrollment Form

Dear Sir or Madam:

The above-captioned form is being filed for your review and approval. This is a new filing and will not replace any other forms on file with your department.

The enrollment form will be used with group accident forms approved by your department.

If you have any questions or require additional information, please contact Sara McCormick either at 1.888.730.2244, ext. 4952 or at [companycompliance@aflac.com](mailto:companycompliance@aflac.com). Thank you for your consideration in this matter.

## Company and Contact

### Filing Contact Information

Sara McCormick, Regulatory Analyst [smccormick@caicworksite.com](mailto:smccormick@caicworksite.com)  
2801 Devine Street 803-354-4952 [Phone]  
Columbia, SC 29205

### Filing Company Information

Continental American Insurance Company	CoCode: 71730	State of Domicile: South Carolina
2801 Devine Street	Group Code:	Company Type: LAH
Columbia, SC 29205	Group Name: Continental Amer Ins Co	State ID Number:
(803) 256-6265 ext. [Phone]	FEIN Number: 57-0514130	

## Filing Fees

**State:** Arkansas **Filing Company:** Continental American Insurance Company  
**TOI/Sub-TOI:** H02G Group Health - Accident Only/H02G.000 Health - Accident Only  
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Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: \$50.00/application \* 1 application = \$50.00.  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Continental American Insurance Company	\$50.00	11/05/2012	64552279

SERFF Tracking #:

CAIC-128755783

State Tracking #:

Company Tracking #:

9097

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H02G Group Health - Accident Only/H02G.000 Health - Accident Only

Product Name:

Accident

Project Name/Number:

Enrollment Form /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/05/2012	11/05/2012

SERFF Tracking #:

CAIC-128755783

State Tracking #:

Company Tracking #:

9097

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H02G Group Health - Accident Only/H02G.000 Health - Accident Only

Product Name:

Accident

Project Name/Number:

Enrollment Form /

## Disposition

Disposition Date: 11/05/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Variability Statement	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

**State:** Arkansas **Filing Company:** Continental American Insurance Company  
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**Product Name:** Accident  
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## Form Schedule

Lead Form Number: C70206.1 AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/05/2012	Enrollment Form	C70206.1A R	AEF	Initial		0.000	C70206.1AR Accident Enrollment Form.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



**CONTINENTAL AMERICAN  
INSURANCE COMPANY**

**ENROLLMENT FORM**

Please Mail: [Post Office Box 427  
Columbia, South Carolina 29202  
800.433.3036]

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
<b>Accident</b>		
Endorsement:		
EFFECTIVE DATE:		
FOR AGENT USE ONLY		
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Enrollment
<input type="checkbox"/> Newly Eligible	<input type="checkbox"/> Re-Submission	
Deduction start date _____		

[Employee] Name/Owner (First, MI, Last)		Social Security Number/ID Number	Gender	Date of Birth
Street Address		City	State	ZIP
[Employer]	Job Class/Occupation	Location	Hire/Change of Status Date	
Hours Worked	Daytime Phone Number ( )	Beneficiary Name/Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)		Gender	Spouse's Date of Birth	
		[Employee]	Spouse	
[Are you currently working [part-time;full-time] for the [employer] listed above?]		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
[Are you now disabled or unable to work?]				<input type="checkbox"/> YES <input type="checkbox"/> NO

**[List all eligible children for whom you are proposing coverage (from Youngest to Oldest):**

Name	Gender	Date of Birth	Name	Gender	Date of Birth

**ACCIDENT**  24 Hour  Non-Occupational] Plan \_\_\_\_\_  New Coverage]  Change in Coverage]

[Employee]  [Employee] & Spouse]  [Employee] & Children]  Family] [Section 125:  Yes  No]

Sickness Rider] Dependent Rider] Catastrophic Rider]  Total Disability Rider] Gunshot Wound Rider]

Cost per pay period:[Including any Riders]\$\_\_\_\_\_

**[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]**

To the best of my knowledge and belief, the answers to the questions on this Enrollment Form are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

[Does this coverage replace any existing Aflac individual policy?  YES  NO]  
Does this coverage replace or change any existing insurance?  YES  NO

If yes, provide carrier and policy number: \_\_\_\_\_

[If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.]

Coverage will not become effective unless you are employed [part-time; full-time] on the enrollment date and on the effective date.

CERTIFICATION: I have read the completed Enrollment Form and I realize any false statement or misrepresentation in the Enrollment Form may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Enrollment Form is approved and the necessary premium is paid.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

[I authorize [my employer] to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.]

[I certify that I currently work [part-time; full-time] for the [employer] listed on this enrollment form [and that my spouse is not currently disabled or unable to work].]

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Date: \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Agent \_\_\_\_\_ Agent No.: \_\_\_\_\_ State of Enrollment: \_\_\_\_\_



### Things to Consider Before Replacing Your Existing Insurance Coverage

Aflac's goal is to provide you with outstanding insurance products that offer important financial protection to you and your loved ones in the event of an accident or illness. To best serve our customers, we offer a robust portfolio of products designed to respond to a variety of needs and circumstances. If you are thinking about replacing one type of policy for another, please be aware that there are important differences between insurance products—specifically group products versus individual products. These differences may affect your coverage. Before making a change to any existing coverage you may have, please make sure to carefully compare the benefits provided by your existing policy and the proposed replacement coverage. Among the items you should consider are the following:

1. If you are currently receiving treatment for an injury or illness: Your new coverage will not cover claims for treatment received as a result of injuries or illnesses diagnosed prior to its effective date.
2. If you terminate existing coverage, no benefits will be paid for diagnoses or treatments you receive after the termination date.
3. Benefits of your existing policy and the replacement coverage you're considering may be different, and you may be subject to new waiting periods and/or coverage exclusions due to preexisting conditions.
4. If you terminate an existing policy, you will lose any accrued benefits. Any such accrued benefits cannot be transferred to new coverage.
5. Individual insurance coverage is guaranteed-renewable and cannot be cancelled for any reason other than non-payment of premium.
6. Group insurance coverage is not guaranteed-renewable. If the master policy held by your employer or organization is cancelled, your coverage terminates.
7. Individual insurance coverage is fully portable. If you leave your current job, you can retain your individual insurance coverage.
8. Group coverage has limited portability. If you change jobs, you may not be able to retain your coverage.

**By signing below, I acknowledge that I have received this notice and wish to apply for new coverage.**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Applicant's Name (printed) \_\_\_\_\_

Address (printed) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Telephone \_\_\_\_\_ ]

SERFF Tracking #:

CAIC-128755783

State Tracking #:

Company Tracking #:

9097

State: Arkansas

Filing Company: Continental American Insurance Company

TOI/Sub-TOI: H02G Group Health - Accident Only/H02G.000 Health - Accident Only

Product Name: Accident

Project Name/Number: Enrollment Form /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/05/2012
Comments:	This application form will be used with policy forms approved by your department with a Flesch score which meets or exceeds your minimum requirements.		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/05/2012
Bypass Reason:	This is an application-only filing.		

		Item Status:	Status Date:
Satisfied - Item:	Variability Statement	Approved-Closed	11/05/2012
Comments:			
Attachment(s):			
C70400 ACC Enrollment Form Variability Statement.pdf			

# CONTINENTAL AMERICAN INSURANCE COMPANY

## VARIABILITY STATEMENT: GROUP ACCIDENT ENROLLMENT FORM

### ENROLLMENT FORM (C70206.1AR)

Variable information is bracketed <i>throughout the form</i> * as follows:	
Throughout the documents, <b>[Employee]</b> is bracketed.	<b>[Employee/Member]</b> applies to each occurrence.
Throughout the documents, <b>[full; part]</b> is bracketed.	<b>[full/part]</b> will indicate whether the group's employees are full- or part-time.
<b>*Please note: Bracketed items listed above are NOT highlighted or explained elsewhere in this variability statement.</b>	
Additional bracketed items outlined <i>individually</i> :	
	<b>[The Aflac logo is variable so that necessary changes to the logo can be incorporated.]</b>
<b>[Post Office Box 427 Columbia, South Carolina 29202 800.433.3036]</b>	<b>[The address is variable so necessary changes can be incorporated.]</b>
<b>[Employer]</b>	<b>[This will reflect the type of group – can be replaced with terms employer, policyholder, association, union]</b>
<b>[Are you currently working [part-time;full-time] for the [employer] listed above?] [Are you now disabled or unable to work?]</b>	<b>[Eligibility Questions: will be either included or deleted from the form based on negotiations with the prospective policyholder and his needs.]</b>
<b>ACCIDENT</b> <input type="checkbox"/> 24 Hour <input type="checkbox"/> Non-Occupational <input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage <input type="checkbox"/> [Employee] <input type="checkbox"/> [Employee] and Spouse <input type="checkbox"/> Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>[Types of coverage can be removed if all types are not offered to a group.]</b>
<input type="checkbox"/> Sickness Rider <input type="checkbox"/> Dependent Rider <input type="checkbox"/> Catastrophic Rider <input type="checkbox"/> Total Disability Rider <input type="checkbox"/> Gunshot Wound Rider Cost per pay period: <input type="checkbox"/> Including any Riders \$ _____	<b>[Optional riders - either included or deleted from the forms based on negotiations with the prospective policyholder and his needs.]</b>
<b>[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [\$0.58].]</b>	<b>[Provision be removed depending on account administration.] [Frequency can be changed depending on account administration.] [The correct fee for the</b>

	individual certificate holder will be included.
Does this coverage replace any existing Aflac individual policy? <input type="checkbox"/> YES <input type="checkbox"/> NO	Statement will either be included or deleted based on the needs of the prospective policyholder.
If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.	Statement will be either included or deleted from the enrollment form based on the needs of the prospective policyholder.
I authorize my employer to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.	Can be adjusted to reflect a different payment method if applicable. Policyholder
I certify that I currently work [part-time; full-time] for the [employer] listed on this enrollment form [and that my spouse is not currently disabled or unable to work]. I further certify that neither my spouse nor I have used tobacco products in the last 12 months.	Either included or deleted from the enrollment form based on the needs of the prospective policyholder.
<b>Things to Consider Before Replacing Your Existing Insurance Coverage</b>	The Disclosure page titled “Things to Consider Before Replacing Your Existing Insurance Coverage”, will be either included or deleted from the enrollment form based on the needs of the prospective policyholder.