

SERFF Tracking Number: CAIC-128427258 State: Arkansas
Filing Company: Continental American Insurance Company State Tracking Number:
Company Tracking Number: 8655
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: Revised Hospital Indemnity Applications
Project Name/Number: Revised Hospital Indemnity Applications/

Filing at a Glance

Company: Continental American Insurance Company

Product Name: Revised Hospital Indemnity Applications SERFF Tr Num: CAIC-128427258 State: Arkansas

Applications

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: 8655

Filing Type: Form

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Author: Sara McCormick

Disposition Date: 05/31/2012

Date Submitted: 05/30/2012

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Revised Hospital Indemnity Applications

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Other

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Explanation for Other Group Market Type: Union

Overall Rate Impact:

Filing Status Changed: 05/31/2012

State Status Changed: 05/31/2012

Deemer Date:

Created By: Sara McCormick

Submitted By: Sara McCormick

Corresponding Filing Tracking Number:

Filing Description:

May 30, 2012

Arkansas Insurance Department

1200 West Third Street

Little Rock, Arkansas 72201-1904

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130

SERFF Tracking Number: CAIC-128427258 State: Arkansas
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Proposed Effective Date: On Approval
Domicile State Approval: SC – Pending
Form: CAI8514 Master Application
CAI8516 Enrollment Form

Dear Sir or Madam:

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

These forms will be used with group hospital indemnity 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. Thank you for your consideration in this matter.

Sincerely,

James J. Hennessy, AIRC, CCP
Vice President, Compliance

/scm

State Narrative:

Company and Contact

Filing Contact Information

Sara McCormick, Regulatory Analyst 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 State ID Number:
Co
(803) 256-6265 ext. [Phone] FEIN Number: 57-0514130

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Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? Yes
Fee Explanation: South Carolina's retaliatory fee is zero dollars; therefore, we are submitting the following:

2 applications x \$50.00 = \$100.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	\$100.00	05/30/2012	59507593

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/31/2012	05/31/2012

SERFF Tracking Number: CAIC-128427258 *State:* Arkansas
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Disposition

Disposition Date: 05/31/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CAIC-128427258

State: Arkansas

Filing Company: Continental American Insurance Company

State Tracking Number:

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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
Form	Master Application	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CAI8514

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/31/2012	CAI8514AR	Application/Enrollment Form	Master Application	Initial		0.000	CAI8514AR Master Application.pdf
Approved-Closed 05/31/2012	CAI8516AR	Application/Enrollment Form	Enrollment Form	Initial		0.000	CAI8516AR Enrollment Form.pdf

MASTER APPLICATION FOR GROUP HOSPITAL INDEMNITY INSURANCE
Application is hereby made to:



CONTINENTAL AMERICAN INSURANCE COMPANY

**[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]**

By _____
[Employer, Union] Name

Of _____
Home Office Location (City and State)

for a Plan of Group Hospital Indemnity Insurance, and representations are made as follows:

1. Class of [Employees] Eligible for Coverage:

- Regular full-time employees under age 64
- Regular full-time employees under age 64 except _____
- Other: _____

[Employee] Requirements

A full-time [Employee] is one who works ____ hours or more per week. An [Employee] must be Actively at Work on the date he applies for coverage and on the date his Group Hospital Indemnity Insurance becomes effective. An [Employee] must complete _____ [month[s]] of continuous service to be eligible for coverage.

2. The minimum number of enrolled [Employees] necessary to keep the Group Policy in force: _____

3. The requested effective date for the Group Policy: _____

4. **Optional Features:** _____

5. Will this Group Hospital Indemnity Policy replace any existing Group Hospital Indemnity Policy?

- Yes No

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

6. General Agreement:

[The policyholder agrees to transmit the total premiums under the Group Policy to Continental American Insurance Company at its Home Office when due.] No agent or other person except an officer can make or change any contract or agreement on behalf of Continental American Insurance Company.

By (Signature)	Date
Title	

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.



**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
Hospital Indemnity		
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
Deduction start date _____		

[Employee] Name/Certificate Holder (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 ()	Spouse's Name (if coverage is requested)	Gender	Spouse Date of Birth
[Employee Height / Weight]		[Spouse Height / Weight]		
			[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

HOSPITAL INDEMNITY Plan: _____		[Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No]		
<input type="checkbox"/> New Coverage] <input type="checkbox"/> Change in Coverage]		Cost per pay period: \$ _____		
<input type="checkbox"/> [Employee] <input type="checkbox"/> Employee & Spouse] <input type="checkbox"/> Employee & Children] <input type="checkbox"/> Family]		Employee	Spouse	Children
[1]	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[2]	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[3]	Have you ever been treated for a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[4]	Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

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 Application and I realize any false statement or misrepresentation in the Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Application 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 application [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 _____]

<i>SERFF Tracking Number:</i>	<i>CAIC-128427258</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Continental American Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>8655</i>		
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<i>Project Name/Number:</i>	<i>Revised Hospital Indemnity Applications/</i>		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/31/2012

Comments:

These application forms are intended to be used with our group hospital indemnity forms approved by your department with a Flesch Reading Score which exceeded the minimum requirement of 40.

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	05/31/2012

Comments:

This filing is solely for application forms.