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**State:** Arkansas **Filing Company:** Continental American Insurance Company  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
**Project Name/Number:** Combo Applications/

## Filing at a Glance

Company: Continental American Insurance Company  
Product Name: Combo Applications  
State: Arkansas  
TOI: H21 Health - Other  
Sub-TOI: H21.000 Health - Other  
Filing Type: Form  
Date Submitted: 08/28/2012  
SERFF Tr Num: CAIC-128656879  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 8909  
  
Implementation: On Approval  
Date Requested:  
Author(s): Sara McCormick  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 09/10/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
**Project Name/Number:** Combo Applications/  
**Filing Company:** Continental American Insurance Company

## General Information

Project Name: Combo Applications  
Project Number:  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Group Market Type: Employer, Other  
Overall Rate Impact:  
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  
Filing Status Changed: 09/10/2012  
State Status Changed: 09/10/2012  
Created By: Sara McCormick  
Corresponding Filing Tracking Number:  
PPACA: Not PPACA-Related

PPACA Notes: null

### Filing Description:

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130  
TOI: H21 — Other  
Sub-TOI: H21.000 Health — Other  
Proposed Effective Date: On Approval  
Domicile State Approval: SC – Pending  
Forms: C00204 Combo Master Application  
C00205 Combo Enrollment Form

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 health forms approved by your department.

We would like to be able to customize these forms as needed for each group and ask that you consider each section (Accident, Critical Illness, Hospital Indemnity, Dental, Disability Income, and Cancer) as variable. This will enable us to delete that specific product section when the product(s) are not being sold to a particular group. Example – If the employer was interested in offering only accident and critical illness insurance to his employees, the form would only contain those two sections.

## Company and Contact

### Filing Contact Information

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

**State:** Arkansas **Filing Company:** Continental American Insurance Company  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
**Project Name/Number:** Combo Applications/

**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**

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? Yes  
 Fee Explanation: Since South Carolina's domiciliary fee is \$0, we are submitting Arkansas's fee of \$50 per form \* 2 forms = \$100.00  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Continental American Insurance Company	\$100.00	08/28/2012	62075400

**SERFF Tracking #:**

CAIC-128656879

**State Tracking #:****Company Tracking #:**

8909

**State:**

Arkansas

**Filing Company:**

Continental American Insurance Company

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

Combo Applications

**Project Name/Number:**

Combo Applications/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/10/2012	09/10/2012

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/07/2012	09/07/2012

#### Response Letters

Responded By	Created On	Date Submitted
Sara McCormick	09/07/2012	09/07/2012

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
**Project Name/Number:** Combo Applications/  
**Filing Company:** Continental American Insurance Company

## Disposition

Disposition Date: 09/10/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form (revised)	Combo Master Application	Approved-Closed	Yes
Form	Combo Master Application	Replaced	Yes
Form	Combo Enrollment Form	Approved-Closed	Yes

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**State:** Arkansas **Filing Company:** Continental American Insurance Company  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/07/2012
Submitted Date	09/07/2012
Respond By Date	10/07/2012

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Dear Sara McCormick,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

- Combo Master Application, C00204 (Form)

Comments:

*Will this form be used on a stand alone basis? If so, the form needs to contain a Fraud Statement.*

**Conclusion:**

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,*

*Rosalind Minor*

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: Combo Applications  
 Project Name/Number: Combo Applications/

Filing Company: Continental American Insurance Company

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 09/07/2012  
 Submitted Date 09/07/2012

Dear Rosalind Minor,

### Introduction:

### Response 1

#### Comments:

I have added a Fraud Statement to the Master Application.

### Related Objection 1

Applies To:

- Combo Master Application, C00204 (Form)

Comments:

Will this form be used on a stand alone basis? If so, the form needs to contain a Fraud Statement.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	C00204AR	AEF	Combo Master Application	Initial	0.000	C00204AR Combo Master Application.pdf	Date Submitted: 09/07/2012 By: Sara McCormick
<i>Previous Version</i>							
1	C00204	AEF	Combo Master Application	Initial	0.000	C00204 Combo Master Application.pdf	Date Submitted: 09/07/2012 By: Sara McCormick

SERFF Tracking #:

CAIC-128656879

State Tracking #:

Company Tracking #:

8909

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State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Combo Applications

Project Name/Number:

Combo Applications/

*No Rate/Rule Schedule items changed.*

**Conclusion:**

*Thank you for your continued review of this filing.*

*Sincerely,*

*Sara McCormick*

*smccormick@aflac.com*

*803-354-4952*

*Sincerely,*

*Sara McCormick*

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: Combo Applications  
 Project Name/Number: Combo Applications/

Filing Company: Continental American Insurance Company

## Form Schedule

### Lead Form Number: C00204

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/10/2012	C00204AR	AEF	Combo Master Application	Initial:	0.000	C00204AR Combo Master Application.pdf
2	Approved-Closed 09/10/2012	C00205	AEF	Combo Enrollment Form	Initial:	0.000	C00205 Combo 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

**GROUP MASTER APPLICATION**  
Application is hereby made to:



**CONTINENTAL AMERICAN INSURANCE COMPANY**

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

By \_\_\_\_\_  
[Employer] Name

Of \_\_\_\_\_  
Home Office Location (City and State)

**REPRESENTATIONS ARE MADE AS FOLLOWS:**

**Class of [Employees] Eligible for [Group Accident,] [Group Critical Illness,] [Group Dental,] [Group Disability Income] Coverage:**

- Regular [full]-time [Employees] [under age [70]]
- Regular [full]-time [Employees] [under age [70]] except \_\_\_\_\_
- Other \_\_\_\_\_

**[Class of [Employees] Eligible for Group Hospital Indemnity 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 Certificate of Insurance becomes effective. An [Employee] must complete \_\_\_\_\_ [month[s]] of continuous service to be eligible for coverage.

The minimum number of enrolled [Employees] necessary to keep the Group Policy in force is: \_\_\_\_\_

**COVERAGE REQUESTED**

**[Group Accident** Series \_\_\_\_\_  24 Hour]  Non-Occupational]

Plan  1]  2]  3]

**Optional Features:**  Sickness Rider]  Total Disability Rider]  Gunshot Wound Rider]

Catastrophic Accident Rider]  Dependent Rider]

The requested Effective Date is \_\_\_\_\_.

Will this Group Accident Policy replace any existing Group Accident Policy? 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 [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.]

**GENERAL AGREEMENT**

[By signing below, 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  <p style="text-align: center;">(Signature)</p>	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
[Accident]
[Critical Illness]
[Dental]
[Disability Income]
[Hospital Indemnity]
Endorsement:

EFFECTIVE DATE:

FOR AGENT USE ONLY
Initial Enrollment New Hire Re-Enrollment Newly Eligible
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
[Are you currently working [part-time;full-time] for the [employer] listed above?]
[Are you now disabled or unable to work?]
[Have you used tobacco products in the last 12 months?]

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

Table with 6 columns: 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]
[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].]

[CRITICAL ILLNESS] [Employee] [Employee] and Spouse [Section 125: Yes No] [With Cancer: Yes No]
[Employee] Face Amount: \$ [Employee] cost per pay period: \$
[Spouse] Face Amount: \$ Spouse cost per pay period: \$
[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]

		[Employee]	Spouse
[1]	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<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, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a 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
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, 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) high blood pressure, resulting in your now taking 3 or more medications for treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[4]	Have you ever received any advice, treatment, or consultation for: any disorder of the central nervous system, Parkinson's Disease, Alzheimer's Disease, dementia, senility, or organic brain syndrome?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[[5 ]	In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[All applicants enrolling in coverage over [\$50,000] in [Employee] benefits MUST answer the following additional questions:			
[[6 ]	Height/Weight	ft in lbs	ft in lbs
[[7 ]	Have you been advised to have any diagnostic test, hospitalization, surgery, or treatment that has not yet been completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[[8 ]	In the past two years, have you had a systolic blood pressure reading of 150 or above or a diastolic blood pressure reading of 100 or above?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[[9 ]	Have you had an annual physical examination in the last [6 months]? If yes, provide name and address of physician and date of exam. _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

New Coverage     Change in Coverage

Level 1 Plan \$25 Dental Wellness     Level 2 Plan \$50 Dental Wellness     Level 3 Plan \$50 Dental Wellness

Orthodontic Benefit Rider]  Cosmetic Benefit Rider - Not available with 125 Plans]

**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].]**

[1]	I understand that the dental plan I am applying for will not cover any person who has attained age 71 before the Effective Date of my certificate.	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	I understand that the dental plan I am applying for contains different Waiting Periods for benefits listed in the Schedule of Dental Procedures. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the Effective Date of my certificate.	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.	<input type="checkbox"/> YES <input type="checkbox"/> NO

**[DISABILITY INCOME]**     24 Hour]  Non-Occupational]    Class:  [Premier]     [Select]]     [Choice]]  
Annual Salary \$ \_\_\_\_\_    [Section 125:  Yes  No]

New Coverage]     Change in Coverage]

Riders: \_\_\_\_\_    Monthly Benefit Amount: \$ \_\_\_\_\_    **Cost per pay period: \$ \_\_\_\_\_**

Elimination Period: Accident: \_\_\_\_\_    [Sickness: \_\_\_\_\_ ]    Benefit Period: \_\_\_\_\_

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

**[If NOT Guaranteed Issue, answer the following questions:]**

<b>[1]</b>	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
<b>2</b>	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
<b>3</b>	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
<b>4</b>	In the last twelve (12) months, have you missed more than five (5) consecutive days of work due to illness or injury other than pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>5</b>	Are you taking prescription medications on a regular basis for any back, neck, knee, or shoulder condition, rheumatoid or degenerative arthritis, respiratory disease, urinary or digestive disease, immune system disease or disorder, mental or nervous disorder? (This does not include simple infections/viral infections treated short term with antibiotics)	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>6</b>	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]

**[HOSPITAL INDEMNITY]** Plan: \_\_\_\_\_ [Section 125:  Yes  No]  
 New Coverage]  Change in Coverage]  
 [Employee]  [Employee] & Spouse]  [Employee] & Children]  Family] **Cost per pay period:** \$ \_\_\_\_\_

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

**[If NOT Guaranteed Issue, answer the following questions:]**

		<b>[Employee]</b>	<b>Spouse</b>	<b>Children</b>
<b>[[1]</b>	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]
<b>[2]</b>	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]
<b>[3]</b>	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]
<b>[4]</b>	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].]

**A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an Application or filing a claim that contains any false or deceptive statement.**

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-128656879

State Tracking #:

Company Tracking #:

8909

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Combo Applications

Project Name/Number:

Combo Applications/

## Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	09/10/2012
Bypass Reason:	This is an application-only filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/10/2012
Bypass Reason:	This is not a policy form filing; the applications being filed will be used with forms approved by your department.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/10/2012
Bypass Reason:	This is an application-only filing and does not affect rates in any way.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/10/2012
Bypass Reason:	Not an Individual Health Product.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/10/2012
Bypass Reason:	Not PPACA-related.		
Comments:			

**SERFF Tracking #:**

CAIC-128656879

**State Tracking #:****Company Tracking #:**

8909

**State:**

Arkansas

**Filing Company:**

Continental American Insurance Company

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

Combo Applications

**Project Name/Number:**

Combo Applications/

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/23/2012	Form	Combo Master Application	09/07/2012	C00204 Combo Master Application.pdf (Superseded)

**GROUP MASTER APPLICATION**  
Application is hereby made to:



**CONTINENTAL AMERICAN INSURANCE COMPANY**

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

By \_\_\_\_\_  
[Employer] Name

Of \_\_\_\_\_  
Home Office Location (City and State)

**REPRESENTATIONS ARE MADE AS FOLLOWS:**

**Class of [Employees] Eligible for [Group Accident,] [Group Critical Illness,] [Group Dental,] [Group Disability Income] Coverage:**

- Regular [full]-time [Employees] [under age [70]]
- Regular [full]-time [Employees] [under age [70]] except \_\_\_\_\_
- Other \_\_\_\_\_

**[Class of [Employees] Eligible for Group Hospital Indemnity 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 Certificate of Insurance becomes effective. An [Employee] must complete \_\_\_\_\_ [month[s]] of continuous service to be eligible for coverage.

The minimum number of enrolled [Employees] necessary to keep the Group Policy in force is: \_\_\_\_\_

**COVERAGE REQUESTED**

**[Group Accident**      Series \_\_\_\_\_     24 Hour]     Non-Occupational]

**Plan**  1]     2]     3]

**Optional Features:**     Sickness Rider]     Total Disability Rider]     Gunshot Wound Rider]

Catastrophic Accident Rider]     Dependent Rider]

The requested Effective Date is \_\_\_\_\_.

Will this Group Accident Policy replace any existing Group Accident Policy? 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 [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.]

**GENERAL AGREEMENT**

[By signing below, 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  <p style="text-align: center;">(Signature)</p>	Date
Title	