

SERFF Tracking Number: CNNA-125992376 State: Arkansas
Filing Company: The Cincinnati Insurance Company State Tracking Number: EFT \$50
Company Tracking Number: CDEN-08-6014-AR
TOI: 05.0 Commercial Multi-Peril - Liability & Non- Sub-TOI: 05.0003 Commercial Package
Liability
Product Name: CDEN-08-6014-AR
Project Name/Number: /

Filing at a Glance

Company: The Cincinnati Insurance Company

Product Name: CDEN-08-6014-AR

SERFF Tr Num: CNNA-125992376 State: Arkansas

TOI: 05.0 Commercial Multi-Peril - Liability &
Non-Liability

SERFF Status: Closed

State Tr Num: EFT \$50

Sub-TOI: 05.0003 Commercial Package

Co Tr Num: CDEN-08-6014-AR

State Status: Fees verified and
received

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi,
Llyweyia Rawlins

Author: Sharon Whitaker

Disposition Date: 01/16/2009

Date Submitted: 01/16/2009

Disposition Status: Approved

Effective Date Requested (New): 07/01/2009

Effective Date (New): 07/01/2009

Effective Date Requested (Renewal): 07/01/2009

Effective Date (Renewal):
07/01/2009

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 01/16/2009

State Status Changed: 01/16/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

At this time, we wish to file forms per the attached explanatory memorandum. These changes correspond to the changes we are making to our installment payment plan and the introduction of our Direct Bill option.

Final printed copies are attached for your review.

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Your approval is respectfully requested for use on policies effective on or after July 1, 2009.

Company and Contact

Filing Contact Information

Sharon Grubbs, Senior Filings Analyst sharon_grubbs@cinfin.com
 6200 S. Gilmore Road (513) 870-2091 [Phone]
 Fairfield, OH 45014

Filing Company Information

The Cincinnati Insurance Company CoCode: 10677 State of Domicile: Ohio
 6200 S. Gilmore Road Group Code: 244 Company Type:
 Fairfield, OH 45014 Group Name: State ID Number:
 (513) 870-2000 ext. [Phone] FEIN Number: 31-0542366

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Cincinnati Insurance Company	\$50.00	01/16/2009	25074591

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Llyweyia Rawlins	01/16/2009	01/16/2009

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Disposition

Disposition Date: 01/16/2009

Effective Date (New): 07/01/2009

Effective Date (Renewal): 07/01/2009

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	FORM MEMORANDUM	Approved	Yes
Form	DENTIST'S PACKAGE POLICY DECLARATIONS	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	DENTIST'S PACKAGE POLICY DECLARATIONS	IF 504	07 09	Declaration Replaced s/Schedule	Replaced Form #:0.00 IF 504 04 07 Previous Filing #:		IF504 07-09 ECLAS.pdf

THE CINCINNATI INSURANCE COMPANY

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496

(513) 870-2000

A Stock Insurance Company

DENTIST'S PACKAGE POLICY DECLARATIONS

Previous Policy Number _____

Policy Number: _____

POLICY PERIOD: FROM: _____ TO: _____ 12:01 A.M. Standard Time at Location of Premises

Named Insured and Mailing Address: _____

Legal Entity / Business Description _____

LOCATION OF PREMISES

Loc. No. Bldg. No. Address

POLICY COVERAGES

In return for the payment of the premium, and subject to all other terms of this policy, we agree with you to provide the insurance as stated in this policy.

SECTION I - PROPERTY

			Buildings			Business Personal Property			Optional Coverages Applicable only when an entry is made			
									Equipment Breakdown		Valued Daily Loss of Income	
									Comprehensive Coverage -			
									Accident			
<u>Loc. No.</u>	<u>Bldg. No.</u>	<u>Limit of Insurance</u>	<u>Actual Cash Value</u>	<u>Repl. Cost</u>	<u>Auto. Increase</u>	<u>Limit of Insurance</u>	<u>Actual Cash Value</u>	<u>Repl. Cost</u>	<u>(including dental related medical equipment)</u>		<u>Limit per Day</u>	<u>Number of Days</u>

\$ _____ Deductible (Refer to Deductible provisions in the Coverage Form for deductible exceptions).

SECTION II - BUSINESS LIABILITY LIMITS OF INSURANCE

Each Occurrence Limit	\$	Any one occurrence
General Aggregate Limit	\$	
Products - Completed Operations Aggregate Limit	\$	
Personal and Advertising Injury Limit	\$	Any one person or organization
Damage to Premises Rented to You Limit	\$	Any one premises
Medical Expenses Limit	\$	Any one person

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Rate Information

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Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty **Review Status:** Approved 01/16/2009

Comments:

Attachments:

F777AR_307[1].pdf

F778AR_307[1].pdf

Satisfied -Name: FORM MEMORANDUM **Review Status:** Approved 01/16/2009

Comments:

Attachment:

CDEN-08-6014-AR F.pdf

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #	CDEN-08-6014-AR
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21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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See Memorandum

22. Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: EFT FILING

Amount: \$50.00

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	CDEN-08-6014-AR			
2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	N/A			
3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement or Withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	BUSINESSOWNERS PACKAGE POLICY DECLARATIONS	IF 504 07 09	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	IF 504 04 07	
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

**ARKANSAS
DENTIST'S PACKAGE PROGRAM
FORMS MEMORANDUM**

NEW FORM	OLD/WITHDRAWN FORM	TITLE/DESCRIPTION OF CHANGE
IF 504 07 09	IF 504 04 07	DENTIST'S PACKAGE POLICY DECLARATIONS Revising the premium payment section to allow for all of the premium payment options – annual, semi-annual, quarterly, monthly or ten pay plans.