

State: District of Columbia **Filing Company:** Combined Insurance Company of America
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: Critical Illness Application - 146570-DC-1116
Project Name/Number: Critical Illness Application - 146570-DC-1116/146570-DC-1116

Filing at a Glance

Company: Combined Insurance Company of America
Product Name: Critical Illness Application - 146570-DC-1116
State: District of Columbia
TOI: H071 Individual Health - Specified Disease - Limited Benefit
Sub-TOI: H071.001 Critical Illness
Filing Type: Form
Date Submitted: 11/21/2016
SERFF Tr Num: ACEH-130814895
SERFF Status: Submitted to State
State Tr Num:
State Status:
Co Tr Num: 16-AH-2013925
Implementation: On Approval
Date Requested:
Author(s): Debra McNally, Marivic Chiong
Reviewer(s):
Disposition Date:
Disposition Status:
Implementation Date:

State: District of Columbia **Filing Company:** Combined Insurance Company of America
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General Information

Project Name: Critical Illness Application - 146570-DC-1116 Status of Filing in Domicile: Not Filed
Project Number: 146570-DC-1116 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Not required to be filed in our domicile state.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 11/21/2016
State Status Changed:
Deemer Date: Created By: Debra McNally
Submitted By: Debra McNally Corresponding Filing Tracking Number:

Filing Description:

Company Tracking Number: 16-AH-2013925
Combined Insurance Company of America
FEIN Number: 36-2136262
NAIC Number: 626-62146
Form Numbers: 146570-DC-1116 – Critical Illness Application
Individual A&H

This is a new filing. Form No. 146570-DC-1116 is a revised version of the previously approved application Form No. 146570-DC-115, previously approved by your Department on January 14, 2015 under SERFF Tracking Number ACEH-129860777. This form will be used with the previously approved Critical Illness Policy, Form No. 16648-DC, also approved by your Department on December 23, 2013 under SERFF Tracking Number ACEH-129315029.

The application will be completed and/or transmitted either by paper or through electronic means (via the telephone or internet). We certify that we will comply with your state's statutes regarding privacy and electronic signatures.

Application Form No. 146570-DC-1116 has been revised to include the ACA disclosure and Attestation. We previously had this as a separate document, but would now like to include this language into the application.

For ease of your review I have attached a redlined copy under the Supporting Documentation tab.

There is no rate impact. The corresponding rates were previously approved by your Department on 5/27/2014 under SERFF Tracking #ACEH-129315042.

Attached under the Supporting Documentation tab for your information is the DC Guaranty Notice, Form No. 106019-DC-1014.

The forms are in final printed format. However, it is possible that actual issued forms may have different format and font style (but not the type size) as a result of different computer publishing systems. Therefore, page breaks may occur at different lines. We do not anticipate refiling for typographical errors, format changes or font style variations.

We appreciate your time in reviewing this filing. Please call me at our toll free number or email me if you have further questions or need additional information.

State: District of Columbia **Filing Company:** Combined Insurance Company of America
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: Critical Illness Application - 146570-DC-1116
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Company and Contact

Filing Contact Information

Debra McNally, Senior Policy Analyst debra.mcnally@combined.com
 100 Milwaukee Ave. 847-953-1527 [Phone]
 Glenview, IL 60025 847-953-1557 [FAX]

Filing Company Information

Combined Insurance Company of America	CoCode: 62146	State of Domicile: Illinois
1000 North Milwaukee Ave.	Group Code: 626	Company Type: A&H
Glenview, IL 60025	Group Name: Chubb	State ID Number:
(847) 953-2025 ext. [Phone]	FEIN Number: 36-2136262	

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State: District of Columbia

Filing Company:

Combined Insurance Company of America

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: Critical Illness Application - 146570-DC-1116

Project Name/Number: Critical Illness Application - 146570-DC-1116/146570-DC-1116

Form Schedule

Lead Form Number: 146570-DC-1116

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application	146570-DC-1116	AEF	Initial		50.270	146570-DC-1116 - 112116.pdf

Form Type Legend:

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

Application for: Critical Illness Coverage Increase to Existing Coverage _____

FORM # []

I am applying for this coverage based on the following information:

(Home Office Use)	Enrollment Date:
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ACTION REQUESTED: New Policy Reinstatement Policy Change

APPLICANT'S (Proposed Insured) NAME (First MI Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr
APPLICANT'S HOME ADDRESS (Street, City, State, Zip)	Work Phone No.	[Social Security No.]
Landline Phone No.	Mobile Phone No.	Email
EMPLOYER NAME	Hire Date: Mo/Day/Yr	Gross Annual Income
Payment Method <input type="checkbox"/> PRD <input type="checkbox"/> PAC <input type="checkbox"/> Other	Sponsoring Organization	Account Number
BENEFICIARY'S Full Name	Relationship	

Are you actively at work at least 17½ hours each week? Yes No

COVERAGE FOR: Applicant Only] Applicant & Spouse] Applicant & Children Applicant, Spouse & Children

[ADDITIONAL BENEFIT RIDERS:

Automatic Maximum Benefit Increase] Membership Endorsement for Health Care Referral]
 Cancer Treatment] Mortgage and Rent Helper]
 Family Care] Waiver of Premium] _____]
 Hospital Admission]

List all eligible persons to be covered on this plan: Applicant; Spouse; and Your Children age [26] or under.

First Name	MI	Last Name	DOB: Mo/Day/Yr	Height	Weight	Relationship	Sex	Indicate if proposed insured(s) smoked cigarettes or used tobacco in any form within the last [12] months

[Spouse includes an eligible Civil Union or Domestic Partner who resides with and is financially interdependent with the Applicant, as defined in the Policy.]

REQUESTED FACE AMOUNT:	PREMIUM - Mode
Proposed Insured: [\$ _____]	<input type="checkbox"/> Weekly (52) <input type="checkbox"/> Monthly (12) <input type="checkbox"/> Bi-Weekly (26)
Spouse: <input type="checkbox"/> _____]	<input type="checkbox"/> Semi-Monthly (24) <input type="checkbox"/> _____]
Child(ren): <input type="checkbox"/> _____]	
Premium Amount	\$

IMPORTANT – READ CAREFULLY

I represent and affirm the following:

	Proposed Insured		Spouse		[Child(ren)]	
	Yes	No	Yes	No	[Yes	[No]
[1. Within the past [10] years, has any proposed insured(s) received any medical advice or treatment for, or taken prescription medicine for, or had:					[[]
a. Stroke, Transient Ischemic Attack (TIA), Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, Alzheimer's, Parkinson's, heart attack, coronary artery disease, heart condition, blood disorder, emphysema, chronic obstructive lung or pulmonary disease, organ transplant, polycystic kidney disease, chronic renal (kidney) failure, cirrhosis of the liver, Hepatitis B or C, alcoholism, drug addiction, diabetes, (excluding diabetes experienced during pregnancy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[<input type="checkbox"/>	[<input type="checkbox"/>
b. Cancer, carcinoma-in-situ, malignant growth, melanoma, or Hodgkin's Disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[<input type="checkbox"/>	[<input type="checkbox"/>
c. Acquired Immunodeficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[<input type="checkbox"/>	[<input type="checkbox"/>
[2. In the past [6 months] has any proposed Insured:	Yes	No	Yes	No	[Yes	[No]
a. been diagnosed as having test results for which follow-up was necessary or recommended from screening examinations such as periodic mammograms, periodic chest x-rays, pap smears, PSA tests, stool occult, or blood tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[<input type="checkbox"/>	[<input type="checkbox"/>
b. been in a hospital as an inpatient for more than 48 hours, except for childbirth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[<input type="checkbox"/>	[<input type="checkbox"/>
c. experience an unexplained weight loss of 20 pounds or more, other than by dieting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[<input type="checkbox"/>	[<input type="checkbox"/>
d. been treated with three or more medications at the same time for high blood pressure or had a reading at or above 150MM.HG Systolic Blood Pressure and/or 100 MM.HG Diastolic Blood Pressure?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[<input type="checkbox"/>	[<input type="checkbox"/>

If Proposed Insured has answered "Yes" to any of the above questions:

Question No.	Name of Proposed Insured/Spouse/Childr(en)	Details (include the condition/illness, dates, and doctor's name & address)

It is very important that you review your application form carefully. Misstatements or omissions could cause an otherwise valid claim to be denied.

CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application Form will not be disclosed to the employer or any other person without the authorization of the Proposed Insured.

I understand that any insurance will not take effect unless and until Combined Insurance Company of America approves my application. If coverage cannot be issued as requested under the rules of the Company, I authorize Combined Insurance Company of America to issue reduced benefits and adjust premiums to match the coverage issued.

In applying for this coverage, I represent and affirm that the information which I have given as recorded on this Application Form is true and complete to the best of my knowledge and belief. [I acknowledge receipt of the Outline of Coverage.]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

- | | |
|---|--|
| <p>(1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States?</p> <p><i>If you answered NO to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.</i></p> <p>(2) Do you understand most supplemental only policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force?</p> <p>(3) Do you understand that the benefits provide under this policy may be limited?</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> |
|---|--|

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

X _____ City: _____ State: _____ Date: _____
Signature of Applicant

I, the authorized agent, have on the date of application recorded the information as given to me by the Applicant.

Signature of Licensed Agent _____ Code # _____

REMARKS OR SPECIAL REQUESTS FOR CONVERSION OR POLICY CHANGE

SERFF Tracking #:

ACEH-130814895

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

16-AH-2013925

State:

District of Columbia

Filing Company:

Combined Insurance Company of America

TOI/Sub-TOI:

H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name:

Critical Illness Application - 146570-DC-1116

Project Name/Number:

Critical Illness Application - 146570-DC-1116/146570-DC-1116

Supporting Document Schedules

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Variability Memorandum - 111816
Comments:	
Attachment(s):	Variability Memorandum - 111816.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlined copy to show recent changes
Comments:	
Attachment(s):	146570-DC-1116 - REDLINES - 112116.pdf
Item Status:	
Status Date:	

Satisfied - Item:	DC Guaranty Association Notice
Comments:	
Attachment(s):	106019-DC-1014.pdf
Item Status:	
Status Date:	



READABILITY CERTIFICATION

Form Numbers: 146570-DC-1116 - Critical Illness Application

The above captioned form(s) have a Flesch Index Score of SEE BELOW and meet(s) the minimum reading ease requirements.

Form Nos.
146570-DC-1116

Flesch Index Score
50.27

Marivic Chiong, Assistant Secretary

Marivic Chiong – Assistant Secretary / Manager - Product Filings/Government Relations/Law
Telephone: (847) 953-8359 Fax: (847) 953-1557 Toll Free: 888-449-3623 E-mail: Marivic.chiong@combined.com



**VARIABILITY MEMORANDUM
Individual Critical Illness**

Application Form No. 146570-DC-1116	
Home Office: [Chicago, Illinois]	Bracketed address to alleviate a future filing of these forms if the company addresses change.
FORM #[]	Bracketed form number to alleviate a future filing of this form if the form number changes.
[Social Security No.]	Bracketed to allow for removal of social security section or to obtain just the last four digits. (1) Company executively gives directive not to obtain the SSN# or just obtain the last four digits. (2) Company may have a directive of not allowing third party vendors to obtain employee SSN#.
Coverage For: [Applicant Only], [Applicant & Spouse]	Bracketed to allow for the removal of either options.
[ADDITIONAL BENEFIT RIDERS: <input type="checkbox"/> Automatic Maximum Benefit Increase] <input type="checkbox"/> Membership Endorsement for Health Care Referral] <input type="checkbox"/> Cancer Treatment] <input type="checkbox"/> Mortgage and Rent Helper] <input type="checkbox"/> Family Care] <input type="checkbox"/> Waiver of Premium] <input type="checkbox"/> Hospital Admission] <input type="checkbox"/> _____]	Bracketed material is dependent on the plan design that will be marketed to the Applicant.
List all eligible persons to be covered on this plan: Applicant; Spouse; and Your Children age [26] or under. Ranges	Bracketed to allow us to adjust if the state statue on dependent age changes. 26 - 30
[Height] [Weight]	Bracketed material to be included based on underwriting.
Indicate if proposed insured(s) smoked cigarettes or used tobacco in any form within the last [12] months	6, 12 months
[Spouse includes an eligible Civil Union or Domestic Partner who resides with and is financially interdependent with the Applicant, as defined in the Policy.]	Bracketed to allow terminology to be inserted if and when your state adopts such legislation.
REQUESTED FACE AMOUNT: Proposed Insured: [\$ _____] Spouse: <input type="checkbox"/> [_____] Child(ren): <input type="checkbox"/> [_____]	Variable to allow for the Insured's specific information to be inserted. Either dollar amounts or percentage.

[NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.]

Bracketed to allow for flexibility to remove if no longer needed.

Application for: Critical Illness Coverage Increase to Existing Coverage _____

FORM # []

I am applying for this coverage based on the following information:

(Home Office Use)	Enrollment Date:
-------------------	------------------

ACTION REQUESTED: New Policy Reinstatement Policy Change

APPLICANT'S (Proposed Insured) NAME (First MI Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr
APPLICANT'S HOME ADDRESS (Street, City, State, Zip)		Work Phone No.	[Social Security No.]
Landline Phone No.	Mobile Phone No.	Email	
EMPLOYER NAME		Hire Date: Mo/Day/Yr	Gross Annual Income
Payment Method <input type="checkbox"/> PRD <input type="checkbox"/> PAC <input type="checkbox"/> Other		Sponsoring Organization	Account Number
BENEFICIARY'S Full Name		Relationship	

Are you actively at work at least 17½ hours each week? Yes No

COVERAGE FOR: Applicant Only] Applicant & Spouse] Applicant & Children Applicant, Spouse & Children

[ADDITIONAL BENEFIT RIDERS:

Automatic Maximum Benefit Increase] Membership Endorsement for Health Care Referral]
 Cancer Treatment] Mortgage and Rent Helper]
 Family Care] Waiver of Premium] _____]
 Hospital Admission]

List all eligible persons to be covered on this plan: Applicant; Spouse; and Your Children age [26] or under.

First Name	MI	Last Name	DOB: Mo/Day/Yr	Height	Weight	Relationship	Sex	Indicate if proposed insured(s) smoked cigarettes or used tobacco in any form within the last [12] months

[Spouse includes an eligible Civil Union or Domestic Partner who resides with and is financially interdependent with the Applicant, as defined in the Policy.]

REQUESTED FACE AMOUNT:	PREMIUM - Mode
Proposed Insured: [\$ _____]	<input type="checkbox"/> Weekly (52) <input type="checkbox"/> Monthly (12) <input type="checkbox"/> Bi-Weekly (26)
Spouse: <input type="checkbox"/> _____]	<input type="checkbox"/> Semi-Monthly (24) <input type="checkbox"/> _____]
Child(ren): <input type="checkbox"/> _____]	
Premium Amount	\$

IMPORTANT – READ CAREFULLY

I represent and affirm the following:

	Proposed Insured		Spouse		[Child(ren)]	
	Yes	No	Yes	No	[Yes	[No]
1. Within the past [10] years, has any proposed insured(s) received any medical advice or treatment for, or taken prescription medicine for, or had:					[]
a. Stroke, Transient Ischemic Attack (TIA), Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, Alzheimer's, Parkinson's, heart attack, coronary artery disease, heart condition, blood disorder, emphysema, chronic obstructive lung or pulmonary disease, organ transplant, polycystic kidney disease, chronic renal (kidney) failure, cirrhosis of the liver, Hepatitis B or C, alcoholism, drug addiction, diabetes, (excluding diabetes experienced during pregnancy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[]
b. Cancer, carcinoma-in-situ, malignant growth, melanoma, or Hodgkin's Disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[]
c. Acquired Immunodeficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[]
2. In the past [6 months] has any proposed Insured:	Yes	No	Yes	No	[Yes	[No]
a. been diagnosed as having test results for which follow-up was necessary or recommended from screening examinations such as periodic mammograms, periodic chest x-rays, pap smears, PSA tests, stool occult, or blood tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[]
b. been in a hospital as an inpatient for more than 48 hours, except for childbirth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[]
c. experience an unexplained weight loss of 20 pounds or more, other than by dieting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[]
d. been treated with three or more medications at the same time for high blood pressure or had a reading at or above 150MM.HG Systolic Blood Pressure and/or 100 MM.HG Diastolic Blood Pressure?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[]

If Proposed Insured has answered "Yes" to any of the above questions:

Question No.	Name of Proposed Insured/Spouse/Childr(en)	Details (include the condition/illness, dates, and doctor's name & address)

It is very important that you review your application form carefully. Misstatements or omissions could cause an otherwise valid claim to be denied.

CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application Form will not be disclosed to the employer or any other person without the authorization of the Proposed Insured.

I understand that any insurance will not take effect unless and until Combined Insurance Company of America approves my application. If coverage cannot be issued as requested under the rules of the Company, I authorize Combined Insurance Company of America to issue reduced benefits and adjust premiums to match the coverage issued.

In applying for this coverage, I represent and affirm that the information which I have given as recorded on this Application Form is true and complete to the best of my knowledge and belief. [I acknowledge receipt of the Outline of Coverage.]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

- (1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States? Yes No
*If you answered **NO** to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.*
- (2) Do you understand most supplemental only policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force?
- (3) Do you understand that the benefits provide under this policy may be limited?

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

X _____ City: _____ State: _____ Date: _____
Signature of Applicant

I, the authorized agent, have on the date of application recorded the information as given to me by the Applicant.

Signature of Licensed Agent _____ Code # _____

REMARKS OR SPECIAL REQUESTS FOR CONVERSION OR POLICY CHANGE

COMBINED INSURANCE COMPANY OF AMERICA

111 East Wacker Drive • Suite 700
Chicago, Illinois 60601

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association (“Guaranty Association”).

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under “Coverage Limitations” section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 (“Act”), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 *et seq.*), provides insolvency protection for certain types of insurance policies and contracts.

The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) the individual insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
 - ▶ \$300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;

- \$300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
- \$300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
- \$300,000 for long-term care insurance benefits;
- \$300,000 for disability insurance benefits;
- \$500,000 for basic hospital, medical, and surgical insurance, or major medical insurance benefits;
- \$100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than \$300,000 in benefits with respect to any one life (\$500,000 in the event of basic hospital, medical and surgical insurance or major medical insurance).

Additionally, the Guaranty Association is not obligated to cover more than \$5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifcga.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) and they will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

**District of Columbia
Department of Insurance, Securities
and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000**

**District of Columbia
Life and Health Guaranty
Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771**

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.