

SERFF Tracking Number: ACEH-125615707 State: Arkansas  
Filing Company: ACE American Insurance Company State Tracking Number: 38740  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Stop Loss Application  
Project Name/Number: Stop Loss Application/Stop Loss Application

## Filing at a Glance

Company: ACE American Insurance Company

Product Name: Stop Loss Application

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: ACEH-125615707 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 38740

Co Tr Num:

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: Joanne Spruill

Disposition Date: 04/22/2008

Date Submitted: 04/18/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Stop Loss Application

Project Number: Stop Loss Application

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/22/2008

State Status Changed: 04/22/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: N/A

Market Type: Group

Group Market Size: Large

Group Market Type: Employer

Deemer Date:

We submit for your review the captioned developed in accordance with Arkansas Bulletin 6-2008 dated April 3, 2008.

This application was originally approved with the Excess Loss Insurance Policy number 25681 on March 5, 2001. No other changes besides the addition of the required notice have been made to the application.

## Company and Contact

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**Filing Contact Information**

Joanne Spruill, Compliance Analyst      joanne.spruill@ace-ina.com  
 436 Walnut Street      (215) 640-4285 [Phone]  
 Philadelphia, PA 19106      (215) 640-5548[FAX]

**Filing Company Information**

ACE American Insurance Company      CoCode: 22667      State of Domicile: Pennsylvania  
 PO Box 1000      Group Code: 626      Company Type:  
 436 Walnut Street  
 Philadelphia, PA 19106      Group Name:      State ID Number:  
 (215) 640-5123 ext. [Phone]      FEIN Number: 95-2371728  
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**Filing Fees**

Fee Required?      Yes  
 Fee Amount:      \$20.00  
 Retaliatory?      No  
 Fee Explanation:      Required fee per bulletin.  
 Per Company:      No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ACE American Insurance Company	\$20.00	04/18/2008	19703569

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/22/2008	04/22/2008

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*Project Name/Number:*      *Stop Loss Application/Stop Loss Application*

## **Disposition**

Disposition Date: 04/22/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Application	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** AR ACE25682AP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-	AR	Application/	Application	Initial			AR
Closed	ACE25682	Enrollment					ACE25682AP
	AP	Form					P.pdf

# APPLICATION FOR INSURANCE COVERAGE

**ACE American Insurance Company**  
Philadelphia, PA 19106

Applicant (Plan Sponsor): \_\_\_\_\_ Proposed Effective Date: \_\_\_\_\_

Address \_\_\_\_\_ Initial Premium Deposit: \$ \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Third Party Administrator: \_\_\_\_\_

Coverage Applied For:  Specific Stop Loss  
 Aggregate Stop Loss  Other \_\_\_\_\_

Insurance applied for replaces prior coverage as follows:

Name of Company \_\_\_\_\_

Type of Coverage \_\_\_\_\_ Termination Date: \_\_\_\_\_

### INSURANCE FRAUD WARNING

"Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties."

The Applicant hereby applies for Stop Loss, Life, and/or other Insurance coverage and:

1. Represents that the answers included in this application have been reviewed and are true and complete to the best of the Applicant's knowledge and belief;
2. Understands and agrees that insurance applied for shall not become effective until the application for insurance is approved by ACE American Insurance Company at its Home Office;
3. Agrees that if the insurance applied for is approved by the Company, the Applicant will pay all premium due after the effective date of insurance, including any premium which may accumulate between the effective date of the insurance and the date the policy is issued.

**NOTICE:** Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

This Application, as it may be amended, will become part of the Group Policy, if issued.

Signed at \_\_\_\_\_ This \_\_\_\_\_ day of \_\_\_\_\_ 19 \_\_\_\_\_

Signed by \_\_\_\_\_ Title \_\_\_\_\_

REMARKS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FOR HOME OFFICE USE ONLY

Approved:  Yes  No By: \_\_\_\_\_ Date: \_\_\_\_\_



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## Supporting Document Schedules

<b>Bypassed -Name:</b>	Certification/Notice	<b>Review Status:</b>	Approved-Closed	04/22/2008
<b>Bypass Reason:</b>	N/A Filing in accordance with Bulletin			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	04/22/2008
<b>Bypass Reason:</b>	See form field			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Health - Actuarial Justification	<b>Review Status:</b>	Approved-Closed	04/22/2008
<b>Bypass Reason:</b>	N/A			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Outline of Coverage	<b>Review Status:</b>	Approved-Closed	04/22/2008
<b>Bypass Reason:</b>	N/A			
<b>Comments:</b>				