

SERFF Tracking Number: AEGG-125671898 State: Arkansas  
Filing Company: Western Reserve Life Assurance Co. of Ohio State Tracking Number: 39280  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: WRL - STOP LOSS APPLICATION  
Project Name/Number: WRL - STOP LOSS APPLICATION/WRL - STOP LOSS APPLICATION

## Filing at a Glance

Company: Western Reserve Life Assurance Co. of Ohio

Product Name: WRL - STOP LOSS APPLICATION SERFF Tr Num: AEGG-125671898 State: ArkansasLH

TOI: H21 Health - Other SERFF Status: Closed State Tr Num: 39280  
Sub-TOI: H21.000 Health - Other Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Author: Donna Lambert Disposition Date: 06/13/2008  
Date Submitted: 06/11/2008 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: WRL - STOP LOSS APPLICATION  
Project Number: WRL - STOP LOSS APPLICATION  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: Resubmission  
Group Market Size:  
Group Market Type:

Status of Filing in Domicile: Not Filed  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Previous Filing Number: 35699  
Overall Rate Impact:  
Filing Status Changed: 06/13/2008  
State Status Changed: 06/13/2008  
Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

The attached application was approved by your Department on May 14, 2007, State Filing Number 35699. We have added the notice required by Bulletin 6-2008. A certification is attached, and the \$20 filing fee is submitted via EFT.

Sincerely,  
Donna Lambert  
501-227-1639

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djlambert@aegonusa.com

## Company and Contact

### Filing Contact Information

Donna Lambert, Contract Analyst djlambert@aegonusa.com  
PO Box 8063 (800) 400-3042 [Phone]  
Little Rock, AR 72203-8063 (501) 227-1097[FAX]

### Filing Company Information

Western Reserve Life Assurance Co. of Ohio CoCode: 91413 State of Domicile: Ohio  
366 E. Broad Street Group Code: Company Type:  
Columbus, OH 43215 Group Name: State ID Number:  
(502) 560-2000 ext. [Phone] FEIN Number: 43-1162657  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$0.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Western Reserve Life Assurance Co. of Ohio	\$20.00	06/11/2008	20795550

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/13/2008	06/13/2008

*SERFF Tracking Number:*      *AEGG-125671898*                      *State:*                      *Arkansas*  
*Filing Company:*              *Western Reserve Life Assurance Co. of Ohio*      *State Tracking Number:*      *39280*  
*Company Tracking Number:*  
*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *WRL - STOP LOSS APPLICATION*  
*Project Name/Number:*      *WRL - STOP LOSS APPLICATION/WRL - STOP LOSS APPLICATION*

## **Disposition**

Disposition Date: 06/13/2008

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>Supporting Document</b>	Bulletin 6-2008 App Notice	Approved-Closed	Yes
<b>Form</b>	Application for Excess Loss Insurance	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** SL40A (3/07)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SL40A (3/07)	Application/Enrollment Form	Application for Excess Loss Insurance	Revised	Replaced Form #: SL40A (3/07) Previous Filing #: 35699	50	

*SERFF Tracking Number:*      *AEGG-125671898*                      *State:*                      *Arkansas*  
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*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *WRL - STOP LOSS APPLICATION*  
*Project Name/Number:*      *WRL - STOP LOSS APPLICATION/WRL - STOP LOSS APPLICATION*

## **Rate Information**

Rate data does NOT apply to filing.

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## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	06/13/2008
<b>Comments:</b>		
<b>Attachments:</b>		
Reg 19 Certification.pdf		
Reg 49 Certification.pdf		
<b>Satisfied -Name:</b> Application	<b>Review Status:</b> Approved-Closed	06/13/2008
<b>Comments:</b>		
<b>Attachment:</b>		
SL40A_ARapp.pdf		
<b>Bypassed -Name:</b> Health - Actuarial Justification	<b>Review Status:</b> Approved-Closed	06/13/2008
<b>Bypass Reason:</b> Not applicable to this filing.		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved-Closed	06/13/2008
<b>Bypass Reason:</b> Not applicable to this filing.		
<b>Comments:</b>		
<b>Satisfied -Name:</b> Bulletin 6-2008 App Notice	<b>Review Status:</b> Approved-Closed	06/13/2008
<b>Comments:</b>		
<b>Attachment:</b>		
AR SL APP REFILING 6-11-08.pdf		

## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Western Reserve Life Assurance Co. of Ohio

Form Number(s): SL40A (3/07)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



\_\_\_\_\_  
Signature of Company Officer

Patsy J. Napier, FLMI, AIRC, HIA, CCP  
\_\_\_\_\_  
Name

Assistant Secretary  
\_\_\_\_\_  
Title

6/11/2008  
\_\_\_\_\_  
Date

**STATE OF ARKANSAS**  
**CERTIFICATION OF COMPLIANCE**

**Company Name:** Western Reserve Life Assurance Co. of Ohio

**Form Titles:** Application for Excess Loss Insurance

**Form Numbers:** SL40A (3/07)

I hereby certify that to the best of my knowledge and belief, the above forms and submission comply with Arkansas Regulation 49, relative to the dissemination of life and health guaranty association notices.



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Officer Signature

Patsy J. Napier, FLMI, AIRC, HIA, CCP

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Name of Officer

Assistant Secretary

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Officer Title

June 11, 2008

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Date

# WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO

A Stock Company

Administrative Office: 550 Stephenson Highway, Suite 407, Troy, Michigan 48083

Phone: 1-800-428-8460

## APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Western Reserve Life Assurance Co. of Ohio, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: \_\_\_\_\_

Address (street, city, state, and zip): \_\_\_\_\_

Key Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Applicant is a:  Corporation  Labor Union  Partnership  Proprietorship  Other: \_\_\_\_\_

Nature of Business of the Group to be Insured: \_\_\_\_\_

Total number of eligible lives: Employees \_\_\_\_\_ Dependents \_\_\_\_\_ Retirees \_\_\_\_\_

Requesting retiree coverage?  YES  NO

Requested Effective Date: \_\_\_\_\_

Affiliates or Subsidiaries:

Addresses of Affiliates or Subsidiaries:

SPECIFIC EXCESS LOSS INSURANCE:  YES  NO

Benefit Period: Covered Expenses Incurred from \_\_\_\_\_ through \_\_\_\_\_,

and Paid from \_\_\_\_\_ through \_\_\_\_\_; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, Covered Expenses must be Incurred from \_\_\_\_\_ through the termination date and Paid from \_\_\_\_\_ through the termination date to be eligible for reimbursement.

Covered Expenses Incurred from \_\_\_\_\_ through \_\_\_\_\_ will be limited to \$\_\_\_\_\_ per  Covered Person  Family.

Specific Deductible per  Covered Person  Family: \$\_\_\_\_\_

Specific Percentage Reimbursable: \_\_\_\_\_%

Maximum Specific Benefit Per Covered Person per Lifetime (including Specific Deductible):

\$500,000  \$1,000,000  \$2,000,000  Other \$\_\_\_\_\_

Covered Expenses under Specific Excess Loss:  Medical  Medical with Stand Alone Prescription Drug Program

### Specific Premium Rates per Month See item i on page 2 of application for special conditions

	Number of lives: _____	\$ _____
	Number of lives: _____	\$ _____
	Number of lives: _____	\$ _____
	Number of lives: _____	\$ _____

- Specific Expedited Reimbursement Endorsement:  YES  NO
- Specific Terminal Liability Endorsement:  YES  NO \$\_\_\_\_\_
- Aggregating Specific Deductible Endorsement:  YES  NO \$\_\_\_\_\_
- Other Endorsement: \_\_\_\_\_  YES  NO \$\_\_\_\_\_

Minimum Annual Specific Premium \$\_\_\_\_\_

AGGREGATE EXCESS LOSS INSURANCE:  YES  NO

Benefit Period: Covered Expenses Incurred from \_\_\_\_\_ through \_\_\_\_\_,

and Paid from \_\_\_\_\_ through \_\_\_\_\_; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, no reimbursement will be made under Aggregate Excess Loss Insurance.

Covered Expenses Incurred from \_\_\_\_\_ through \_\_\_\_\_ will be limited to \$\_\_\_\_\_ or \_\_\_\_\_% of the Annual Aggregate Deductible.

Covered Expenses under Aggregate Excess Loss Coverage:  Medical  Medical with Stand Alone Prescription Drug Program

Dental  Vision  Weekly (Disability) Income  Other (Please Specify) \_\_\_\_\_

Aggregate Percentage Reimbursable: \_\_\_\_\_%

Maximum Aggregate Benefit:  \$500,000  \$1,000,000  Other \$\_\_\_\_\_

Minimum Annual Aggregate Deductible: \$\_\_\_\_\_ or \_\_\_\_\_% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.

Loss Limit per Covered Person \$ \_\_\_\_\_

- Aggregate Excess Loss Premium:  Monthly  Annually \$ \_\_\_\_\_
1. Aggregate Terminal Liability Endorsement:  YES  NO \$ \_\_\_\_\_
2. Aggregate Accommodation Endorsement:  YES  NO \$ \_\_\_\_\_
3. Other Endorsement: \_\_\_\_\_  YES  NO \$ \_\_\_\_\_

Monthly Aggregate Factors							
	Medical	# of lives	Prescription Drugs	# of lives	Dental	# of lives	#of lives

**Full Name of Third Party Administrator:** \_\_\_\_\_  
 Address: (street, city, state, and zip): \_\_\_\_\_  
 Key Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Agent or Broker:** \_\_\_\_\_  
 SS No. or Tax ID: \_\_\_\_\_  
 Address: \_\_\_\_\_

**It is understood and agreed by the undersigned that:**

- a. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document describing the benefits provided by the Plan which shall be kept on file in the office of the Company. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company. In the event of a material variance, in the judgement of the Company, between the Plan Document received by the Company and the Plan benefit provisions upon which the terms and rates of the Aggregate and Specific Excess Loss Coverage were based, any Policy that has been issued will not take effect unless a Plan Document is received, accepted, and on file in the Company's office.
- b. The undersigned will provide or employ a Third Party Administrator (TPA) to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the TPA is the undersigned's agent and that statements and answers given by the TPA are binding on the undersigned.
- c. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such premium to the undersigned.
- d. Any Aggregate and/or Specific Excess Loss Insurance shall be described in the Policy issued.
- e. Experience, census, and other information contained in the underwriting information as furnished by the Applicant directly, or through its representative, are the primary data elements on which the Company's proposal was based. The undersigned will provide any additional underwriting information required by the Company.
- f. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including underwriting requirements, have been met and the required premiums paid.
- g. The undersigned represents that the statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document accurately and completely reflect the true facts. The undersigned understands that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations are part of this Application.
- h. The Company will evaluate the undersigned's risk, and may require adjustments of rates, factors, and/or special limitations to accommodate for abnormal risks.
- i. Other: \_\_\_\_\_

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: \_\_\_\_\_

Signature of Authorized Person: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Agent or Broker: \_\_\_\_\_

Print Name of Agent or Broker: \_\_\_\_\_

**ARKANSAS**

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.

**FRAUD WARNING NOTICES: (Please review notice that applies in your state)**

**ALASKA**

“A person who knowingly and with intent to injure, defraud, or deceive an insurance company files claim containing false, incomplete, or misleading information may be prosecuted under state law.”

**ARIZONA**

“**For your protection, Arizona law requires the following statement to appear on this form.** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties”.

**ARKANSAS, LOUISIANA, TEXAS and WEST VIRGINIA**

“Any person who knowingly presents a false or fraudulent claim for payment for 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.”

**CALIFORNIA**

**For your protection California law requires the following to appear on this form.**

“Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison”.

**COLORADO**

“**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading fact of information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement for award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**”

**DELAWARE, IDAHO, and INDIANA**

“Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a state of claim containing any false, incomplete or misleading information is guilty of a felony.”

**DISTRICT OF COLUMBIA**

“**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.**”

## **FLORIDA**

“Any person who knowingly and with intent to injure, defraud, or deceive any Insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a Felony of the Third Degree.”

## **KENTUCKY**

“Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.”

## **MAINE**

“It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.”

## **MINNESOTA**

“A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.”

## **NEW HAMPSHIRE**

“Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20.”

## **NEW JERSEY**

“Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.”

## **NEW MEXICO**

“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 civil fines and criminal penalties.”

## **OHIO**

“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 is guilty of insurance fraud.”

## **OKLAHOMA**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

## **PENNSYLVANIA**

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

## **TENNESSEE, MAINE, and VIRGINIA**

“It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”

## **ALL OTHER STATES**

**WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**



Administrative Office:  
P.O. Box 8063  
Little Rock, AR 72203-8063  
Telephone: (888) 763-7474

Transamerica Occidental Life Insurance Company  
Transamerica Life Insurance Company  
Monumental Life Insurance Company  
Life Investors Insurance Company of America

**Company Name:** Western Reserve Life Assurance Co. of Ohio

**Form Titles:** Application for Excess Loss Insurance

**Form Numbers:** SL40A (3/07)

I hereby certify that the application named above has not been changed in any way except the addition of the notice required by Arkansas Bulletin 6-2008.

A handwritten signature in cursive script that reads "Patsy J. Napier".

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Patsy J. Napier, FLMI, AIRC, HIA, CCP  
Assistant Secretary

June 11, 2008

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Date