

SERFF Tracking Number: AEGX-125662807 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 39062
Company Tracking Number: HS AR0021115F02
TOI: H07I Individual Health - Specified Disease - Sub-TOI: H07I.001 Critical Illness
Limited Benefit
Product Name: Critical Illness
Project Name/Number: Critical Illness/HS AR0021115F02

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Critical Illness SERFF Tr Num: AEGX-125662807 State: ArkansasLH

TOI: H07I Individual Health - Specified Disease SERFF Status: Closed State Tr Num: 39062

- Limited Benefit

Sub-TOI: H07I.001 Critical Illness

Co Tr Num: HS AR0021115F02

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI ADMSLH

Disposition Date: 06/04/2008

Date Submitted: 05/22/2008

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Critical Illness

Status of Filing in Domicile:

Project Number: HS AR0021115F02

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/04/2008

Deemer Date:

State Status Changed: 06/04/2008

Corresponding Filing Tracking Number:

Filing Description:

RE: Stonebridge Life Insurance Company

NAIC # 0468-65021

FEIN: 03-0164230

IUH014AR - Individual Application Verification Form

SERFF Tracking Number: AEGX-125662807 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 39062
Company Tracking Number: HS AR0021115F02
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit
Product Name: Critical Illness
Project Name/Number: Critical Illness/HS AR0021115F02

Dear Commissioner:

Attached for your review and approval is a copy of the above captioned form. This form is new and does not replace any form previously approved by your Department. This form has been completed in "John Doe" fashion. Variable information is bracketed and printed in red.

Individual Application Verification Form IUH014AR will be used to solicit Individual Critical Illness Policy SL-215-0505 AR, approved by your Department on June 28, 2005. This form may also be used with other similar products as they become approved by the Department. This form will be sent to Insureds who apply via telemarketing methods for their records.

The flesch score for IUH014AR is 45.0. Microsoft Word was used to obtain this score.

We request approval of this form in various format, dimensions, shading and colors. We certify that no dimension, format, shading or color change will affect the text content or product unacceptable print.

The Company has reviewed the enclosed policy form that the form submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.

Completed filing forms are attached. Our filing fee is being sent under separate cover.

I respectfully request your favorable review and approval. We appreciate your consideration of this form. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6289 or contact me by e-mail at mfrei@aegonusa.com.

Sincerely,

STONEBRIDGE LIFE INSURANCE COMPANY
Margaret Frei, ACS, AIRC, ACP, HIA, HCSA
Senior Contract Analyst

SERFF Tracking Number: AEGX-125662807 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 39062
Company Tracking Number: HS AR0021115F02
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit
Product Name: Critical Illness
Project Name/Number: Critical Illness/HS AR0021115F02

Attachments

Company and Contact

Filing Contact Information

Margaret Frei, Senior Contract Analyst
2700 W Plano Parkway
Plano, TX 75075

mfrei@aegonusa.com
(972) 881-6289 [Phone]
(972) 881-4097[FAX]

Filing Company Information

Stonebridge Life Insurance Company
29 South Main Street
Rutland, VT 05701-5014
(410) 685-5500 ext. [Phone]

CoCode: 65021
Group Code: 468
Group Name:
FEIN Number: 03-0164230

State of Domicile: Vermont
Company Type:
State ID Number:

Filing Fees

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

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
7010063428	\$50.00	04/28/2008

SERFF Tracking Number: AEGX-125662807 State: Arkansas
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TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit
Product Name: Critical Illness
Project Name/Number: Critical Illness/HS AR0021115F02

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/04/2008	06/04/2008

SERFF Tracking Number: AEGX-125662807 State: Arkansas
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 Limited Benefit
 Product Name: Critical Illness
 Project Name/Number: Critical Illness/HS AR0021115F02

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	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	Cover Letter	Approved-Closed	Yes
Supporting Document	NAIC Transmittal	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Form	Individual Application Verification Form	Approved-Closed	Yes

SERFF Tracking Number: AEGX-125662807 State: Arkansas
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 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
 Limited Benefit
 Product Name: Critical Illness
 Project Name/Number: Critical Illness/HS AR0021115F02

Form Schedule

Lead Form Number: IUH014AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	IUH014AR	Application/Individual Enrollment Form	Application Initial Verification Form			45	IUH014AR.PDF

[Critical Illness Insurance]
Application Verification

Keep this form with your Policy. Your acceptance of this offer is on file at our Administrative Office.

This document is a verification record of your telephone-recorded application for the [Critical Illness Insurance Plan]. It is designed to help you verify that we have correctly recorded your name, address, [date of birth,] [gender,] [height] [and] [weight] and the answers you provided to the health questions which qualified you for this plan.

Our records indicate the following information:

Name/Address: [John Q. Public]
[1000 Anywhere Street]
[Any Town, AR 75000]

[Date of Birth:] [01/05/1968] [Gender:] [Male]

[Height:] [5'10"] [Weight:] [185 lbs.]

[Tobacco User: Yes No]

Are you currently eligible to receive Medicare benefits? Yes No

I wish to add the Return of Premium Rider. Yes No

Health Questions

Response

1. Have you ever been diagnosed or treated by a physician or other medical practitioner for: a. Cancer, tumor, Hodgkin's disease, lymphoma, leukemia or melanoma? b. Heart attack, angina, high blood pressure, transient ischemic attack (TIA), (mini stroke), stroke or any other disease or disorder of the heart, aorta, arteries or circulatory system? c. Diabetes, paralysis, hepatitis or any other disease or disorder of the lungs, brain, kidney, liver or nervous system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Have you ever been diagnosed with or told you have AIDS or are infected with the HIV (AIDS) virus?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have your parents or siblings (brothers, sisters) been diagnosed with or died from cancer, heart attack, heart disease, stroke or diabetes before age 60?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Will this policy replace any accident or health insurance policy that you now have in force?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

I represent that my above answers are true and complete to the best of my knowledge and belief. I understand that incorrect or misleading answers (material misrepresentations) to any of the questions may void the application during the first 24 months of coverage. I understand [a separate Policy will be issued to each applicant and] that no insurance is in effect until Stonebridge Life Insurance Company issues my Policy and receives my first premium before the Policy Effective Date.

I understand that the Policy only covers specified Critical Illnesses that are first diagnosed after the Policy Effective Date. I understand that a limited benefit is paid for a Critical Illness that is first diagnosed during the first 30 days of coverage. I also understand that any Critical Illness caused by or resulting from a pre-existing condition that I received medical treatment for during the 12 month period prior to the Effective Date will not be covered during the first 12 months of coverage. I understand that I cannot be covered by this Policy if I am also covered by any Title XIX program. I further understand that I can have only one Policy/Certificate providing the same or similar coverage. I have read the fraud statement on the back of this application and the NOTICE TO APPLICANT enclosed with this form as required by the Fair Credit Reporting Act.

Stonebridge Life Insurance Company
Home Office: Rutland, Vermont

IUH014AR

Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

Authorization for disclosures of medical information to Stonebridge Life Insurance Company

I understand I am not required to sign this authorization; however, without it Stonebridge Life Insurance Company can not achieve two purposes, (1) its underwriters can not determine my eligibility for insurance; and (2) its claim adjusters may not be able to pay my claim. I authorize any medical practitioner, medical related institution, government agency, paramedic facility, medical record retrieval services, pharmaceutical services, insurance company, reinsurer, plan administrator, the Medical Information Bureau, or any Consumer Reporting Agency, to disclose to Stonebridge all of my medical records except psychotherapy notes (e.g., my medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS). I understand that entities to which this information may be disclosed may not be covered by federal privacy rules and if this information is redisclosed, it may no longer be protected by those rules. I understand this authorization or a copy: (1) expires 24 months from the date signed or if earlier, upon completion of any claim for benefits; (2) a copy will be sent to me; and (3) I may revoke it in writing at any time by sending written notice to Stonebridge Life Insurance Company [2700 West Plano Parkway, Plano, Texas 75075-8200] except to the extent it is already relied upon.

The Policy provides limited benefits. Review your Policy carefully.

Any person who, with intent to defraud or knowing that he/she 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.

[Application signed electronically. Signature on file with the Company ____]
[Applicant's Signature]

If any of the information is incorrect, contact our Customer Service Department at: [1-800-XXX-XXXX]

Stonebridge Life Insurance Company
Home Office: Rutland, Vermont

IUH014AR

Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

SERFF Tracking Number: *AEGX-125662807* *State:* *Arkansas*
Filing Company: *Stonebridge Life Insurance Company* *State Tracking Number:* *39062*
Company Tracking Number: *HS AR0021115F02*
TOI: *H071 Individual Health - Specified Disease -* *Sub-TOI:* *H071.001 Critical Illness*
 Limited Benefit
Product Name: *Critical Illness*
Project Name/Number: *Critical Illness/HS AR0021115F02*

Rate Information

Rate data does NOT apply to filing.

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 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
 Limited Benefit
 Product Name: Critical Illness
 Project Name/Number: Critical Illness/HS AR0021115F02

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 06/04/2008

Comments:

The Company has reviewed the enclosed policy form that the form submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.

Attachment:

Readability Certification.PDF

Bypassed -Name: Application **Review Status:** Approved-Closed 06/04/2008

Bypass Reason: The form being submitted for review and approval is attached to the Forms Schedule.

Comments:

Bypassed -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 06/04/2008

Bypass Reason: N/A - Application form filing only

Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 06/04/2008

Bypass Reason: N/A - Application form filing only

Comments:

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 06/04/2008

Comments:

Attachment:

Cover Letter.PDF

Satisfied -Name: NAIC Transmittal **Review Status:** Approved-Closed 06/04/2008

SERFF Tracking Number: AEGX-125662807 State: Arkansas
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Limited Benefit
Product Name: Critical Illness
Project Name/Number: Critical Illness/HS AR0021115F02

Satisfied -Name: Explanation of Variables **Review Status:** Approved-Closed 06/04/2008
Comments:
Attachment:
Explanation of Variables.PDF

STONEBRIDGE LIFE INSURANCE COMPANY

CERTIFICATE OF COMPLIANCE

TO: DEPARTMENT OF INSURANCE
STATE OF ARKANSAS

RE: IUH014: Application Verification Form

We hereby certify that we have carefully reviewed the forms submitted herewith, and to the best of our knowledge and ability find:

1. That the said form(s) comply with the readability requirements of this state.
2. That the said form(s) have a reading ease score of 45.0.

STONEBRIDGE LIFE INSURANCE COMPANY

DATE: May 21, 2008



Cheryl Penner
Assistant Secretary



STONEBRIDGE LIFE
Insurance Company
2700 West Plano Parkway • Plano, Texas 75075-8200

May 22, 2008

The Honorable Julie Benafield Bowman
Commissioner of Insurance
Arkansas Insurance Department
Life & Health Division
1200 W 3rd St
Little Rock AR 72201-1904

Attention: Ms. Rosalinda Minor

RE: Stonebridge Life Insurance Company
NAIC # 0468-65021
FEIN: 03-0164230
IUH014AR – Individual Application Verification Form

Dear Commissioner:

Attached for your review and approval is a copy of the above captioned form. This form is new and does not replace any form previously approved by your Department. This form has been completed in “John Doe” fashion. Variable information is bracketed and printed in red.

Individual Application Verification Form IUH014AR will be used to solicit Individual Critical Illness Policy SL-215-0505 AR, approved by your Department on June 28, 2005. This form may also be used with other similar products as they become approved by the Department. This form will be sent to Insureds who apply via telemarketing methods for their records.

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I respectfully request your favorable review and approval. We appreciate your consideration of this form. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6289 or contact me by e-mail at mfrei@aegonusa.com.

Sincerely,

STONEBRIDGE LIFE INSURANCE COMPANY

A handwritten signature in cursive script that reads "Margaret Frei".

Margaret Frei, ACS, AIRC, ACP, HIA, HCSA
Senior Contract Analyst

Attachments

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Stonebridge Life Insurance Company 2700 West Plano Parkway Plano, TX 75075	VT	Life, Accident/H ealth	0468	65021	03-0164230	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Margaret Frei	1-877-527-6444 Ext 6289	1-972-881-4097	mfrei@aegonusa.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	IUH014AR
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8.	Market	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9.	Type of Insurance	H07I Individual Health – Specified Disease – Limited Benefit
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10.	Product Coding Matrix Filing Code	H07I.001 Critical Illness
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11.	Submitted Documents	<p><u>FORMS</u></p> <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other
		<p><u>Rates</u></p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate
		<p><input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____</p>
		<p><u>SUPPORTING DOCUMENTATION</u></p> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input checked="" type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____

12.	Filing Submission Date	May 22, 2008	
13	Filing Fee (If required)	Amount <u> \$50.00 </u>	Check Date <u> 04/28/08 </u>
		Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Check Number <u> 7010063428 </u>
14.	Date of Domiciliary Approval	Filed concurrently in Vermont, our state of domicile, and is currently pending.	
15.	Filing Description:		
<p>Attached for your review and approval is a copy of the above captioned form. This form is new and does not replace any form previously approved by your Department. This form has been completed in "John Doe" fashion. Variable information is bracketed and printed in red.</p> <p>Individual Application Verification Form IUH014AR will be used to solicit Individual Critical Illness Policy SL-215-0505 AR, approved by your Department on June 28, 2005. This form may also be used with other similar products as they become approved by the Department. This form will be sent to Insureds who apply via telemarketing methods for their records.</p> <p>The flesch score for IUH014AR is 45.0. Microsoft Word was used to obtain this score.</p> <p>We request approval of this form in various format, dimensions, shading and colors. We certify that no dimension, format, shading or color change will affect the text content or product unacceptable print.</p> <p>The Company has reviewed the enclosed policy form that the form submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.</p> <p>Completed filing forms are attached. Our filing fee is being sent under separate cover.</p> <p>I respectfully request your favorable review and approval. We appreciate your consideration of this form. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6289 or contact me by e-mail at mfrei@aegonusa.com.</p>			

16.	Certification (If required)		
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u> Arkansas </u>.</p>			
Print Name <u> Margaret Frei </u>		Title <u> Senior Contract Analyst </u>	
Signature <u> Margaret Frei </u>		Date: <u> May 22, 2008 </u>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		IUH014AR
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Individual Application Verification Form	IUH014AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		N/A		
This filing corresponds to form filing company tracking number		N/A		
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01	N/A	N/A	<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	N/A
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1

EXPLANATION OF VARIABLES

Variable information is bracketed and printed in red. The following is an explanation of the variables indicated in the submitted form.

1. This application verification form may be used with other similar products approved by your Department.
2. Date of birth, gender, height and weight may or may not appear depending on the coverage solicited and the level of underwriting used.
3. John Doe information will vary as it pertains to the applicant/insured.
4. We have several toll free numbers that are assigned according to marketing plan and to accommodate our many customers. As a result, the toll free number will vary based on solicitation.
6. COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:
 - a) 2700 West Plano Parkway
Plano, Texas 75075-8200
 - b) 520 Park Avenue
Baltimore, Maryland 21201
 - c) Valley Forge, Pennsylvania 19493