

SERFF Tracking Number: ICCI-125688173 State: Arkansas
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 39236
Company Tracking Number: SSL AE CEBT 1206
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: SSL AE CEBT 1206
Project Name/Number: SSL AE CEBT 1206 /SSL AE CEBT 1206

Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: SSL AE CEBT 1206 SERFF Tr Num: ICCI-125688173 State: ArkansasLH
TOI: H16G Group Health - Major Medical SERFF Status: Closed State Tr Num: 39236
Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: SSL AE CEBT 1206 State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Author: Brenda Dawson Disposition Date: 06/11/2008
Date Submitted: 06/09/2008 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: SSL AE CEBT 1206 Status of Filing in Domicile: Not Filed
Project Number: SSL AE CEBT 1206 Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small
Overall Rate Impact: Group Market Type: Trust
Filing Status Changed: 06/11/2008 Deemer Date:
State Status Changed: 06/11/2008
Corresponding Filing Tracking Number:
Filing Description:
See attached cover letter, riders and application.

Company and Contact

Filing Contact Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

SERFF Tracking Number: ICCI-125688173 State: Arkansas
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 39236
Company Tracking Number: SSLAE CEBT 1206
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: SSLAE CEBT 1206
Project Name/Number: SSLAE CEBT 1206 /SSLAE CEBT 1206

Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com
519 Colman Center Drive (815) 316-6714 [Phone]
Rockford, IL 61108 (815) 316-6720[FAX]

Filing Company Information

Standard Security Life Insurance Company of New York CoCode: 69078 State of Domicile: New York
485 Madison Avenue, 14th Floor Group Code: Company Type:
New York, NY 10022 Group Name: State ID Number:
(212) 355-4141 ext. [Phone] FEIN Number: 13-5679267

SERFF Tracking Number: ICCI-125688173 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$80.00
Retaliatory? No
Fee Explanation: \$20 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Security Life Insurance Company of New York	\$80.00	06/09/2008	20736685

SERFF Tracking Number: ICCI-125688173 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/11/2008	06/11/2008

SERFF Tracking Number: *ICCI-125688173* State: *Arkansas*
Filing Company: *Standard Security Life Insurance Company of New York* State Tracking Number: *39236*
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Disposition

Disposition Date: 06/11/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	SSL Authorization Letter	Approved-Closed	Yes
Supporting Document	Filing fee schedule	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Form	Employee Application	Approved-Closed	Yes
Form	Waiver of Coverage Rider	Approved-Closed	Yes
Form	Waiver of Coverage Rider for Dependents	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SSL AE CEBT 1206

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SSL AE CEBT 1206	Certificate Amendmen	Amendatory Endorsement t, Insert Page, Endorseme nt or Rider	Initial		50	AE - SSL AE CEBT 1206 (1-25-07).pdf
Approved-Closed	SSL CEBT EEAPP AR 0107	Application/Employee Enrollment Form	Application	Initial		50	AR SSL CEBT EEAPP AR 0107 6-4-08.pdf
Approved-Closed	SSL CEBT WVR 0107	Certificate Amendmen	Waiver of Coverage Rider t, Insert Page, Endorseme nt or Rider	Initial		50	SSL CEBT WVR 0107.pdf
Approved-Closed	SSL CEBT WVR D 0107	Certificate Amendmen	Waiver of Coverage Rider for Dependents t, Insert Page, Endorseme nt or Rider	Initial		50	SSL CEBT WVR D 0107 - (Dependent only).pdf

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue, New York, NY 10022

AMENDATORY ENDORSEMENT

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this Amendatory Endorsement is attached is amended as follows:

[A. Schedule of Benefits – under the section entitled “**Medical Deductible Per Calendar Year**” the following changes are hereby made:

a. The text “Failure to Pre-Certify specified Prescription Medications” is deleted and replaced with the following:

Failure to Pre-Determine specified Prescription Medications – No coverage for specified medication

[b. The following is added under this section:

[Failure to Pre-Determine Non-Emergency Care Ambulance Transportation Services – [No coverage for the ambulance service]]

[Failure to Pre-Determine Durable Medical Equipment in excess of [\$1,000] – [No coverage for the durable medical equipment.]]]

[B.] SECTION 2 – DEFINITIONS

1. The following definitions are hereby added:

Bundling. Inclusion of related Charges for room, supplies and other Charges for goods, services and medications as recognized by industry standards including, but not limited to National Correct Coding Initiative, Packaging and Bundling Rules, Current Procedure Terminology, Outpatient Prospective Payment System, Complete Global Service Data for Orthopedic Surgery, Relative Value for Physicians, and Diagnosis Related Grouping as being included in the Charge for the primary medical procedure or room Charge. “**Unbundling**” or “**Unbundled Charges**” occurs when a Physician or a Facility separates some of the Charges that should be included in the “global” bundle charge for room, surgical, operation of other Charges which results in duplication of Charges.

[Electronic Consultations: The practice, by a Physician of health care delivery, diagnosis, consultation, treatment, by means of the Internet or similar electronic communications, that does not require a face-to-face encounter with the patient for all or any part of the Electronic Consultation.

The term includes online medical evaluations, online visits and terms with similar web-based nomenclature.]

Pre-Certification. A screening process to determine if the proposed Inpatient Hospital Confinement and treatment plan are Medically Necessary. Pre-Certification is not pre-authorization or pre-approval of coverage and does not guarantee payment of benefits.

[Pre-Determination/Pre-Determine. A screening process to determine if the proposed services, drugs or supplies are Medically Necessary. Pre-Determination is not pre-authorization or pre-approval of coverage and does not guarantee payment of benefits.]

[Retail Health Clinics. A medical clinic located in a retail setting that offers medical services on a non-Emergency or Urgent Care basis and meets all of the following conditions:

- a. It has a well-defined and limited scope of clinical services;
- b. Clinical services and treatment plans must be evidenced-based and quality improvement-oriented;
- c. It must have a formal connection with physician practices in the local community, to provide continuity of care;
- d. It must be duly licensed by the state or regulatory agency responsible for such licensing in the state in which the Clinic is located; [and]
- e. [Other health professionals, such as nurse practitioners, can only operate in accordance with state and local regulations, as part of a “team-based” approach to health care and under responsible supervision of a practicing, licensed physician;] [and]
- f. It must have a referral system to physician practices or to other appropriate entities when the patient’s symptoms exceed the clinic’s scope of services; [and]
- g. [It uses an electronic health record systems compatible with the continuity of care record supported by the American Academy of Family Physicians that can communicate the patient’s information with the family physician’s offices].

The term shall also apply to an institution which otherwise meets the required conditions, referring to itself as a convenience clinic or any such other facility. A Retail Health Clinic does not include: Ambulatory Surgical Centers, Urgent Care Facility, or any other such Facility.]

2. The definition “Specialty Medications” is deleted in its entirety and replaced with the following:

Specialty Medications. Prescription Medications that may be administered by a Physician as an Outpatient or self-administered in a home setting and are listed on the Specialty Drug List maintained by Us or Our designee, as revised from time to time at Our discretion.

3. The definition “Usual, Reasonable and Customary” is deleted in its entirety and replaced with the following:

Usual, Reasonable and Customary. Charges for services and supplies, which are the lesser of: (a) the Charge usually made for the service or supply by the Physician or Facility who furnished it; (b) the negotiated rate; and; (c) the reasonable Charge as determined by Us made for the same service or supply in the same geographic area.

We shall determine to what extent the Charge is reasonable, taking into account: (a) The complexity involved; (b) The degree of professional skill involved; (c) Data compiled and regularly updated from Our records or those of Our agents. We use and subscribe to a standard industry reference source that collects data for determining excessive fees and makes it available to its member companies. The data base used reflects the amounts Charged by providers for health care services based on the smallest geographic zip code areas generating a statistically credible charge distribution. This data is updated and published twice annually. The data is reflective of reported provider Charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base. We then use a specific representative percentile of that range of Charges; (d) The condition being treated; (e) Any medical complications or unusual circumstances; (f) The amounts the Physician or Facility routinely accepts as full payment from all payers after good faith collection efforts; and (g) other pertinent factors.

The Physician’s or Facility’s usual Charge must not exceed the usual Charge made by most providers of like service in the same geographic area. Area means the geographical area as determined by Us which is significant enough to establish a representative base of Charges for the treatment.

The following are examples of Charges that will not be considered Usual, Reasonable and Customary: (1) Pharmaceutical charges which exceed 200% of Average Wholesale Price or cost, which ever is less; (2) Unbundled Charges; and (3) Charges which industry standards recognize as included in the primary charge. When it is determined by this specific payment methodology that a Charge by a Physician or Facility is above the Usual, Reasonable and Customary amount, the Charge is not a Covered Charge.

4. The definition "Utilization Review" is amended as follows:

Item #3 pertaining to "Certification," the term is deleted and replaced with "Pre-Certification."

[C]. **SECTION 3 – ELIGIBILITY FOR INSURANCE AND EFFECTIVE DATE OF COVERAGE** – under the subparagraph entitled **Late Enrollee Eligibility {Employee or Dependent}** – the second paragraph pertaining to the Effective Date of coverage for Late Enrollees is deleted in its entirety and replaced with the following:

For Late Enrollees, the Effective Date of coverage under the Policy will be the first date of the month next following the date on which We receive and approve the Enrollment Form. Pre-Existing Conditions will not be covered until the Late Enrollee is continuously covered under the Policy for a period of 18 months following the Late Enrollee's Effective Date.

[D]. **SECTION 5 – BENEFITS** – under the subparagraph entitled **Major Medical Benefits**, the following changes are hereby made:

[1.] [Item [8] pertaining to Medical services and supplies, subparagraph I. pertaining to the rental of Durable Medical Equipment is amended by adding the following at the end of the subparagraph:

Pre-Determination is required for Durable Medical Equipment that exceeds \$[1000].]

[2.] Item [12] pertaining to Screening services, [subparagraph D] pertaining to Colorectal Cancer Screening is amended by adding the following at the end of the subparagraph:

A person may be at high risk for colorectal cancer if they have any of the following colorectal cancer risk factors:

- a personal history of colorectal cancer or adenomatous polyps;
- a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative {parent, sibling, or child} younger than 60 or in 2 first-degree relatives of any age);
- a personal history of chronic inflammatory bowel disease;
- a family history of an hereditary colorectal cancer syndrome (familial adenomatous polyposis or hereditary non-polyposis colon cancer)

The colorectal cancer screening and examination, includes the following:

- (i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test; and
- (ii) Flexible sigmoidoscopy every five years; or
- (iii) Double contrast barium enema every five years; or
- (iv) Colonoscopy every ten years.

[This benefit is not subject to the [In-Network] [Calendar Year Deductible] [Copayment] [and] [Coinsurance].] [If the Insured Person uses an Out-of-Network Provider, the Out-of-Network Deductible and Coinsurance requirements apply.] Additional screenings needed for the Medically Necessary treatment of a covered Sickness will be considered under the Policy as a Covered Charge and benefits are payable on the same basis as other covered diagnostic tests

[3.] The following benefit is added:

[13.] Medical treatment, services and supplies received in a Retail Health Clinic for the treatment of a covered Sickness or Injury. [Covered Charges are [not] subject to the [Deductibles] [Co-payments] [and] [or] [Coinsurance] requirements.] [Covered Charges are subject to the [[In Network] Physician Office Visit Co-pay] [and] [In-Network] Physician Office Visit Coinsurance] as specified in the Schedule Benefits.] [Covered Charges will be paid at the In-Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge].]

[E]. **[SECTION 5 – BENEFITS** – under the subparagraph entitled **Limited Major Medical Benefits**, the following benefit[s] [are][is] hereby added:

[10.] [Electronic Consultations for non-urgent medical care, provided such Electronic Consultations are provided for the Medically Necessary treatment of a covered Sickness or Injury and in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the Electronic Consultation is rendered. [Covered Charges are subject to the [[In Network] Physician Office Visit Co-pay] [and] [In-Network] Physician Office Visit Coinsurance] as specified in the Schedule Benefits.] [Covered Charges will be paid [at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge]] [up to a maximum benefit of [\$35] per Electronic Consultation [and a maximum of [3] Electronic Consultations per [calendar week] [day]] per Insured Person]].

To be considered a Covered Charge, Electronic Consultations must meet all of the following conditions:

1. The Insured Person is currently a patient of and under the care of the Physician rendering the Electronic Consultation;
2. The Physician provides online medical evaluation and management service in response to the Insured Person's request; and
3. The Physician maintains all documentation related to the Electronic Consultation in the Insured Person's medical file, including:
 - a. written documentation of the Insured Person's condition and symptoms;
 - b. the Physician's diagnosis and plan of treatment; and
 - c. the name and dosage of any medications prescribed.

The following are not Covered Charges under this benefit:

1. Urgent medical needs or urgent message responses;
2. Appointment scheduling, cancellations or rescheduling, or reminders of scheduled office visit appointments;
3. Refilling, renewing or transferring existing prescriptions;
4. Scheduling of diagnostic tests or the reporting of normal test results; or
5. Providing counseling, instructional or educational training or materials.]

[11.] [Telephone medical consultation with a [In-Network] Physician for non-emergency health care, provided such consultation is provided for the Medically Necessary treatment of a covered Sickness or Injury. [Benefits are subject to a [\$35] telephone consultation fee per consultation.] [Benefits are subject to the [[In-Network] Physician Office Visit Co-pay] [and] [In-Network] Physician Office Visit Coinsurance] as specified on the Schedule of Benefits.] [Benefits are payable up to a maximum benefit of [\$35] per consultation [and a maximum of [3] consultations per [calendar week] [day] per Insured Person].]

[To be considered a Covered Charge, telephone medical consultations must meet all of the following conditions:

1. The Insured Person is currently a patient of and under the care of the Physician rendering the telephone medical consultation; and
2. The Physician maintains all documentation related to the telephone consultation in the Insured Person's medical file, including:
 - a. written documentation of the Insured Person's condition and symptoms;
 - b. the Physician's diagnosis and plan of treatment; and
 - c. the name and dosage of any medications prescribed.]

[The following are not Covered Charges under this benefit:

1. Urgent medical needs or urgent message responses;
2. Appointment scheduling, cancellations or rescheduling, or reminders of scheduled office visit appointments;
3. Refilling, renewing or transferring existing prescriptions;

4. Scheduling of diagnostic tests or the reporting of normal test results; or
5. Providing counseling, instructional or educational training or materials.]

[F]. **SECTION 6 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE** – the following change[s] [is] [are] hereby made:

[a.] Item # 1 pertaining to a Pre-Existing Condition is deleted in its entirety and replaced with the following:

1. A Pre-Existing Condition, until a continuous period of (a) twelve (12) months has elapsed from the Enrollment Date for other than Late Enrollees and (b) eighteen (18) months has elapsed from the Effective Date with respect to Late Enrollees. This paragraph does not apply to a newborn or newly adopted child or child placed for adoption under the age of 18 if such child is enrolled for coverage within 31 days from the date of birth or the date of adoption or placement for adoption. We will credit the time the Insured Person was covered by a plan of Creditable Coverage against this Pre-existing Condition exclusion period if no more than 63 days elapsed between the termination of the Insured Person's prior Creditable Coverage and the Insured Person's Enrollment Date or, the Late Enrollee's Effective Date; or

[b. Item [# 56] pertaining to telephone consultations is deleted in its entirety and replaced with the following:

- [56.] Missed appointment fees, fees for completing claim forms, fees related to obtaining hospital Pre-Certification, and fees related to the provision of medical records; or]

[G]. **SECTION 7 – ACCESSING AND ADMINISTERING YOUR BENEFITS** – the following changes are hereby made:

1. Under the subparagraph entitled **Managed Care**, and the provision captioned "**Pre-Certification Program**," the following changes are hereby made:

- a. The first two paragraphs pertaining to Pre-Certification as applicable to Inpatient Confinements and certain Prescription Drug Orders are deleted in its entirety and replaced with the following:

The Pre-Certification Program is applicable to all Inpatient Confinements. An additional Deductible Amount per Hospital Confinement is specified in the Schedule of Benefits (Applicable to Covered Charges incurred in connection with an Inpatient Confinement when the Insured Person does **NOT** comply with the Pre-Certification. If the Insured Person complies with the Pre-Certification, the additional Deductible will not apply.)

- b. The fourth paragraph pertaining to the Policy's Pre-Certification requirements is deleted in its entirety and replaced with the following:

The Policy requires Pre-Certification by an Insured Person of all proposed Inpatient Confinements in a Hospital, as defined by the Policy for more than 23 hours.

2. Under the subparagraph entitled **Managed Care**, and the provision captioned "**Medications Subject to Pre-Certification Program**" is deleted in its entirety and replaced with the following:

Pre-Determination of [Non Emergency Care Ambulance Transportation Services,] [Durable Medical Equipment that exceeds \$[1000]] [and] Certain Prescription Drugs

Pre-Determination is required in order to receive any benefits for the Charges listed below. The Insured Person is responsible for assuring that the required Pre-Determination is received before the Charges are incurred by calling the designated Pre-Determination service. Failure to comply with the Pre-Determination requirement will result in no benefits being paid and no coverage for such Charges.

The Insured Person must obtain Pre-Determination for the following Charges. **If the Insured Person does not obtain Pre-Determination, Charges incurred for the following are not Covered Charges:**

- [1.] [Non-Emergency Care licensed professional Ambulance transportation services to transport an Insured Person to a Facility or from a Facility to another Facility.]
- [2.] [Durable Medical Equipment as provided in Section 4 A. Major Medical Benefits, subparagraph [8i] herein that exceeds \$[1000].]
- [3.] The following Prescription Medications:
 - a. Specialty Medications including, but not limited to, growth hormones, insulin, chemotherapy immunosuppressants; *provided however*, injectible antibiotics, vitamins, allergen desensitizing agents, vaccines and local anesthetics do not require Pre-Determination.
 - b. Immunosuppressants;
 - c. AZT, Retrovir, Zidovudine or any HIV antiretroviral medication;
 - d. "Off Label" use, Orphan Drugs and Investigative New Drugs (IND);
 - e. Group "C" Cancer Drugs (drugs for specific types of tumors that have specified to have beneficial effect, but are awaiting FDA approval);

Pre-Determination of the above described Prescription Medications is required [only if the [Optional] Prescription Medication Benefit Rider is specified as applicable on the Schedule of Benefits.] [The Prescription Medications listed in sub-paragraph 3 above are covered only if the [Optional] Prescription Medication Benefit Rider is specified as applicable in the Schedule of Benefits and the Pre-Determination requirement has been met.]]

3. Under the subparagraph entitled **Managed Care** and the provision captioned "**Provider Networks**", the following changes are hereby made:

- a. The fifth paragraph pertaining to treatment, services and supplies an Insured Person receives outside the In-Network service area while traveling is deleted in its entirety and replaced with the following:

When an Insured Person receives treatment, services or supplies outside the In Network service area for a Sickness or Injury with symptoms which arise suddenly and require immediate care and treatment while traveling out of the In Network service area for business or vacation, Covered Charges received from Out-of-Network Providers will be paid at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge] provided such treatment, services or supplies were not pre-arranged or pre-scheduled prior to the Insured Person's trip and were received or purchased within the United States.

- [b. The following paragraphs are added:

When an Insured Dependent Child is a full-time student actively attending an accredited college, vocational or high school outside the In Network service area [for more than [ninety (90)] days], Covered Charges received from Out-of-Network Providers will be paid at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge] provided such Charges were received or purchased within the United States.

[When an Insured Dependent Child lives apart from You and resides outside the In Network service area [for more than [ninety (90)] days], Covered Charges received from Out-of-Network Providers will be paid at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge] provided such Charges were received or purchased within the United States.]]

4. Under the subparagraph entitled **Managed Care** and the provision captioned "**Pre-existing Conditions Limitation**", item #2 pertaining to Insured Persons who are Late Enrollees is deleted in its entirety and replaced with the following:

2. For Insured Persons who enroll outside an Initial Enrollment Period or Special Enrollment Period (Late Enrollees), Covered Charges incurred for the treatment of Pre-Existing Conditions will not be covered under the Policy for a period of 18 months after the Effective Date. A Pregnancy will not be considered a Pre-Existing Condition; and

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] whichever is later] [the Effective Date as specified by an attached Endorsement.]

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK



Rachel Lipari
President



Adam C. Vandervoort
Secretary

GROUP HEALTH PLANS EMPLOYEE APPLICATION Contractors Employee Benefit Trust

Underwritten by Standard Security Life Insurance Company of New York, New York

A. EMPLOYEE INFORMATION

NAME LAST	HOME PHONE NUMBER	BEST TIME FOR US TO CALL <input type="checkbox"/> AM <input type="checkbox"/> PM
FIRST NAME M. I.	WORK PHONE NUMBER	BEST TIME FOR US TO CALL <input type="checkbox"/> AM <input type="checkbox"/> PM
ADDRESS	FAX NUMBER (if available)	DATE OF BIRTH (Month/Day/Yr)
CITY/STATE/ZIP	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
COUNTY	BENEFICIARY NAME AND RELATIONSHIP (Life and AD&D)	
SOCIAL SECURITY NUMBER		

B. EMPLOYER INFORMATION

1. NAME OF EMPLOYER	5. DATE OF FULL-TIME EMPLOYMENT
2. NAME OF JOBSITE	6. OCCUPATION OR DUTIES
3. JOBSITE CITY & STATE	7. HOURLY WAGE RATE OR MONTHLY EARNINGS
4. PAY CLASSIFICATION <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARIED	8. WEEKLY HOURS WORKED

C. COVERAGE INFORMATION

1. COVERAGES REQUESTED <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE & SPOUSE <input type="checkbox"/> EMPLOYEE & CHILD (REN) <input type="checkbox"/> EMPLOYEE, SPOUSE & CHILD (REN)

D. DEPENDENT INFORMATION

LAST NAME (IF DIFFERENT)	FIRST	MI	DATE OF BIRTH	SEX	RELATIONSHIP	FULL-TIME STUDENT	NAME OF SCHOOL
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	

ARE ANY OF THE DEPENDENTS IDENTIFIED ABOVE CURRENTLY RECEIVING SOCIAL SECURITY DISABILITY BENEFITS? YES NO

I hereby apply for insurance to which I am now or may become entitled under the provisions of the Master Policy issued by Standard Security Life Insurance Company of New York. I authorize my employer to deduct the required premium contribution, if any, from my earnings. I understand that insurance will not be in force until the first day of the month following satisfaction of any waiting period or accumulation of hours worked as required by the Plan selected by my Employer.

I understand that one of the requirements for eligibility on the effective date and for continued eligibility under the plan is that I am employed by my employer at the jobsite address indicated above based on the required hours specified on my employer's plan of insurance.

I am applying for coverage under the Contractors Employee Benefit Trust under Pre-certification of medical-services conditions. I authorize any physician, medical practitioner, hospital, clinic or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition and/or treatment of me or my insured dependents to give/allow the Insurance Company or their legal representatives (including Med-Valu) any and all such information. I understand that failure to pre-certify results in the application of additional deductibles.

Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application claim or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.

Furthermore, I hereby authorize any physician or practitioner, hospital or other organization, institution or person, that has any medical records or knowledge of me or my family, to give to Standard Security Life Insurance Company of New York such information (photocopy of this authorization shall be valid as the original).

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 fines and confinement in prison.

I also understand that my coverage and that of my dependents, if any, will be subject to the pre-existing condition limitation and exclusion provision specified in the Master Policy and that this provision has been fully explained to me. (See Section E for important information)

Dated

Signature of Employee

ADMINISTRATIVE USE ONLY	TIMELY EE <input type="checkbox"/>	SPEC ENROLL <input type="checkbox"/>	LATE ENROLL <input type="checkbox"/>	LIFE AMOUNT	PCEFDT	PRE-EX ENDS	ELIG DATE	UW APPRV	Case #	PART #	ENTERED BY
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E. CREDIT FOR PRE-EXISTING CONDITION LIMITATION NOTICE

1. HAVE YOUR OR ANY OF YOUR DEPENDENTS BEEN INSURED THROUGH ANY OTHER PLAN OF HEALTH INSURANCE WITHIN THE PAST 63 DAYS (90 DAYS IN GEORGIA)? YES NO IF YES, PLEASE COMPLETE THE FOLLOWING REQUIREMENTS:

2. NAME & PHONE NUMBER OF <u>HEALTH</u> INSURANCE COMPANY		3. NAME & SOCIAL SECURITY NUMBER OF PRIMARY INSURED		
4. POLICY OR CERTIFICATE HOLDER NUMBER	5. TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> EMPLOYER-SPONSORED	6. EFFECTIVE DATE	7. TERMINATION DATE	
8. NAME & PHONE NUMBER OF <u>DENTAL</u> INSURANCE COMPANY		9. NAME & SOCIAL SECURITY NUMBER OF PRIMARY INSURED		
10. POLICY OR CERTIFICATE NUMBER	11. TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> EMPLOYER-SPONSORED	12. EFFECTIVE DATE	13. TERMINATION DATE	

14. IF YOU OR ANY OF YOUR DEPENDENTS HAVE BEEN INSURED THROUGH ANY OTHER PLAN OF CREDITABLE HEALTH INSURANCE WITHIN THE PAST 63 DAYS, YOU HAVE THE RIGHT TO RECEIVE CREDIT TOWARD THE PRE-EXISTING CONDITION LIMITATION UNDER THE PLAN.
 This group health plan contains a pre-existing condition exclusion period of 12 months (18 months for late enrollees). This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, the plan will not take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you must submit your certificate(s) of prior creditable coverage. Creditable coverage can include coverage under another group health plan, an individual health policy, short term health plans, student health plans, Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corp Act. You may request a Certificate of Creditable Coverage from a previous employer's insurance company or Health Maintenance Organization (HMO). If you submit a Certificate of Creditable Coverage (or documentation of creditable coverage through other means) then we will make a determination regarding the length of any pre-existing condition exclusion that applies to you or your dependents. We reserve the right to modify an initial determination of creditable coverage if we determine that your claimed coverage is in error, provided that we send you a notice of reconsideration. Until the final determination is made, we will, for purpose of pre-certification under the plan, act in a manner consistent with the initial determination.
ATTACH A COPY OF THE CERTIFICATION OF GROUP HEALTH INSURANCE PLAN COVERAGE OR OTHER DOCUMENTATION OF CREDITABLE COVERAGE.

F. HEALTH INFORMATION

EMPLOYEE HEIGHT (FEET/INCHES)	EMPLOYEE WEIGHT	SPOUSE HEIGHT (FEET/INCHES)	SPOUSE WEIGHT
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YES NO
 1. Has any proposed insured person been unable to work by reason of disability for 3 or more consecutive weeks during the past 5 years?
 2. Are you or your dependents pregnant? (Answer for all dependents whether or not applying for coverage.)

YES NO
 3. Has any proposed insured person within the past 5 years:
 a. consulted, been examined by or treated by any physician, chiropractor, psychologist, or other practitioner?
 b. been to a clinic, hospital or other medical facility for treatment or observation?
 c. had any operation, surgical procedure or special tests performed or advised to have performed?

YES NO
 4. Within the past 10 years (5 in Colorado), has any proposed insured person ever had, sought treatment, or received medication for, been told he or she had, or been advised to have treatment for:
 a. high blood pressure, heart attack or disease, chest pain, heart murmur or vein or artery disorder?
 b. stroke, headaches, fainting, convulsions or seizures, paralysis or other brain disorder?
 c. diabetes or sugar intolerance, thyroid, pituitary, adrenal, pancreas or other gland disorder?
 d. kidney, bladder, prostate, urinary tract, breast or reproduction organ disorder, sexually transmitted disease, infertility, irregular menstruation, or complications or pregnancy?
 e. liver, hepatitis, cirrhosis, stomach, intestine or gall bladder disorder, colitis, ulcer, hernia, hemorrhoids or other rectal disorder?
 f. asthma, emphysema, shortness of breath or any disease of the lungs or respiratory system?
 g. nervousness, anxiety, depression or any other mental or nervous disorder?
 h. spine or back disorder, muscle, joint or bone disorder, arthritis or gout?
 i. eye, ear, nose or throat disorder or allergies?
 j. cancer, tumor or cyst; disorder or blood, skin or lymph nodes?
 k. Human Immunodeficiency Virus (HIV) infections, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune system disorder?
 l. Alcoholism or drug addiction?

YES NO
 5. Are all proposed insured persons now in good health and free from physical impairment or disease?

Use space below to give details of questions 1 through 4 if answered "Yes" or question 5 if answered "No." Attach extra pages as needed.

NUMBER	NAME OF INDIVIDUAL	MEDICAL SYMPTOMS & DIAGNOSIS	ONSET DATE (MO/YR)	DATE OF LAST TREATMENT	FULLY RECOVERED?	NAME AND ADDRESS OF HOSPITAL AND LAST ATTENDING PROVIDER
					<input type="checkbox"/> YES <input type="checkbox"/> NO	
					<input type="checkbox"/> YES <input type="checkbox"/> NO	
					<input type="checkbox"/> YES <input type="checkbox"/> NO	
					<input type="checkbox"/> YES <input type="checkbox"/> NO	

I hereby certify that the foregoing statements and answers made by me on behalf of myself and my dependents, if applying, are complete and true, to the best of my knowledge and belief, that they are correctly and fully recorded, and that no material circumstance or information has been withheld or omitted concerning myself and my dependents, if any, past and present state of health, and I agree that the answers and statements herein shall form a part of the contract. I understand that any misstatements or failure to report information may be used as the basis of rescission of insurance for myself, or my dependents, if any, or the reformation of the premiums charged to my employer. I also understand that insurance will not be in force until the effective date assigned by Standard Security Life Insurance Company of New York.

Furthermore, I hereby authorize any physician or practitioner, hospital or other organization, institution or person, that has any medical records or knowledge of me or my family, to give Standard Security Life Insurance Company of New York such information (photocopy of this authorization shall be valid as the original).

Dated _____ Signature of Employee _____ Signature of Spouse, if applying _____

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

[485 Madison Avenue, New York, NY 10022]

CEBT GROUP HEALTH PLANS WAIVER OF COVERAGE

Must be completed by all employees only if declining coverage for themselves or their dependents.

LAST NAME <input style="width: 90%;" type="text"/>	FIRST <input style="width: 90%;" type="text"/>	M.I. <input style="width: 80%;" type="text"/>
ADDRESS <input style="width: 90%;" type="text"/>	CITY/STATE/ZIP <input style="width: 90%;" type="text"/>	
SOCIAL SECURITY NUMBER <input style="width: 90%;" type="text"/>	EMPLOYER <input style="width: 90%;" type="text"/>	

1. MY DEPENDENTS OR I DECLINE COVERAGE BECAUSE THE FOLLOWING INDIVIDUALS: A. 1) HAVE COVERAGE UNDER MY SPOUSE'S GROUP HEALTH PLAN: 2) HAVE COVERAGE UNDER OTHER HEALTH OR HMO PLANS: 3) CHOOSE NOT TO HAVE HEALTH COVERAGE CURRENTLY: B. OTHER (explain): <input style="width: 400px; height: 20px;" type="text"/>	<table border="1" style="width: 100%; border-collapse: collapse;"><thead><tr><th style="width: 33%;">Myself</th><th style="width: 33%;">Spouse</th><th style="width: 33%;">Child(ren)</th></tr></thead><tbody><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr></tbody></table>	Myself	Spouse	Child(ren)	<input type="checkbox"/>											
Myself	Spouse	Child(ren)														
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														

2. IF OTHER COVERAGE IS AVAILABLE, PLEASE IDENTIFY THE INSURERS OR PLAN NAMES: MYSELF: <input style="width: 460px; height: 20px;" type="text"/> SPOUSE: <input style="width: 460px; height: 20px;" type="text"/> CHILDREN: <input style="width: 460px; height: 20px;" type="text"/>	PHONE NUMBERS: <input style="width: 90%; height: 20px;" type="text"/> <input style="width: 90%; height: 20px;" type="text"/> <input style="width: 90%; height: 20px;" type="text"/>
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NOTICE:
This is to acknowledge I have been given the opportunity to apply for the available coverages and have elected not to enroll myself or my dependents, if any. I understand that by applying for coverage at a later date I may be considered a late applicant and I will be subject to an 18 month preexisting condition limitation or exclusion period if I am considered a late applicant. I represent I have not been persuaded to waive coverage by my employer or the producing agent.

SPECIAL EXCEPTION NOTICE:
I understand that if I waive coverage for myself or my dependents because of being covered under other health insurance coverages, I may, in the future, be able to enroll myself or my dependents in this plan if the other health coverages terminate. The other health coverages must have terminated because of either: 1) the "loss of eligibility" for coverage, or 2) the termination of employer contributions towards the cost of other coverage. I understand I must apply for coverage within 30 days after my other coverage ends to be eligible for this special exception.

"Loss of eligibility" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. Loss of eligibility does not include an individual's failure to pay premiums on a timely basis or by termination of coverage for cause. Examples of a loss of coverage for cause includes the making of a fraudulent claim or an initial misrepresentation of fact in connection with a group health plan.

In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll my dependents, if any, or myself, provided that I apply within 30 days after the marriage, birth, adoption or placement for adoption.

_____ Signature of Employee (and parent if applicant is under age 18)	_____ Date
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STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

[485 Madison Avenue, New York, NY 10022]

CEBT GROUP HEALTH PLANS DEPENDENT WAIVER OF COVERAGE

Must be completed by all employees only if declining coverage for their dependents.

LAST NAME <input style="width: 95%;" type="text"/>	FIRST <input style="width: 95%;" type="text"/>	M.I. <input style="width: 95%;" type="text"/>
ADDRESS <input style="width: 95%;" type="text"/>	CITY/STATE/ZIP <input style="width: 95%;" type="text"/>	
SOCIAL SECURITY NUMBER <input style="width: 95%;" type="text"/>	EMPLOYER <input style="width: 95%;" type="text"/>	

1. I DECLINE COVERAGE FOR MY DEPENDENTS BECAUSE:

A. 1) HAS HEALTH COVERAGE UNDER OTHER HEALTH OR HMO PLANS:	Spouse	Child(ren)
2) CHOOSE NOT TO HAVE HEALTH COVERAGE CURRENTLY:	<input type="checkbox"/>	<input type="checkbox"/>
B. OTHER (explain): <input style="width: 400px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. IF OTHER COVERAGE IS AVAILABLE, PLEASE IDENTIFY THE INSURERS OR PLAN NAMES: PHONE NUMBERS:

SPOUSE: <input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
CHILDREN: <input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

NOTICE:
This is to acknowledge I have been given the opportunity to apply for the available coverages for my dependents and I have elected not to enroll my dependents. I understand that my dependents may be considered late applicant(s) by applying for coverage at a later date and will be subject to an 18 month preexisting condition limitation or exclusion period if I am considered a late applicant. I represent I have not been persuaded to waive coverage by my employer or the producing agent.

SPECIAL EXCEPTION NOTICE:
I understand that if I waive coverage for my dependents because of being covered under other health insurance coverages, I may, in the future, be able to enroll my dependents in this plan if the other health coverages terminate. The other health coverages must have terminated because of either: 1) the "loss of eligibility" for coverage, or 2) the termination of employer contributions towards the cost of other coverage. I understand I must apply for dependent coverage within 30 days after the other coverage ends for my dependents to be eligible for this special exception.

"Loss of eligibility" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. Loss of eligibility does not include an individual's failure to pay premiums on a timely basis or by termination of coverage for cause. Examples of a loss of coverage for cause includes the making of a fraudulent claim or an initial misrepresentation of fact in connection with a group health plan.

In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll my dependents, provided that I apply within 30 days after the marriage, birth, adoption or placement for adoption.

Signature of Employee (and parent if applicant is under age 18)Date

SERFF Tracking Number: ICCI-125688173 State: Arkansas
 Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 39236
 Company Tracking Number: SSL AE CEBT 1206
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: SSL AE CEBT 1206
 Project Name/Number: SSL AE CEBT 1206 /SSL AE CEBT 1206

Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	06/11/2008
Comments:		
Attachment: Cert of Comp with Rule 19 SSL AE CEBT 1206 6-9-08.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	06/11/2008
Comments: Application included in forms.		
Satisfied -Name: SSL Authorization Letter	Review Status: Approved-Closed	06/11/2008
Comments:		
Attachment: ICC Authorization letter SSL 2008.pdf		
Satisfied -Name: Filing fee schedule	Review Status: Approved-Closed	06/11/2008
Comments:		
Attachment: AR_Fee_Schedule CEBT AE 1206 6-9-08.pdf		
Satisfied -Name: Cover letter	Review Status: Approved-Closed	06/11/2008
Comments:		
Attachment: AR universal CEBT AE 1206 & wvr riders 6-9-08.pdf		

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Standard Security Life Insurance Company of New York

Form Number(s): SSL AE CEBT 1206, SSL CEBT EEAPP AR 0107, SSL CEBT WVR 0107,
SSL CEBT WVR D 0107

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



Signature of Company Officer

Rachel Lipari

Name

President

Title

June 9, 2008

Date



January 1, 2008

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
519 Colman Center Dr.
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Standard Security Life Insurance Company of New York regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Standard Security may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Kettig". The signature is fluid and cursive, with a long, sweeping tail.

David Kettig



ARKANSAS INSURANCE DEPARTMENT

1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Standard Security Life Insurance Company
Company NAIC Code: 69078
Company Contact Person & Telephone # Brenda Dawson, Insurance Compliance Consultants, Inc., (815) 316-6714
Form Number(s): SSL AE CEPT 1206, SSL CEPT EEAPP AR 0107, SSL CEPT WVR 0107, SSL CEPT WVR D 0107

* INSURANCE DEPARTMENT USE ONLY *
* ANALYST: AMOUNT: ROUTE SLIP: *

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing * x \$50 = **Retaliatory

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer. * x \$50 = **Retaliatory

Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form. *4 x \$20 = \$80 **Retaliatory

Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms. * x \$20 = **Retaliatory

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer. * x \$25 = **Retaliatory

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to
amend an Insurer's Certificate of Authority.

 * x \$400 =

Filing to amend Certificate of Authority.

 *** x \$100 =

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE
AND REGULATION 57.

**THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK.
CODE ANN. 23-63-102, RETALIATORY TAX.

***THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.



INSURANCE
COMPLIANCE
CONSULTANTS, INC.

519 Colman Center Drive
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 316-6720

June 9, 2008

Honorable Julie Benafield Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK - NAIC# 69078
FEIN# 13-5679267
Amendatory Endorsement – SSL AE CEBT 1206
Application – SSL CEBT EEAPP AR 0107
Waiver Form – SSL CEBT WVR 0107
Waiver Form – SSL CEBT WVR D 0107

Dear Commissioner Benafield Bowman:

We are hereby submitting the above referenced form for filing in your state. These forms are new and are not intended to replace any form previously approved in your state.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Standard Security Life Insurance Company of New York. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

Amendatory Endorsement form SSL AE CEBT 1206 is intended to be attached to Group Major Medical Expense Certificate form SSL CEBT MMP 0405, Amendatory Endorsement form SSL CEBT AEAR 0405, previously approved by your Department on August 12, 2005, and Amendatory Endorsement form SSL CEBT AEAR 0306 approved by your Department on April 27, 2006

This Endorsement replaces references to “Pre-Certify/Pre-Certification” with “Pre-Determine/Pre-Determination” where applicable, in the Certificate. Certain Benefits and definitions were also added. Bracketed data reflects variable information.

Waiver of Coverage form SSL CEBT WVR 0107 will be completed by the employees who are declining coverage for themselves and their dependents. Dependent Waiver of Coverage form SSL CEBT WVR D 0107 will be completed by the employees who are declining coverage for their dependents.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

Your prompt review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at (815)316-6714, fax me at (815)316-6720, or e-mail me at Brendadawson@inscompliance.com . Thank you.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.