

SERFF Tracking Number:	NWLC-125596721	State:	Arkansas
Filing Company:	Nationwide Life Insurance Company	State Tracking Number:	38634
Company Tracking Number:	NSHSL 2300 AR		
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	Stop Loss		
Project Name/Number:	Revised Application - Bulletin 6-2008/NSHSL2300 AR		

Filing at a Glance

Company: Nationwide Life Insurance Company

Product Name: Stop Loss

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: NWLC-125596721 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: NSHSL 2300 AR

Co Status:

Author: Susan Coulter

Date Submitted: 04/07/2008

State Tr Num: 38634

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 04/12/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Revised Application - Bulletin 6-2008

Project Number: NSHSL2300 AR

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/12/2008

State Status Changed: 04/12/2008

Corresponding Filing Tracking Number:

Filing Description:

This stop loss program was approved by your department on February 25, 2008 (NSHSL2000 et al). We are filing an amended application to comply with Bulletin 6-2008. Please substitute NSHSL 2300 for NSHSL 2300 AR.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: AR specific application

Market Type: Group

Group Market Size: Large

Group Market Type: Employer

Deemer Date:

Company and Contact

Filing Contact Information

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Bobby Handley, Assistant General Counsel handleb2@nationwide.com
5525 Parkcenter Circle (614) 854-3375 [Phone]
Dublin, OH 43017 (614) 854-3469[FAX]

Filing Company Information

Nationwide Life Insurance Company CoCode: 66869 State of Domicile: Ohio
5525 Parkcenter Circle Group Code: -99 Company Type:
Dublin, OH 43017 Group Name: State ID Number:
(800) 525-8669 ext. 43508[Phone] FEIN Number: 31-4156830

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Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	\$20.00	04/07/2008	19332754

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/12/2008	04/12/2008

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Disposition

Disposition Date: 04/12/2008

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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	authorization	Approved-Closed	Yes
Form	revised application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: NSHSL 2300 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	NSHSL 2300 AR	Application/ revised application Enrollment Form		Revised	Replaced Form #: Previous Filing #: NSHSL 2300		NSHSL 2300 ARStop Loss Application.pdf



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

APPLICATION FOR STOP LOSS INSURANCE COVERAGE

Application is hereby made to **Nationwide Life Insurance Company** ("Company") for [Aggregate] [and] [Specific] Stop Loss Insurance. This Application must be accepted and approved by the Company prior to any Contract being in effect.

1. Full Legal name of Policyholder _____

2. Key contact at Policyholder _____
3. Address _____
4. City, State, ZIP Code _____

5. Subsidiary or affiliated companies (companies under common control through stock ownership, contract or otherwise) that are to be included. List legal names and addresses of such companies.

6. Other locations. Include city, state and ZIP code.

7. Name of UR Provider and/or PPO Organization(s).

9. Nature of Policyholder's Business

 Corporation Partnership Proprietorship Other _____
10. Has the Policyholder ever voluntarily applied for relief in the Bankruptcy Court?
 Yes No If yes, explain

11. Enter the full name of the Policyholder's Employee Benefit Plan

12. Name and address of Policyholder's Third Party Administrator

13. Proposed Effective Date _____
14. Total eligible employees _____ Estimated initial enrollment _____
15. Are retirees covered? ___ YES ___ NO
16. Deposit premium \$ _____
17. Writing agent or broker of Policyholder _____
Social Security No. or Tax ID _____
Address _____
18. Where is the Contract and other correspondence to be mailed? _____

Persons to be covered under the Stop Loss Contract: Employees and dependents who meet the eligibility requirements as set forth under the Policyholder's underlying Plan, except an employee or dependent who is listed in the Special Limitations section of this application or who is required to be disclosed in the Stop Loss Disclosure Statement - unless named on the Stop Loss Disclosure Statement and approved by the Company.

GENERAL SCHEDULE OPTIONS

A. Aggregate Stop Loss Yes No

Benefit Period: Eligible Policyholder Losses from Plan expenses
Incurred from _____ through _____, and
Paid from _____ through _____.

[Losses Incurred prior to the Effective Date will be limited to the amount as set forth in the Schedule of Stop Loss.]

Coverages applying to Aggregate Stop Loss include (check all that apply):

- Medical [Prescription Drug Card Program]
 [Dental Care] [Mail Order Prescription Drug Card Program]
 [Vision Care] [Weekly (Disability) Income]
 [Other] _____

[Aggregate Percentage Reimbursable (excess of Attachment Point) _____ %]

[Maximum Aggregate Benefit, excess of Annual Aggregate Attachment Point, per Benefit Period
\$ _____]

[Maximum Employee Benefit Plan Losses per Covered Person per Benefit Period

\$ _____]

[Minimum Annual Aggregate Attachment Point \$ _____]

[Aggregate Terminal Liability Protection Yes No]

B. Specific Stop Loss Yes No

Benefit Period: Eligible Policyholder Losses from Plan expenses

Incurred from _____ through _____, and

Paid from _____ through _____.

[Losses Incurred Prior to the Effective Date will be limited to the amount reimbursable as set forth in the Schedule of Stop Loss.]

Eligible expenses for Specific Stop Loss include (check all that apply):

- Medical [Prescription Drug Card Program]
- [Dental Care] [Mail Order Prescription Drug Card Program]
- [Vision Care] [Weekly (Disability) Income]
- [Other] _____

Specific Deductible (per person)\$ _____

Specific Percentage Reimbursable (excess of deductible) _____ %

Lifetime Maximum Specific Benefit \$ _____

(per Covered Person in excess of Specific Deductible)

[SPECIAL CONDITIONS AND/OR LIMITATIONS: _____]

GENERAL CONDITIONS

It is understood and agreed as conditions precedent to the approval of this Application that:

- The Policyholder is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;
- The Third Party Administrator retained by the Policyholder will be considered the Policyholder's Agent and not the Company's Agent;
- All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within [thirty (30) days] of the Effective Date;
- The Company will evaluate the Policyholder's risk, and may require adjustments of rates, factors and or special limitations to accommodate for abnormal risks;
- Premiums are not considered paid until the premium check is received by the Company and at the rates set forth in the Schedule of Stop Loss.
- If the Policyholder has more than one business location, a representative of the Policyholder knowledgeable of the employees at each location has reviewed and completed the Disclosure Statement.

In making this Application, the Policyholder represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Policyholder to the proposed Contract. Accordingly, this Application, including the Disclosure Statement, will be a part of the Contract if accepted by the Company.

NOTICE:

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.

Employer/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.

Dated at _____ this ____ day of _____, [2008]

Policyholder _____

Authorized Officer/Partner _____
Type or Print

Title _____

Signature _____

Tax ID # _____

Witness: _____

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Supporting Document Schedules

Bypassed -Name:	Certification/Notice	Review Status:	Approved-Closed	04/12/2008
Bypass Reason:	recently approved form; filing to comply with new bulletin			
Comments:				
Bypassed -Name:	Application	Review Status:	Approved-Closed	04/12/2008
Bypass Reason:	see forms tab			
Comments:				
Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	04/12/2008
Bypass Reason:	rate not affected			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	04/12/2008
Bypass Reason:	not applicable			
Comments:				
Satisfied -Name:	authorization	Review Status:	Approved-Closed	04/12/2008
Comments:				
Attachment:	Letter of authorization - NWL.pdf			



Nationwide Life Insurance Company
PO Box 2399
Columbus OH 43216-2399
Mail Code C0-03-24

To Whom It May Concern:

This letter or a copy thereof, gives authority to Susan Coulter of Coulter and Associates, Inc. to prepare our filing submission, sign certification forms, as appropriate, and correspond with your department on form and rate issues.

We trust this information is satisfactory, however should you have any questions regarding this authorization, please contact our Associate Vice President, Thomas DeNoma.

Please direct all inquiries and correspondence relating to this filing to Ms. Susan Coulter at:

Coulter and Associates, Inc
379 Princeton-Hightstown Road
Suite 15
Cranbury, New Jersey 08512

Phone: (609) 443-7540 Fax: (609) 443-4103 email: susan@coulter-and-associates.com

This authorization shall be valid until revoked by us.

Company Name: Nationwide Life Insurance Company

Signature: _____

A handwritten signature in cursive script, appearing to read "Bobby J. DeNoma", written over a horizontal line.

Date: February 22, 2008