

SERFF Tracking Number: TRST-125640497 State: Arkansas
Filing Company: Trustmark Life Insurance Company State Tracking Number: 38995
Company Tracking Number: 8.00884
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: SL-0601 APP AR R05-08
Project Name/Number: STOP LOSS APPLICATION FILING /8.00884

Filing at a Glance

Company: Trustmark Life Insurance Company

Product Name: SL-0601 APP AR R05-08

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: TRST-125640497

SERFF Status: Closed

Co Tr Num: 8.00884

Co Status:

Author: Charlotte Johnson

Date Submitted: 05/14/2008

State: ArkansasLH

State Tr Num: 38995

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 05/23/2008

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: STOP LOSS APPLICATION FILING

Project Number: 8.00884

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/23/2008

State Status Changed: 05/23/2008

Corresponding Filing Tracking Number: 8.00884

Filing Description:

May 12, 2008

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Deemer Date:

Rosalind Minor

Life and Health Division

Insurance Department

1200 West Third Street

Little Rock, AR 72201-1904

SERFF Tracking Number: TRST-125640497 *State:* Arkansas
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Product Name: SL-0601 APP AR R05-08
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RE: TRUSTMARK LIFE INSURANCE COMPANY

FEIN# 36-3421358; NAIC# 276-62863

Stop Loss Application Filing

Forms#: SL-0601 APP AR R05/08

WCSL-0700 APP AR

Our File# 8.00884

Dear Ms. Minor:

Pursuant to the requirements of Bulletin 1008-6, enclosed please find a previously approved application for stop loss coverage. The form now includes the required notice. We respectfully request your approval.

Thank you for your time in this matter. If you have any questions, please contact me at 800-666-6977, ext. 34004 or at cjohnson@trustmarkins.com.

Sincerely,

Charlotte Johnson
Senior Compliance Analyst
Law Department

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 Project Name/Number: STOP LOSS APPLICATION FILING /8.00884

Company and Contact

Filing Contact Information

Charlotte Johnson, Senior Compliance Analyst cjohnson@trustmarkins.com
 400 Field Drive (800) 666-6977 [Phone]
 Lake Forest, IL 60045 (847) 615-3872[FAX]

Filing Company Information

| | | |
|----------------------------------|-------------------------|-----------------------------|
| Trustmark Life Insurance Company | CoCode: 62863 | State of Domicile: Illinois |
| 400 Field Drive | Group Code: 276 | Company Type: |
| Lake Forest, IL 60045 | Group Name: | State ID Number: |
| (800) 666-6977 ext. [Phone] | FEIN Number: 36-3421358 | |

Filing Fees

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

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|----------------------------------|--------|----------------|---------------|
| Trustmark Life Insurance Company | \$0.00 | 05/14/2008 | |

| CHECK NUMBER | CHECK AMOUNT | CHECK DATE |
|--------------|--------------|------------|
| 00163958 | \$20.00 | 05/13/2008 |

SERFF Tracking Number: TRST-125640497 State: Arkansas
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Product Name: SL-0601 APP AR R05-08
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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 05/23/2008 | 05/23/2008 |

SERFF Tracking Number: TRST-125640497 *State:* Arkansas
Filing Company: Trustmark Life Insurance Company *State Tracking Number:* 38995
Company Tracking Number: 8.00884
TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
Product Name: SL-0601 APP AR R05-08
Project Name/Number: STOP LOSS APPLICATION FILING /8.00884

Disposition

Disposition Date: 05/23/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: TRST-125640497 State: Arkansas
 Filing Company: Trustmark Life Insurance Company State Tracking Number: 38995
 Company Tracking Number: 8.00884
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: SL-0601 APP AR R05-08
 Project Name/Number: STOP LOSS APPLICATION FILING /8.00884

| 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 |
| Form | Application for stop loss | Approved-Closed | Yes |
| Form | Application | Approved-Closed | Yes |

SERFF Tracking Number: TRST-125640497 State: Arkansas
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 Company Tracking Number: 8.00884
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
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Form Schedule

Lead Form Number: SL-0601 APP AR R05-08

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------|-----------------------|------------------------------|---------------------------|---------|----------------------|-------------|---------------------------|
| Approved-Closed | SL-0601 APP AR R05-08 | Application/ Enrollment Form | Application for stop loss | Initial | | | SL-0601 APP AR R05-08.pdf |
| Approved-Closed | WCSL-0700 APP AR | Application/ Enrollment Form | Application | Initial | | | WCSL-0700 APP AR.pdf |

TRUSTMARK LIFE INSURANCE COMPANY
Application for Stop Loss Insurance Coverage

[Application is hereby made to Trustmark 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 [Employer/Policyholder/Applicant]] _____

2. [Key contact at [Employer/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. **[Persons to be covered under the Stop Loss Contract:** Employees and dependents who meet the eligibility requirements as set forth under the [Employer/Policyholder]’s underlying Plan, except an employee or dependent who satisfies a description indicated in Item Numbers 1, through 7 of the Stop Loss Disclosure Statement, completed on behalf, and signed by a duly authorized officer of the [Employer/Policyholder], unless named on the Stop Loss Disclosure Statement and approved by Trustmark.]

7. [Other locations. Include city, state and ZIP code.]

8. [Name of UR Provider and/or PPO Organization(s).]

9. [Nature of [Employer/Policyholder]’s Business]

 [Corporation] [Partnership] [Proprietorship] [Other] _____

10. [Has the [Employer/Policyholder] ever voluntarily applied for relief in the Bankruptcy Court?
 Yes No If yes, explain]

11. [Enter the full name of your Employee Benefit Plan]

12. [Name and address of [Employer/Policyholder]'s Third Party Administrator]

13. [Retirees covered?] Yes No

[Please note: [Employer/Policyholder]'s Third Party Administrator must complete and submit a - Trustmark Stop Loss Administrator Application. Trustmark shall rely on such application in underwriting [Employer/Policyholder]'s application for Stop Loss Insurance coverage. Should subsequent information about the [Employer/Policyholder]'s Third Party Administrator's controls and processes become known, which, if known prior to underwriting this application was material because it would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of Coverage by providing notice to you.]

1. [Proposed Effective Date] _____
2. [Total eligible employees] _____ [Estimated initial enrollment] _____
3. [Deposit premium]\$ _____
4. [Writing agent or broker of [Employer/Policyholder]] _____
[Social Security No. or Tax ID] _____
[Address] _____
5. [Where is the Contract and other correspondence to be mailed?] _____

[GENERAL SCHEDULE OPTIONS]

[A. Aggregate Stop Loss Yes No]

[Benefit Period: Eligible [Employer/Policyholder] Losses from Plan expense

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 (not included unless checked):]

- [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
\$ _____]

[Monthly Aggregate Accommodation Yes No]

[Aggregate Terminal Liability Protection Yes No]

[B. Specific Stop Loss Yes No]

[Benefit Period: Eligible [Employer/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:

[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 person in excess of Specific Deductible)]

[RISK ASSUMPTIONS]

[Active Employees and Dependents:]

[The Company will rely on the data included in this application to assist in underwriting the [Employer/Policyholder] for Insurance. [Note, that without Company review and consent in writing of each individual risk in the categories listed below, the participating [Employer/Policyholder]'s Losses will not be reimbursable under the Stop Loss Insurance Contract.]]

1. [Eligible persons provided with health care during the last [twelve] months where the expenses for health care exceeded or are expected to exceed \$ _____;]
2. [Eligible persons with health conditions which have the potential to exceed \$ _____ in the next [twelve] months;]
3. [Eligible persons currently hospital or institution confined, or expected to be confined within [90 days] of the effective date;]
4. [Eligible persons who have had an organ or bone marrow transplant, or who have been evaluated for, or accepted into a transplant program;]
5. [Eligible persons who opt out of coverage under the [Employer/Policyholder]'s underlying Plan for any reason.]

[Please list all individuals who fall into any of the categories listed above and attach a completed Disclosure Statement listing all of these individuals.]

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

(Question 5, continued)

[Please attach additional pages if needed.]

[Disabled and Continuing Employees and Dependents:]

[Are extended benefits available from the prior insurer for presently disabled eligible employees and/or their dependents? Yes No]

[Are any eligible employees or dependents presently disabled or confined in a hospital or similar facility? Yes No]

[Will any former employee or dependent be continuing coverage under the Plan in accordance with federal, state or local law on the effective date of this Contract? Yes No]

[If the answer is yes to any of the above three questions, please explain.]

[The [Employer/Policyholder]'s Losses from Plan benefits for any Employee who is not at his customary place of employment (or scheduled vacation) and any dependent, COBRA beneficiary, retiree and any Covered Person who is on Social Security disability continuance or any other leave of absence who is confined in a medical facility on the [Employer/Policyholder]'s Effective Date, will not be eligible for reimbursement under the Stop Loss Insurance Contract until:

- an employee returns to active, full-time work at his customary place of employment for at least one complete work day, performing all of the normal job duties required and expected of his position; or
- a dependent or continuation beneficiary is discharged from the medical facility of confinement.]

[If a Covered Person's health care coverage under the Plan is being continued in accordance with federal, state or local legislation on the [Employer/Policyholder]'s Stop Loss Insurance Contract effective date, his claims will not apply towards any Stop Loss Insurance deductibles or factors unless specifically agreed upon by the Company in writing.]

[The [Employer/Policyholder] hereby requests that the claims under the Plan for the following disabled persons and those individuals being continued in accordance with federal, state or local legislation be considered under the Stop Loss Contract. The [Employer/Policyholder] understands that the Company will evaluate the risk involved and may allow consideration of the following person's claims under the Stop Loss Insurance Contract by an adjustment in rates and or limitations placed upon such claims. The Company will provide the [Employer/Policyholder] specific written notification of its decision.]

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

[The individuals listed above must be included on the Disclosure Statement.]

[GENERAL CONDITIONS]

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

- [The [Employer/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 [Employer/Policyholder] will be considered the [Employer/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 [Employer/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 [Employer/Policyholder] has more than one business location, a representative of the [Employer/Policyholder] at each location has reviewed and completed the Risk Assumption section of this application and appropriate responses on the Disclosure Statement.]

[In making this application, the [Employer/Policyholder] represents that such information accurately reflects the true facts and that the undersigned has authority to bind the [Employer/Policyholder] to the proposed Contract. Accordingly, this request will be a part of the Contract if accepted by the Company.]

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.

Any person who knowingly presents a false or fraudulent claim for payment of loss or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Dated at _____ this ____ day of _____, [2005]]

[Employer/Policyholder] _____
Type or Print

[Authorized Office/Partner] _____

[Title] _____

[Tax ID #] _____

[Witness:] _____

[TRUSTMARK LIFE INSURANCE COMPANY]
Application for [Stop Loss Insurance] Coverage

[Application is hereby made to [Trustmark Life Insurance Company] (“Company”) for [Aggregate] [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 [Employer/Policyholder/Contractholder/Applicant]] _____

2. [Key contact at [Employer/Policyholder/Contractholder]] _____

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).]

8. [Nature of [Employer/Policyholder/Contractholder]'s Business]

[Corporation] [Partnership] [Proprietorship] [Other] _____

9. [Has the [Employer/Policyholder/Contractholder] ever voluntarily applied for relief in the Bankruptcy Court?

Yes No If yes, explain]

10. [Enter the full name of your Employee Benefit Plan]

11. [Name and address of [Employer/Policyholder/Contractholder]'s Third Party Administrator]

[Please note: [Employer/Policyholder/Contractholder]'s Third Party Administrator must complete and submit a [Trustmark] [Stop Loss] Administrator Application. [Trustmark] shall rely on such application in underwriting [Employer/Policyholder/Contractholder]'s application for [Stop Loss] Insurance coverage. Should subsequent information about the [Employer/Policyholder/Contractholder]'s Third Party Administrator's controls and processes become known, which, if known prior to underwriting this application was material because it would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of Coverage by providing notice to you.]

1. [Proposed Effective Date] _____
2. [Total eligible employees] _____ [Estimated initial enrollment] _____
3. [Deposit premium]\$ _____
4. [Writing agent or broker of [Employer/Policyholder/Contractholder]] _____
 [Social Security No. or Tax ID] _____
 [Address] _____
5. [Where is the [Contract] and other correspondence to be mailed?] _____

[GENERAL SCHEDULE OPTIONS]

[A. [Aggregate] [Stop Loss] Yes No]

[Benefit Period: Eligible [Employer/Policyholder/Contractholder] Losses from Plan expense
 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 (not included unless checked):]

- [Medical] [Prescription Drug Card Program]
 [Mail Order Prescription Drug Card Program]
 [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 \$ _____]

[RISK ASSUMPTIONS]

[Active Employees and Dependents:]

[The Company will rely on the data included in this application to assist in underwriting the [Employer/Policyholder/Contractholder] for Insurance. Note, that without Company review and consent in writing of each individual risk in the categories listed below, the participating [Employer/Policyholder/Contractholder]'s Losses will not be reimbursable under the [Stop Loss Insurance] [Contract].]

1. [Eligible persons provided with health care during the last [twelve] months where the expenses for health care exceeded or are expected to exceed [\$ _____];]
2. [Eligible persons with health conditions which have the potential to exceed [\$ _____] in the next [twelve] months;]
3. [Eligible persons currently hospital or institution confined, or expected to be confined within [90 days] of the effective date;]
4. [Eligible persons who have had an organ or bone marrow transplant, or who have been evaluated for, or accepted into a transplant program;]

[Please list all individuals who fall into any of the categories listed above and attach a completed Disclosure Statement listing all of these individuals.]

| | |
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| _____ | _____ |
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| _____ | _____ |
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[Please attach additional pages if needed.]

[Disabled and Continuing Employees and Dependents:]

[Are extended benefits available from the prior insurer for presently disabled eligible employees and/or their dependents? Yes No]

[Are any eligible employees or dependents presently disabled or confined in a hospital or similar facility? Yes No]

[Will any former employee or dependent be continuing coverage under the Plan in accordance with federal, state or local law on the effective date of this [Contract]? Yes No]

[If the answer is yes to any of the above three questions, please explain.]

[The [Employer/Policyholder/Contractholder]'s Losses from Plan benefits for any Employee who is not at his customary place of employment (or scheduled vacation) and any dependent, COBRA beneficiary, retiree and any Covered Person who is on Social Security disability continuance or any other leave of absence who is confined in a medical facility on the [Employer/Policyholder/Contractholder]'s Effective Date, will not be eligible for reimbursement under the [Stop Loss Insurance] [Contract] until:

- an employee returns to active, full-time work at his customary place of employment for at least one complete work day, performing all of the normal job duties required and expected of his position; or
- a dependent or continuation beneficiary is discharged from the medical facility of confinement.]

[If a Covered Person's health care coverage under the Plan is being continued in accordance with federal, state or local legislation on the [Employer/Policyholder/Contractholder]'s [Stop Loss Insurance] [Contract] effective date, his claims will not apply towards any [Stop Loss Insurance] deductibles or factors unless specifically agreed upon by the Company in writing.]

[The [Employer/Policyholder/Contractholder] hereby requests that the claims under the Plan for the following disabled persons and those individuals being continued in accordance with federal, state or local legislation be considered under the [Stop Loss Contract]. The [Employer/Policyholder/Contractholder] understands that the Company will evaluate the risk involved and may allow consideration of the following person's claims under the [Stop Loss Insurance] [Contract] by an adjustment in rates and or limitations placed upon such claims. The Company will provide the [Employer/Policyholder/Contractholder] specific written notification of its decision.]

| | |
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| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

[The individuals listed above must be included on the Disclosure Statement.]

[GENERAL CONDITIONS]

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

- [The [Employer/Policyholder/Contractholder] 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 [Employer/Policyholder/Contractholder] will be considered the [Employer/Policyholder/Contractholder]'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 [Employer/Policyholder/Contractholder]'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 [Employer/Policyholder/Contractholder] has more than one business location, a representative of the [Employer/Policyholder/Contractholder] at each location has reviewed and completed the Risk Assumption section of this application and appropriate responses on the Disclosure Statement.]

[In making this application, the [Employer/Policyholder/Contractholder] represents that such information accurately reflects the true facts and that the undersigned has authority to bind the [Employer/Policyholder/Contractholder] to the proposed [Contract]. Accordingly, this request will be a part of the [Contract] if accepted by the Company.]

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

Any person who knowingly presents a false or fraudulent claim for payment of loss or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Dated at _____ this ____ day of _____, [2003]]

[Employer/Policyholder/Contractholder] _____
Type or Print

[Authorized Officer/Partner] _____

[Title] _____

[Tax ID #] _____

[Witness:] _____

SERFF Tracking Number: TRST-125640497 *State:* Arkansas
Filing Company: Trustmark Life Insurance Company *State Tracking Number:* 38995
Company Tracking Number: 8.00884
TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
Product Name: SL-0601 APP AR R05-08
Project Name/Number: STOP LOSS APPLICATION FILING /8.00884

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: TRST-125640497 State: Arkansas
 Filing Company: Trustmark Life Insurance Company State Tracking Number: 38995
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 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: SL-0601 APP AR R05-08
 Project Name/Number: STOP LOSS APPLICATION FILING /8.00884

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 05/23/2008
Comments:
Attachment:
 Readability.pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 05/23/2008
Bypass Reason: N/A - only filing application
Comments:

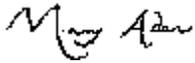
Bypassed -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 05/23/2008
Bypass Reason: N/A - filing application pursuant to Bulletin 2008-6, to add required notice.
Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 05/23/2008
Bypass Reason: N/A - filing application pursuant to Bulletin 2008-6, to add required notice.
Comments:

Trustmark
LIFE INSURANCE COMPANY

This is to certify the forms shown below comply with the requirements of Arkansas Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and have achieved a Flesch reading ease score as follows:

| <u>Form</u> | <u>Flesch Score</u> |
|-----------------------|---------------------|
| SL-0601 APP AR R05-08 | 45.9 |



Mary Ader
Second Vice President, Compliance

ARKANSAS