

SERFF Tracking Number: AEGX-125976332 State: Arkansas  
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41240  
Company Tracking Number: HA AR0045415F01  
TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/HA AR0045415F01

## Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Accidental Death SERFF Tr Num: AEGX-125976332 State: Arkansas  
TOI: H03G Group Health - Accidental Death & SERFF Status: Closed- State Tr Num: 41240  
Dismemberment Disapproved  
Sub-TOI: H03G.000 Health - Accidental Death Co Tr Num: HA AR0045415F01 State Status: Disapproved-Closed  
& Dismemberment  
Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI ADMSLH Disposition Date: 01/14/2009  
Date Submitted: 01/06/2009 Disposition Status: Disapproved

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Accidental Death  
Project Number: HA AR0045415F01  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 01/14/2009

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Group  
Group Market Size: Large  
Group Market Type: Discretionary  
Explanation for Other Group Market Type:  
State Status Changed: 01/14/2009  
Created By: SPI ADMSLH  
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI ADMSLH

Filing Description:

RE: Stonebridge Life Insurance Company

NAIC # 0468-65021

FEIN: 03-0164230

"Out of State" Group

SLAD3100GP: Group Accidental Death Insurance Master Policy

SLAD3100GC: Group Accidental Death Insurance Certificate

SLAD3200GP: Group Accidental Death Insurance Master Policy

SLAD3200GC: Group Accidental Death Insurance Certificate

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Project Name/Number: Accidental Death/HA AR0045415F01

SLAD3000GE: Group Accidental Death Insurance Enrollment Form  
Actuarial Memorandum

Dear Commissioner:

Attached for your review and approval are copies of the above captioned forms. These forms are new and do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion. Variable information is bracketed and printed in red.

Group Certificate SLAD3100GC provides accidental death benefits if an Insured suffers loss of life as a result of bodily injury caused by an accident that occurs during the Coverage Period. The loss must occur within 90 days after the date of the accident which caused the injury. The single premium for the Coverage Period will be paid by the Insured.

SLAD3100GP is the master policy under which the certificates will be issued.

Group Certificate SLAD3200GC provides accidental death benefits if an Insured suffers loss of life as a result bodily injury caused by an accident that occurs during the Coverage Period. The loss must occur within 90 days after the date of the accident which caused the injury. The single premium for the Coverage Period will be paid by the Policyholder.

SLAD3200GP is the master policy under which the certificates will be issued.

Group Accidental Death Insurance Enrollment Form SLAD3000GE will be used to solicit this and other similar products.

These forms were approved by Missouri, our situs state, on December 22, 2008.

We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print.

The readability scores are as follows:

SLAD3100GP 43.4  
SLAD3100GC 50.9  
SLAD3200GP 43.1  
SLAD3200GC 49.7

Microsoft Word was used to obtain these scores.

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Project Name/Number: Accidental Death/HA AR0045415F01

This product will be mass marketed by direct response, telemarketing methods, point of sale transactions at various cash centers and possibly on the Internet through our website.

We request approval for general use of various discretionary groups that are situated in Missouri.

The referenced form may be used in other media formats including translations into (Spanish, Chinese, Korean, Vietnamese, Polish, etc) and in such case, we certify the content will not change.

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

We certify that we comply with the requirements of Rule 49.

Completed filing forms are attached. Our filing fee is being sent via EFT.

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

Sincerely,

STONEBRIDGE LIFE INSURANCE COMPANY  
Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA

Attachments

## Company and Contact

### Filing Contact Information

Margaret Frei, Filing Specialist  
2700 W Plano Parkway  
Plano, TX 75075

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

### Filing Company Information

Stonebridge Life Insurance Company  
29 South Main Street  
Rutland, VT 05701-5014

CoCode: 65021  
Group Code: 468  
Group Name:

State of Domicile: Vermont  
Company Type: Life and Health  
State ID Number:

SERFF Tracking Number: AEGX-125976332 State: Arkansas  
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Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/HA AR0045415F01  
(410) 685-5500 ext. [Phone] FEIN Number: 03-0164230  
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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$50.00	01/06/2009	24850187

SERFF Tracking Number: AEGX-125976332 State: Arkansas  
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 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/HA AR0045415F01

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	01/14/2009	01/14/2009
Deemed- Approved	Rosalind Minor	01/14/2009	01/14/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	01/13/2009	01/13/2009	SPI ADMSLH	01/13/2009	01/13/2009

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Group Accidental Death Insurance Enrollment Form	SPI ADMSLH	01/06/2009	01/06/2009

*SERFF Tracking Number:* AEGX-125976332      *State:* Arkansas  
*Filing Company:* Stonebridge Life Insurance Company      *State Tracking Number:* 41240  
*Company Tracking Number:* HA AR0045415F01  
*TOI:* H03G Group Health - Accidental Death &      *Sub-TOI:* H03G.000 Health - Accidental Death &  
Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
*Project Name/Number:* Accidental Death/HA AR0045415F01

## **Disposition**

Disposition Date: 01/14/2009

Implementation Date:

Status: Disapproved

Comment: Please ignore the first disposition which reflected a Deemed Approved status. I hit the wrong key.

In the discretion of the Insurance Commissioner, ACA 23-86-106(5), we are disapproving this submission because it is not a true group under ACA 23-86-106.

Rate data does NOT apply to filing.

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 Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/HA AR0045415F01

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Disapproved	Yes
Supporting Document	Certification/Notice	Disapproved	Yes
Supporting Document	SLAD3100GP Actuarial Memorandum	Disapproved	Yes
Supporting Document	SLAD3200GP Actuarial Memorandum	Disapproved	Yes
Supporting Document	NAIC Transmittal	Disapproved	Yes
Supporting Document	Explanation of Variables	Disapproved	Yes
Form	Group Accidental Death Insurance Certificate	Disapproved	Yes
Form	Group Accidental Death Insurance Master Policy	Disapproved	Yes
Form	Group Accidental Death Insurance Certificate	Disapproved	Yes
Form	Group Accidental Death Insurance Master Policy	Disapproved	Yes
Form (revised)	Group Accidental Death Insurance Enrollment Form	Disapproved	Yes
Form	Group Accidental Death Insurance Enrollment Form	Disapproved	Yes

*SERFF Tracking Number:* AEGX-125976332      *State:* Arkansas  
*Filing Company:* Stonebridge Life Insurance Company      *State Tracking Number:* 41240  
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Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
*Project Name/Number:* Accidental Death/HA AR0045415F01

## **Disposition**

Disposition Date: 01/14/2009

Implementation Date:

Status: Deemed-Approved

Comment: At the discretion of the Insurance Commissioner, ACA 23-86-108(5), we are disapproving this submission since it is not a true group as outlined under ACA 23-86-108.

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-125976332 State: Arkansas  
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 Product Name: Accidental Death  
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Supporting Document	SLAD3100GP Actuarial Memorandum	Disapproved	Yes
Supporting Document	SLAD3200GP Actuarial Memorandum	Disapproved	Yes
Supporting Document	NAIC Transmittal	Disapproved	Yes
Supporting Document	Explanation of Variables	Disapproved	Yes
Form	Group Accidental Death Insurance Certificate	Disapproved	Yes
Form	Group Accidental Death Insurance Master Policy	Disapproved	Yes
Form	Group Accidental Death Insurance Certificate	Disapproved	Yes
Form	Group Accidental Death Insurance Master Policy	Disapproved	Yes
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Form	Group Accidental Death Insurance Enrollment Form	Disapproved	Yes

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Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
*Project Name/Number:* Accidental Death/HA AR0045415F01

## **Objection Letter**

Objection Letter Status      Pending Industry Response  
Objection Letter Date      01/13/2009  
Submitted Date      01/13/2009

Respond By Date

Dear Margaret Frei,

This will acknowledge receipt of the captioned filing.

Objection 1

- NAIC Transmittal (Supporting Document)

Comment:

The marketing method described in the transmittal seems to indicate that consumers could be contacted directly which would indicate that this product could be an individual product and not a group product.

If the product is issued with the policyholder being a trust, please attach a copy of the trust agreement for our review.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Project Name/Number: Accidental Death/HA AR0045415F01

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/13/2009  
Submitted Date 01/13/2009

Dear Rosalind Minor,

### Comments:

January 13, 2009

Ms. Rosalinda Minor  
Arkansas Insurance Department  
Life & Health Division  
1200 W 3rd St  
Little Rock AR 72201-1904

RE: Stonebridge Life Insurance Company  
NAIC # 0468-65021  
FEIN: 03-0164230  
"Out of State" Group  
SLAD3100GP: Group Accidental Death Master Policy  
SLAD3100GC: Group Accidental Death Certificate  
SLAD3200GP: Group Accidental Death Master Policy  
SLAD3200GC: Group Accidental Death Certificate  
SLAD3000GE AR: Group Accidental Death Insurance Enrollment Form  
Actuarial Memorandum

Dear Ms. Minor:

In reply to your Objection Letter dated January 13, 2009, we would like to provide the following information.

### Response 1

Comments: Group Master Policies SLAD3100GP and SLAD3200GP will be issued to ACE CASH EXPRESS, INC. for solicitation of their customers.

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Project Name/Number: Accidental Death/HA AR0045415F01

For solicitations of ACE CASH EXPRESS, INC. the group is defined as the following:

Each natural person AGE 18 THROUGH 75 WHO IS A CUSTOMER (or who is the spouse of a CUSTOMER age 18 THROUGH 75) OF ACE CASH EXPRESS, INC., is eligible to become insured if that person resides in a state in which the insurance coverage may legally be offered.

We respectfully request your approval of this group under Section 23-86-106(5).

The group is not a trust. It is issued directly to Ace Cash Express, Inc.

#### **Related Objection 1**

Applies To:

- NAIC Transmittal (Supporting Document)

Comment:

The marketing method described in the transmittal seems to indicate that consumers could be contacted directly which would indicate that this product could be an individual product and not a group product.

If the product is issued with the policyholder being a trust, please attach a copy of the trust agreement for our review.

#### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We believe the objection raised in the Objection Letter dated January 13, 2009 has been addressed with the above information. Thank you for your continued consideration of our filing. Should you have any questions, please call me toll free at (877) 527-6444, Extension 6289 or contact me by e mail at mfrei@aegonusa.com.

Sincerely,

STONEBRIDGE LIFE INSURANCE COMPANY



SERFF Tracking Number: AEGX-125976332 State: Arkansas  
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 Dismemberment Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/HA AR0045415F01

**Amendment Letter**

Submitted Date: 01/06/2009

**Comments:**

This submission was originally created with an incorrect Enrollment Form SLAD3000GE. The correct Enrollment Form for this product is SLAD3000GE AR. The corrected enrollment form includes the fraud warning language required by the state of Arkansas. The correct enrollment form is attached to the forms schedule.

I apologize for this error and any inconvenience it may have caused.

Margaret

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
SLAD3000GE AR	Application/Enrollment Form	EGroup Accidental Death Insurance Enrollment Form	Initial				0.000	SLAD3000GE AR.PDF

SERFF Tracking Number: AEGX-125976332 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41240  
 Company Tracking Number: HA AR0045415F01  
 TOI: H03G Group Health - Accidental Death & Dismemberment Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/HA AR0045415F01

## Form Schedule

### Lead Form Number: SLAD3100GC

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Disapproved 01/14/2009	SLAD3100GC	Certificate	Group Accidental Death Insurance Certificate	Initial		50.900	SLAD3100GC.PDF
Disapproved 01/14/2009	SLAD3100GP	Policy/Contract Certificate	Group Accidental Death Insurance Master Policy	Initial		43.400	SLAD3100GP.PDF
Disapproved 01/14/2009	SLAD3200GC	Certificate	Group Accidental Death Insurance Certificate	Initial		43.100	SLAD3200GC.PDF
Disapproved 01/14/2009	SLAD3200GP	Policy/Contract Certificate	Group Accidental Death Insurance Master Policy	Initial		43.100	SLAD3200GP.PDF
Disapproved 01/14/2009	SLAD3000GE AR	Application/Enrollment Form	Group Accidental Death Insurance Enrollment Form	Initial		0.000	SLAD3000GE AR.PDF

# STONEBRIDGE LIFE INSURANCE COMPANY

A Stock Company

Home Office: Rutland, Vermont

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

## GROUP ACCIDENTAL DEATH INSURANCE SINGLE PREMIUM, NONRENEWABLE

### CERTIFICATE OF INSURANCE

Person(s) insured and benefits are shown in the Schedule of Insurance.

Stonebridge Life Insurance Company (herein called "we," "us" or "our") has issued Policy No. [XXXXXXXX] to [ACE CASH EXPRESS, INC.] (herein called Policyholder) which makes available accidental death insurance for eligible persons.

We agree to pay the benefits herein provided with respect to the person(s) insured hereunder, subject to all terms of the Policy.

#### RIGHT TO EXAMINE CERTIFICATE

If you are not satisfied with this insurance, you may void it by returning this Certificate within 10 days after you receive it to our Administrative Office or to our authorized agent. You will receive a full refund of any premium you have paid. The Certificate is treated as if it never existed. No benefit will be paid.

The records maintained by the [Policyholder/Participating Group] shall determine the insurance provided under the Policy for any Insured. Important provisions of the Policy are outlined herein.



Secretary



President

#### DEFINITIONS

**INSURED** (herein called "you," "your," or "yours") means you, the insured named in the Schedule of Insurance, provided coverage has become effective.

**COVERAGE PERIOD** means the [35 day] period immediately following a Covered Event.

**COVERED EVENT** means the execution of a transaction including [check cashing] [,short term consumer loan][, or other money service business] transaction[s]. A covered event cannot be a transaction in violation of federal or state law.

**INJURY** means bodily harm caused by an accident which occurs while this Certificate is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

**INJURED** means having suffered an Injury.

**LOSS** means loss of life.

**POLICY** means the contract issued to the Policyholder.

[**PARTICIPATING GROUP** means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by us. The name of such group is shown in the Certificate Schedule of Insurance.]

## WHEN YOUR INSURANCE BEGINS

Issuance of a Certificate is not a waiver of any of the following conditions:

You will become insured on the Certificate Effective Date subject to your enrollment and payment of the single premium. The premium and the Effective Date of Coverage are shown on the Certificate Schedule of Insurance. Your insurance for a Covered Event begins immediately upon the execution of that Covered Event and will continue during the Coverage Period for that Covered Event.

## WHEN YOUR INSURANCE ENDS

Your insurance ends on the earlier of:

1. the end of the Coverage Period for the Covered Event; or
2. the date the Policy is terminated or cancelled; or
3. the date of your death.

In the event the insurance terminates, it does not affect payment of a claim for a Loss which began while the coverage was in force.

## COVERAGE

### ACCIDENTAL DEATH BENEFIT

If you suffer a Loss as a direct result of an Injury from an accident not otherwise excluded in the Policy, we will pay the Accidental Death Benefit shown in the Certificate Schedule of Insurance when we receive proof that:

1. the Injury caused by an accident occurred during the Coverage Period (the [35 day] period immediately following the Covered Event) and
2. Loss occurred within [90] days following the date of the accident that caused the Injury.

## EXCLUSIONS

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war;
3. your taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. your blood alcohol level being .08 percent weight by volume or higher;
5. your operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. your committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative;
10. an accident which occurs outside the United States[,] or Canada or [Mexico]; or
11. riding or driving as a professional in any kind of race for prize money or profit; or
12. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

## BENEFICIARY

At your death, unless otherwise specified, any benefit due for Loss will be paid as follows:

1. to your living lawful spouse; or if you do not have one,
2. in equal shares to your living lawful children; or if there are none,
3. in equal shares to your living lawful parents; or if there are none,
4. in equal shares to your living lawful brothers and sisters; or if there are none,
5. to your estate.

Spouse means only the one to whom you are lawfully married on the date of your death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

## INCONTESTABILITY

We cannot contest this Certificate except for fraud or for not paying the premium.

## **PAYMENT OF PREMIUM**

We will provide coverage as described in this Certificate in return for payment of premium. A single premium for a Covered Event is payable by you. Your premium is due on or before the Certificate Effective Date.

The premium rates may be changed at any time the terms of the Policy are changed.

## **NOTICE OF CLAIM**

Written notice of claim must be given to us within 20 days after your Loss or as soon as possible thereafter. If it is not reasonably possible to furnish the notice within the 20 days, a claim will not be reduced or denied because of failure to do so. Notice can be given to our Administrative Office. Notice should include your name and Certificate Number.

## **CLAIM FORMS**

When we receive a notice of claim we will send the claimant forms for filing Proof of Loss. If we do not do so within 15 days, the claimant is deemed to have complied with the requirements for providing Proof of Loss if written Proof of Loss covering the occurrence, character, and extent of the Loss is provided to us within the time fixed for Proof of Loss.

## **PROOF OF LOSS**

Written proof of loss must be given to us within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

## **MISSTATEMENT OF AGE**

If your age has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

## **TIME OF PAYMENT OF CLAIMS**

We will pay all benefits as soon as we receive proper written Proof of Loss sufficient to determine liability.

## **PAYMENT OF CLAIMS**

Benefits are payable in accordance with the beneficiary designation in effect at the time of payment.

## **AUTOPSY**

At our expense, we may have an autopsy done where it is not forbidden by law.

## **LEGAL ACTIONS**

No action can be brought to recover on the Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required. (10 years in Missouri)

## **OTHER INSURANCE**

If you are insured under more than one Accidental Death Policy or Certificate in effect with us or any AEGON affiliate at any one time, our maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or **[\$1,000,000]**. Upon discovery of duplication in excess of our maximum liability, we will refund all premiums paid for all such Policies or Certificates. The excess will be voided and all premiums paid for such excess shall be returned to your or to your beneficiary.

# STONEBRIDGE LIFE INSURANCE COMPANY

## SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No.       [XXXXXXX]       to       [ACE CASH EXPRESS, INC.]      

**[PARTICIPATING GROUP NUMBER: XXXXXX]**

**PARTICIPATING GROUP: XXXXXXXXXX]**

**[CERTIFICATE NUMBER: 82A1000000]**

**[EFFECTIVE DATE: 6-01-2009]**

**[INSURED: JOHN DOE  
221 ANYSTREET  
APARTMENT 1231  
ANYTOWN, USA 12345]**

**[SINGLE PREMIUM: \$XX.XX]**

**[ACCIDENTAL DEATH BENEFIT: \$12,000]**

**[THE ACCIDENTAL DEATH BENEFIT WILL BE PAID [AS A LUMP SUM BENEFIT][AS A MONTHLY BENEFIT IN EQUAL INSTALLMENTS FOR A PERIOD OF [12] CONSECUTIVE MONTHS FROM THE DATE OF LOSS.]**

**[COVERAGE ENDS [XX DAYS] FOLLOWING THE COVERED EVENT].**

# Stonebridge Life Insurance Company

A STOCK COMPANY

Home Office: Rutland, Vermont  
Administrative Office: [2700 West Plano Parkway  
Plano, Texas 75075]

Stonebridge Life Insurance Company  
(Herein called the Company)

Having issued this Policy to

[ACE CASH EXPRESS, INC.]  
(Herein called Policyholder)

Agrees to pay the benefits herein provided with respect to  
persons Insured hereunder, subject to all terms of this Policy.

This Policy is issued in consideration of the payment of premium and statements made in the application herein provided, and shall take effect on [JANUARY 1, 2009] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR]. This is a legal contract between Stonebridge Life Insurance Company and the Policyholder.

This Policy is issued in the State of Missouri, and its terms shall be construed in accordance with the laws of the State of Missouri.

## RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return the Certificate of Insurance within 10 days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded.

The provisions and conditions of this Policy shall form a part of the contract as fully as if recorded in detail above the signatures hereunder affixed.



Secretary



President

Policy No.: [xxxxxxxxx]

GROUP ACCIDENTAL DEATH INSURANCE POLICY  
SINGLE PREMIUM, NONRENEWABLE

## DEFINITIONS

**INSURED** means the person named on the Certificate Schedule of Insurance. as an Insured, and whose coverage has become effective.

**COVERAGE PERIOD** means the [35 day] period immediately following a Covered Event.

**COVERED EVENT** means the execution of a transaction including [check cashing,] [short term consumer loan,][or other money service business] transaction[s]. A covered event cannot be a transaction in violation of federal or state law.

**INJURY** means bodily harm caused by an accident which occurs while the Insured's Certificate is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

**INJURED** means having suffered an Injury.

**LOSS** means loss of life;

**POLICY** means the contract issued to the Policyholder.

[PARTICIPATING GROUP means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by the Company. The name of such group is shown in the Certificate Schedule of Insurance.]

## ELIGIBILITY

Each natural person [AGE 18 THROUGH 75 WHO IS A [CUSTOMER][LOYALTY PROGRAM MEMBER] (or who is the spouse of a [CUSTOMER][LOYALTY PROGRAM MEMBER] age 18 THROUGH 75) OF [ACE CASH EXPRESS, INC.], is eligible to become insured if that person resides in a state in which the insurance coverage may legally be offered.

Each Certificate may cover only one Insured.

In no event will a corporation, partnership, or business entity, other than a natural person, is eligible to be covered.

## WHEN A PERSON BECOMES INSURED

Each Insured will be issued a Certificate of Insurance which will indicate the coverage and the effective date of coverage.

Each eligible person shall become insured on the Certificate Effective Date shown in the Certificate Schedule of Insurance subject to the person's enrollment and payment of the single premium. Insurance for a Covered Event begins immediately upon the execution of that Covered Event and will continue during the Coverage Period for that Covered Event.

## WHEN A PERSON'S INSURANCE ENDS

Insurance ends on the earlier of:

1. the end of a Coverage Period for the Covered Event; or
2. the date this Policy is terminated or cancelled; or
3. the date of the Insured's death.

In the event the insurance terminates, it does not affect payment for a Loss which began while the coverage was in force.

## AMOUNTS OF INSURANCE - SCHEDULE OF INSURANCE

When an eligible person enrolls as an Insured under this Policy, he or she will receive coverage as described in the Coverage section of this Policy. The amounts of insurance for each Insured shall be the amount shown in the Certificate Schedule of Insurance issued for each individual Insured.

## COVERAGE

### ACCIDENTAL DEATH BENEFIT

If the Insured suffers a Loss as a direct result of an Injury from an accident not otherwise excluded in this Policy, the Company will pay the Accidental Death Benefit shown in the Certificate Schedule of Insurance when the company receives proof that:

1. the Injury caused by an accident occurred during the Coverage Period (the [35 day] period immediately following the Covered Event) and
2. Loss occurred with [90] days following the date of the accident that caused the Injury.

## EXCLUSIONS

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war;
3. the Insured's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Insured's blood alcohol level being .08 percent weight by volume or higher;
5. the Insured's operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Insured committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. an accident which occurs outside the United States, [or] Canada [or Mexico]; or
11. riding or driving as a professional in any kind of race for prize money or profit; or
12. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

## PREMIUM

The single Premium for the Insured's Coverage Period is on the attached rate sheet.

## **BENEFICIARY**

At the Insured's death, unless otherwise specified, any benefit due for Loss will be paid as follows:

1. to the Insured's living lawful spouse; or if there is not one,
2. in equal shares to the Insured's living lawful children; or if there are none,
3. in equal shares to the Insured's living lawful parents; or if there are none,
4. in equal shares to the Insured's living lawful brothers and sisters; or if there are none,
5. to the Insured's estate.

Spouse means only the one to whom the Insured is lawfully married on the date of the Insured's death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

## **GENERAL PROVISIONS**

### **ENTIRE CONTRACT**

This Policy is issued in consideration of the application and payment of the premium. The Policy, and any attached papers form the entire contract of insurance.

Any change in this Policy must be in the form of an amendment or endorsement signed by one of the officers of the Company. Agreements made by the Policyholder and the Company in this manner will be binding on all persons insured. Certificate anniversaries are measured from the Certificate Effective Date.

### **INCONTESTABILITY**

The Company cannot contest the Certificate except for fraud or for not paying premiums.

### **INFORMATION TO BE FURNISHED**

The Policyholder shall furnish the Company with any information required to administer this Policy. The Company shall have the right to inspect any record of the Policyholder or in possession of the Policyholder which relates to this Policy.

### **CLERICAL ERROR**

A clerical error in the records relative to this insurance shall not invalidate insurance or cause insurance to be in force or to continue in force. Upon discovery of such error, an equitable adjustment shall be made in the premium.

### **INSURED'S CERTIFICATE**

The Company will issue an individual Certificate to each Insured. The Certificate will describe the insurance coverage and state to which the benefits will be paid.

### **PAYMENT OF PREMIUM**

The Company will provide coverage as described in this Policy in return for payment of premium. The single premium for a Covered Event is payable by the Insured. The Insured's single premium is due on or before the Certificate Effective Date under this Policy.

The premium rates may be changed at any time the terms of the Policy are changed.

### **NOTICE OF CLAIM**

Written notice of claim must be given to us within 20 days after the date of the Loss or as soon as possible thereafter. If it is not reasonably possible to furnish the notice within the 20 days, a claim will not be reduced or denied because of failure to do so. Notice can be given to our Administrative Office. Notice should include your name and Certificate Number.

## **CLAIM FORMS**

When the Company receives a notice of claim the Company will send the claimant forms for filing Proof of Loss. If the Company does not do so within 15 days, the claimant is deemed to have complied with the requirements for providing Proof of Loss if written Proof of Loss covering the occurrence, character, and extent of the Loss is provided to the Company within the time fixed for Proof of Loss.

## **PROOF OF LOSS**

Written proof of loss must be given to the Company within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

## **MISSTATEMENT OF AGE**

If the age of an Insured has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, the Company accepts a premium for any period when coverage would not normally have been in effect, then the Company's liability for such period shall be a refund, upon request, of all premiums paid for such period.

## **TIME OF PAYMENT OF CLAIMS**

The Company will pay all benefits covered by this Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

## **PAYMENT OF CLAIMS**

Benefits for each Insured are payable in accordance with the beneficiary designation in effect at the time of payment.

## **AUTOPSY**

The Company, at its own expense, may have an autopsy done where it is not forbidden by law.

## **LEGAL ACTIONS**

No action can be brought to recover on this Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years (10 years in Missouri) after the date Proof of Loss is required.

## **OTHER INSURANCE**

If the Insured is covered under more than one Accidental Death Policy or Certificate in effect with the Company or any AEGON affiliate at any one time, the Company's maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or **[\$1,000,000]**. Upon discovery of duplication in excess of the Company's maximum liability, the Company will refund all premiums paid for all such Policies or Certificates. The excess will be voided and all premiums paid for such excess shall be returned.

# STONEBRIDGE LIFE INSURANCE COMPANY

A Stock Company

Home Office: Rutland, Vermont

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

## GROUP ACCIDENTAL DEATH INSURANCE SINGLE PREMIUM, NONRENEWABLE

### CERTIFICATE OF INSURANCE

Person(s) insured and benefits are shown in the Schedule of Insurance.

Stonebridge Life Insurance Company (herein called "we," "us" or "our") has issued Policy No. [XXXXXXXX] to [ACE CASH EXPRESS, INC.] (herein called Policyholder) which makes available accidental death insurance for eligible persons.

We agree to pay the benefits herein provided with respect to the person(s) insured hereunder, subject to all terms of the Policy.

#### RIGHT TO EXAMINE CERTIFICATE

If you are not satisfied with this insurance, you may void it by returning this Certificate within 10 days after you receive it to our Administrative Office or to our authorized agent. Any premium paid will be refunded. The Certificate is treated as if it never existed. No benefit will be paid.

The records maintained by the [Policyholder/Participating Group] shall determine the insurance provided under the Policy for any Insured. Important provisions of the Policy are outlined herein.



Secretary



President

#### DEFINITIONS

**INSURED** (herein called "you," "your," or "yours") means you, the insured named in the Schedule of Insurance, provided coverage has become effective.

**COVERAGE PERIOD** means the [35 day] period immediately following a Covered Event.

**COVERED EVENT** means the execution of a transaction including [check cashing] [,short term consumer loan][, or other money service business] transaction[s]. A covered event cannot be a transaction in violation of federal or state law.

**INJURY** means bodily harm caused by an accident which occurs while this Certificate is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

**INJURED** means having suffered an Injury.

**LOSS** means loss of life.

**POLICY** means the contract issued to the Policyholder.

[PARTICIPATING GROUP means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by us. The name of such group is shown in the Schedule of Insurance.]

## WHEN YOUR INSURANCE BEGINS

Issuance of a Certificate is not a waiver of any of the following conditions:

You will become insured on the Certificate Effective Date subject to your enrollment and payment of the single premium. The premium and the Effective Date of Coverage are shown on the Certificate Schedule of Insurance. Your insurance for a Covered Event begins immediately upon the execution of that Covered Event and will continue during the Coverage Period for that Covered Event.

## WHEN YOUR INSURANCE ENDS

Your insurance ends on the earlier of:

1. the end of the Coverage Period for the Covered Event; or
2. the date the Policy is terminated or cancelled; or
3. the date of your death.

In the event the insurance terminates, it does not affect payment of a claim for a Loss which began while the coverage was in force.

## COVERAGE

### ACCIDENTAL DEATH BENEFIT

If you suffer a Loss as a direct result of an Injury from an accident not otherwise excluded in the Policy, we will pay the Accidental Death Benefit shown in the Certificate Schedule of Insurance when we receive proof that:

1. the Injury caused by an accident occurred during the Coverage Period (the [35 day] period immediately following the Covered Event) and
2. Loss occurred within [90] days following the date of the accident that caused the Injury.

## EXCLUSIONS

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war;
3. your taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. your blood alcohol level being .08 percent weight by volume or higher;
5. your operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. your committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative;
10. an accident which occurs outside the United States[,] [or] Canada [or Mexico]; or
11. riding or driving as a professional in any kind of race for prize money or profit; or
12. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

## BENEFICIARY

At your death, unless otherwise specified, any benefit due for Loss will be paid as follows:

1. to your living lawful spouse; or if you do not have one,
2. in equal shares to your living lawful children; or if there are none,
3. in equal shares to your living lawful parents; or if there are none,
4. in equal shares to your living lawful brothers and sisters; or if there are none,
5. to your estate.

Spouse means only the one to whom you are lawfully married on the date of your death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

## **INCONTESTABILITY**

We cannot contest this Certificate except for fraud or for not paying the premium.

## **PAYMENT OF PREMIUM**

We will provide coverage as described in this Certificate in return for payment of premium. The single premium for the Coverage Period is payable by the [Policyholder/Participating Group] on or before the Certificate Effective Date.

The premium rates may be changed at any time the terms of the Policy are changed.

## **NOTICE OF CLAIM**

Written notice of claim must be given to us within 20 days after your Loss or as soon as possible thereafter. If it is not reasonably possible to furnish the notice within the 20 days, a claim will not be reduced or denied because of failure to do so. Notice can be given to our Administrative Office. Notice should include your name and Certificate Number.

## **CLAIM FORMS**

When we receive a notice of claim we will send the claimant forms for filing Proof of Loss. If we do not do so within 15 days, the claimant is deemed to have complied with the requirements for providing Proof of Loss if written Proof of Loss covering the occurrence, character, and extent of the Loss is provided to us within the time fixed for Proof of Loss.

## **PROOF OF LOSS**

Written proof of loss must be given to us within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

## **MISSTATEMENT OF AGE**

If your age has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

## **TIME OF PAYMENT OF CLAIMS**

We will pay all benefits covered as soon as we receive proper written Proof of Loss sufficient to determine liability.

## **PAYMENT OF CLAIMS**

Benefits are payable in accordance with the beneficiary designation in effect at the time of payment.

## **AUTOPSY**

At our expense, we may have an autopsy done where it is not forbidden by law.

## **LEGAL ACTIONS**

No action can be brought to recover on the Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required. (10 years in Missouri)

## **OTHER INSURANCE**

If you are insured under more than one Accidental Death Policy or Certificate in effect with us or any AEGON affiliate at any one time, our maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or [\$1,000,000]. Upon discovery of duplication in excess of our maximum liability, we will refund all premiums paid for all such Policies or Certificates. The excess will be voided and all premiums paid for such excess shall be returned to your or to your beneficiary.

# STONEBRIDGE LIFE INSURANCE COMPANY

## SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. \_\_\_\_\_ [XXXXXXX] to \_\_\_\_\_ [ACE CASH EXPRESS, INC.]

[PARTICIPATING GROUP NUMBER: XXXXXX]

[PARTICIPATING GROUP: XXXXXXXXX]

[CERTIFICATE NUMBER: 82A1000000]

[EFFECTIVE DATE: 6-01-2009]

[INSURED: JOHN DOE  
221 ANYSTREET  
APARTMENT 1231  
ANYTOWN, USA 12345]

[SINGLE PREMIUM: \$XX.XX]

[ACCIDENTAL DEATH BENEFIT: \$12,000]

[THE ACCIDENTAL DEATH BENEFIT WILL BE PAID [AS A LUMP SUM BENEFIT][AS A MONTHLY BENEFIT IN EQUAL INSTALLMENTS FOR A PERIOD OF [12] CONSECUTIVE MONTHS FROM THE DATE OF LOSS.]

[COVERAGE TERMINATES [XX DAYS] FOLLOWING THE COVERED EVENT].

# Stonebridge Life Insurance Company

A STOCK COMPANY

Home Office: Rutland, Vermont  
Administrative Office: [2700 West Plano Parkway  
Plano, Texas 75075]

Stonebridge Life Insurance Company  
(Herein called the Company)

Having issued this Policy to

[ACE CASH EXPRESS, INC.]  
(Herein called Policyholder)

Agrees to pay the benefits herein provided with respect to  
persons Insured hereunder, subject to all terms of this Policy.

This Policy is issued in consideration of the payment of premium and statements made in the application herein provided, and shall take effect on [JANUARY 1, 2009] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR]. This is a legal contract between Stonebridge Life Insurance Company and the Policyholder.

This Policy is issued in the State of Missouri, and its terms shall be construed in accordance with the laws of the State of Missouri.

## RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return the Certificate of Insurance within 10 days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded.

The provisions and conditions of this Policy shall form a part of the contract as fully as if recorded in detail above the signatures hereunder affixed.



Secretary



President

Policy No.: [xxxxxxxxx]

GROUP ACCIDENTAL DEATH INSURANCE POLICY  
SINGLE PREMIUM, NONRENEWABLE

## DEFINITIONS

**INSURED** means the person named on the Certificate Schedule of Insurance. as an Insured, and whose coverage has become effective.

**COVERAGE PERIOD** means the [35 day] period immediately following a Covered Event.

**COVERED EVENT** means the execution of a transaction including [check cashing,] [short term consumer loan,][or other money service business] transaction[s]. A covered event cannot be a transaction in violation of federal or state law.

**INJURY** means bodily harm caused by an accident which occurs while the Insured's Certificate is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

**INJURED** means having suffered an Injury.

**LOSS** means loss of life;

**POLICY** means the contract issued to the Policyholder.

**[PARTICIPATING GROUP** means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by the Company. The name of such group is shown in the Certificate Schedule of Insurance.]

## ELIGIBILITY

Each natural person [AGE 18 THROUGH 75 WHO IS A [CUSTOMER][LOYALTY PROGRAM MEMBER] (or who is the spouse of a [CUSTOMER][LOYALTY PROGRAM MEMBER] age 18 THROUGH 75) OF [ACE CASH EXPRESS, INC.], is eligible to become insured if that person resides in a state in which the insurance coverage may legally be offered.

Each Certificate may cover only one Insured.

In no event will a corporation, partnership, or business entity, other than a natural person, is eligible to be covered.

## WHEN A PERSON BECOMES INSURED

Each Insured will be issued a Certificate of Insurance which will indicate the coverage and the effective date of coverage.

Each eligible person shall become insured on the Certificate Effective Date shown in the Certificate Schedule of Insurance subject to the person's enrollment and payment of the single premium. Insurance for a Covered Event begins immediately upon the execution of that Covered Event and will continue during the Coverage Period for that Covered Event.

## WHEN A PERSON'S INSURANCE ENDS

Insurance ends on the earlier of:

1. the end of a Coverage Period for the Covered Event; or
2. the date this Policy is terminated or cancelled; or
3. the date of the Insured's death.

In the event the insurance terminates, it does not affect payment for a Loss which began while the coverage was in force.

## AMOUNTS OF INSURANCE - SCHEDULE OF INSURANCE

When an eligible person enrolls as an Insured under this Policy, he or she will receive coverage as described in the Coverage section of this Policy. The amounts of insurance for each Insured shall be the amount shown in the Certificate Schedule of Insurance issued for each individual Insured.

## COVERAGE

### ACCIDENTAL DEATH BENEFIT

If the Insured suffers a Loss as a direct result of an Injury from an accident not otherwise excluded in this Policy, the Company will pay the Accidental Death Benefit shown in the Certificate Schedule of Insurance when the company receives proof that:

1. the Injury caused by an accident occurred during the Coverage Period (the [35 day] period immediately following the Covered Event) and
2. Loss occurred with [90] days following the date of the accident that caused the Injury.

## EXCLUSIONS

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war;
3. the Insured's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Insured's blood alcohol level being .08 percent weight by volume or higher;
5. the Insured's operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Insured committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. an accident which occurs outside the United States, [or] Canada [or Mexico]; or
11. riding or driving as a professional in any kind of race for prize money or profit; or
12. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

## PREMIUM

The single Premium for the Insured's Coverage Period is on the attached rate sheet.

## **BENEFICIARY**

At the Insured's death, unless otherwise specified, any benefit due for Loss will be paid as follows:

1. to the Insured's living lawful spouse; or if there is not one,
2. in equal shares to the Insured's living lawful children; or if there are none,
3. in equal shares to the Insured's living lawful parents; or if there are none,
4. in equal shares to the Insured's living lawful brothers and sisters; or if there are none,
5. to the Insured's estate.

Spouse means only the one to whom the Insured is lawfully married on the date of the Insured's death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

## **GENERAL PROVISIONS**

### **ENTIRE CONTRACT**

This Policy is issued in consideration of the application and payment of the premium. The Policy, and any attached papers form the entire contract of insurance.

Any change in this Policy must be in the form of an amendment or endorsement signed by one of the officers of the Company. Agreements made by the Policyholder and the Company in this manner will be binding on all persons insured. Certificate anniversaries are measured from the Certificate Effective Date.

### **INCONTESTABILITY**

The Company cannot contest the Certificate except for fraud or for not paying premiums.

### **INFORMATION TO BE FURNISHED**

The Policyholder shall furnish the Company with any information required to administer this Policy. The Company shall have the right to inspect any record of the Policyholder or in possession of the Policyholder which relates to this Policy.

### **CLERICAL ERROR**

A clerical error in the records relative to this insurance shall not invalidate insurance or cause insurance to be in force or to continue in force. Upon discovery of such error, an equitable adjustment shall be made in the premium.

### **INSURED'S CERTIFICATE**

The Company will issue an individual Certificate to each Insured. The Certificate will describe the insurance coverage and state to which the benefits will be paid.

### **PAYMENT OF PREMIUM**

The Company will provide coverage as described in this Policy in return for payment of premium. The single premium for a Covered Event is payable by the [Policyholder][Participating Group]. The Insured's single premium is due on or before the Certificate Effective Date under this Policy.

The premium rates may be changed at any time the terms of the Policy are changed.

### **NOTICE OF CLAIM**

Written notice of claim must be given to us within 20 days after the date of the Loss or as soon as possible thereafter. If it is not reasonably possible to furnish the notice within the 20 days, a claim will not be reduced or denied because of failure to do so. Notice can be given to our Administrative Office. Notice should include your name and Certificate Number.

## **CLAIM FORMS**

When the Company receives a notice of claim the Company will send the claimant forms for filing Proof of Loss. If the Company does not do so within 15 days, the claimant is deemed to have complied with the requirements for providing Proof of Loss if written Proof of Loss covering the occurrence, character, and extent of the Loss is provided to the Company within the time fixed for Proof of Loss.

## **PROOF OF LOSS**

Written proof of loss must be given to the Company within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

## **MISSTATEMENT OF AGE**

If the age of an Insured has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, the Company accepts a premium for any period when coverage would not normally have been in effect, then the Company's liability for such period shall be a refund, upon request, of all premiums paid for such period.

## **TIME OF PAYMENT OF CLAIMS**

The Company will pay all benefits covered by this Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

## **PAYMENT OF CLAIMS**

Benefits for each Insured are payable in accordance with the beneficiary designation in effect at the time of payment.

## **AUTOPSY**

The Company, at its own expense, may have an autopsy done where it is not forbidden by law.

## **LEGAL ACTIONS**

No action can be brought to recover on this Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years (10 years in Missouri) after the date Proof of Loss is required.

## **OTHER INSURANCE**

If the Insured is covered under more than one Accidental Death Policy or Certificate in effect with the Company or any AEGON affiliate at any one time, the Company's maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or **[\$1,000,000]**. Upon discovery of duplication in excess of the Company's maximum liability, the Company will refund all premiums paid for all such Policies or Certificates. The excess will be voided and all premiums paid for such excess shall be returned.



SERFF Tracking Number: AEGX-125976332 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41240  
 Company Tracking Number: HA AR0045415F01  
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment  
 Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/HA AR0045415F01

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Disapproved	01/14/2009
<b>Bypass Reason:</b>	The Enrollment Form for this product is attached to the Forms Schedule for your review and approval.		

**Comments:**

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Certification/Notice	Disapproved	01/14/2009

**Comments:**

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

We certify that we comply with the requirements of Rule 49.

**Attachment:**

AR - READABILITY CERTIFICATION.PDF

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	NAIC Transmittal	Disapproved	01/14/2009

**Comments:**

**Attachment:**

NAIC Transmittal.PDF

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Explanation of Variables	Disapproved	01/14/2009

**Comments:**

**Attachment:**

Explanation of Variables.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** Stonebridge Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
SLAD3100GC	50.9
SLAD3100GP	43.4
SLAD3200GC	43.1
SLAD3200GP	43.1
SLAD3000GE	0

Signed:   
Name: Edward G. Weigand  
Title: Assistant Secretary  
Date: January 6, 2009

## Life, Accident & Health, Annuity, Credit Transmittal Document

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas					
<b>2.</b>	<b>Department Use Only</b>						
	State Tracking ID						
<b>3.</b>	<b>Insurer Name &amp; Address</b>	<b>Domicile</b>	<b>Insurer License Type</b>	<b>NAIC Group #</b>	<b>NAIC #</b>	<b>FEIN #</b>	<b>State #</b>
	Stonebridge Life Insurance Company 2700 West Plano Parkway Plano, TX 75075	VT	Life, Accident/ Health	0468	65021	03-0164230	
<b>4.</b>	<b>Contact Name &amp; Address</b>	<b>Telephone #</b>	<b>Fax #</b>		<b>E-mail Address</b>		
	Margaret Frei	1-877-527-6444 ext 6289	1-972-881-4097		mfrei@aegonusa.com		
<b>5.</b>	<b>Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____					
<b>6.</b>	<b>Company Tracking Number</b>	SLAD3100GC, et al					
<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b>		Previous file # _____				
<b>8.</b>	<b>Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input checked="" type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____					
<b>9.</b>	<b>Type of Insurance</b>	H03G – Group Health – Accidental Death & Dismemberment					
<b>10.</b>	<b>Product Coding Matrix Filing Code</b>	H03G.000 Health – Accidental Death & Dismemberment					
<b>11.</b>	<b>Submitted Documents</b>	<input type="checkbox"/> <b>FORMS</b> <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other  <u><b>Rates</b></u> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <u><b>SUPPORTING DOCUMENTATION</b></u> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input checked="" type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____					

12.	<b>Filing Submission Date</b>	<b>01/06/09</b>									
13	<b>Filing Fee (If required)</b>	Amount <u>50.00</u>	Check Date <u>N/A – via EFT</u>								
		Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Check Number <u>N/A – via EFT</u>								
14.	<b>Date of Domiciliary Approval</b>	<b>Exempt from filing in Vermont, our state of domicile. Approved in Missouri, our situs state, on December 22, 2008.</b>									
15.	<b>Filing Description:</b>										
<p>Attached for your review and approval are copies of the above captioned forms. These forms are new and do not replace any forms previously approved by your Department. The forms have been completed in “John Doe” fashion. Variable information is bracketed and printed in red.</p> <p>Group Certificate SLAD3100GC provides accidental death benefits if an Insured suffers loss of life as a result of bodily injury caused by an accident that occurs during the Coverage Period. The loss must occur within 90 days after the date of the accident which caused the injury. The single premium for the Coverage Period will be paid by the Insured.</p> <p>SLAD3100GP is the master policy under which the certificates will be issued.</p> <p>Group Certificate SLAD3200GC provides accidental death benefits if an Insured suffers loss of life as a result of bodily injury caused by an accident that occurs during the Coverage Period. The loss must occur within 90 days after the date of the accident which caused the injury. The single premium for the Coverage Period will be paid by the Policyholder.</p> <p>SLAD3200GP is the master policy under which the certificates will be issued.</p> <p>Group Accidental Death Insurance Enrollment Form SLAD3000GE will be used to solicit this and other similar products.</p> <p>These forms were approved by Missouri, our situs state, on December 22, 2008.</p> <p>We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print.</p> <p>The readability scores are as follows:</p> <table data-bbox="370 1234 699 1352"> <tr> <td>SLAD3100GP</td> <td>43.4</td> </tr> <tr> <td>SLAD3100GC</td> <td>50.9</td> </tr> <tr> <td>SLAD3200GP</td> <td>43.1</td> </tr> <tr> <td>SLAD3200GC</td> <td>49.7</td> </tr> </table> <p>Microsoft Word was used to obtain these scores.</p> <p>This product will be mass marketed by direct response, telemarketing methods, point of sale transactions at various cash centers and possibly on the Internet through our website.</p> <p>We request approval for general use of various discretionary groups that are situated in Missouri.</p> <p>The referenced form may be used in other media formats including translations into (Spanish, Chinese, Korean, Vietnamese, Polish, etc) and in such case, we certify the content will not change.</p> <p>The Company has reviewed the enclosed policy forms and certifies that each form submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.</p> <p>Completed filing forms are attached. Our filing fee is being sent via EFT.</p> <p>I respectfully request your favorable review and approval. We appreciate your consideration of these forms. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6289 or contact me by e-mail at mfrei@agonusa.com.</p>				SLAD3100GP	43.4	SLAD3100GC	50.9	SLAD3200GP	43.1	SLAD3200GC	49.7
SLAD3100GP	43.4										
SLAD3100GC	50.9										
SLAD3200GP	43.1										
SLAD3200GC	49.7										

<b>16.</b>	<b>Certification (If required)</b>		
<b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u> .			
Print Name	<u>Margaret Frei</u>	Title	<u>Product Filing Specialist</u>
Signature	<u><i>Margaret Frei</i></u>	Date:	<u>January 6, 2009</u>

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<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		<b>SLAD3100GC, et al</b>
<b>This filing corresponds to rate filing company tracking number</b>		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Group Accidental Death Master Policy	SLAD3100GP	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
02	Group Accidental Death Certificate	SLAD3100GC	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
03	Group Accidental Death Master Policy	SLAD3200GP	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
04	Group Accidental Death Certificate	SLAD3200GC	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
05	Group Accidental Death Insurance Enrollment Form	SLAD3000GE	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

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18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		SLAD3100GC, et al		
This filing corresponds to form filing company tracking number		SLAD3100GC, et al		
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01	Actuarial Memorandum	SLAD3100GP SLAD3100GC	<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	N/A
02	Actuarial Memorandum	SLAD3200GP SLAD3200GC	<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	N/A
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

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# Explanation of Variables

The following is an explanation of the variables indicated in the submitted forms.

## **CERTIFICATES SLAD3100GC and SLAD3200GC**

### **PAGE 1**

COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

- a) 2700 West Plano Parkway  
Plano, Texas 75075-8200
- b) 520 Park Avenue  
Baltimore, Maryland 21201
- c) Valley Forge, Pennsylvania 19493

Policy number and Policyholder name are specific to each policy

The term Participating Group will be used when the policy is issued to a participating group trust.

#### DEFINITIONS:

The **Coverage Period** will vary based on the Policyholder's choice

Under the definition of **Covered Event**, the type of transaction depends on the type of business the Policyholder services.

**Participating Group** will be included when the policy is issued to a participating group.

### **PAGE 2**

COVERAGE: The number of days of coverage provided is determined by the Policyholder. The number of days following an Injury that caused a Loss is determined by what the Policyholder chooses to offer.

EXCLUSIONS: Exclusion number 10 will vary based on the coverage chosen by the Policyholder in the U. S., Canada and Mexico.

### **PAGE 3**

OTHER INSURANCE: The maximum benefit payable may be other than the stated amount.

### **PAGE 4**

SCHEDULE PAGE: Personal data on the Schedule of Insurance is variable as it pertains to the Insured, and the amount of coverage purchased.

## **MASTER POLICIES SLAD3100GP AND SLAD3200GP**

### **PAGE 1**

COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

- d) 2700 West Plano Parkway  
Plano, Texas 75075-8200
- e) 520 Park Avenue  
Baltimore, Maryland 21201
- f) Valley Forge, Pennsylvania 19493

Policy number and Policyholder name are specific to each policy

The term Participating Group will be used when the policy is issued to a participating group trust.

### **PAGE 2**

#### **DEFINITIONS:**

The **Coverage Period** will vary based on the Policyholder's choice

Under the definition of **Covered Event**, the type of transaction depends on the type of business the Policyholder services.

**Participating Group** will be included when the policy is issued to a participating group.

#### **ELIGIBILITY:**

Defines the group and will vary based on the group the Policyholder is insuring.

### **PAGE 3**

**COVERAGE:** The number of days of coverage provided is determined by the Policyholder. The number of days following an Injury that caused a Loss is determined by what the Policyholder chooses to offer.

**EXCLUSIONS:** Exclusion number 10 will vary based on the coverage chosen by the Policyholder in the U. S., Canada and Mexico.

### **PAGE 5**

**OTHER INSURANCE:** The maximum benefit payable may be other than the stated amount.

SERFF Tracking Number: AEGX-125976332 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41240  
 Company Tracking Number: HA AR0045415F01  
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
 Dismemberment Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/HA AR0045415F01

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/06/2009	Form	Group Accidental Death Insurance Enrollment Form	01/06/2009	SLAD3000GE.PDF (Superseded)

**ACCIDENTAL DEATH INSURANCE  
ENROLLMENT FORM**

**Underwritten by Stonebridge Life Insurance Company  
Rutland, Vermont**

[John Doe] ]  
[Social Security Number]  
[123 Main Street] ]  
[Apartment #X] ]  
[Columbia, MO XXXXX] ]  
[Phone (Home) \_\_\_\_\_] [(Business) \_\_\_\_\_]  
[• M[ale] • F[emale] [Date of Birth][Birth Date] \_\_\_\_/\_\_\_\_/\_\_\_\_]

[Check here to [activate]][select] your coverage... • [\$10,000]]

[I, as a [customer]][loyalty program member]] of [Money Service Business, Inc.] hereby enroll in the [Accidental Death Insurance Plan] as provided by Stonebridge Life Insurance Company Group Policy Number [GP3000].]

[Single Premium: \$xx.xx]

[Please Note: In order to be eligible to apply for this coverage, you must be a [customer]][loyalty program member]] of [Money Service Business, Inc.] between the ages of [18 to 75].]

[[Customer]][Member] Signature: \_\_\_\_\_ Date: \_\_\_\_\_

[Covered Person] 7 \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_]  
Signature of [Covered Person] (Required) Mo. Day Yr.

[If you currently have another Accidental Death Insurance policy or certificate in effect and do not intend to replace the current coverage, please indicate the insurance carrier: \_\_\_\_\_."]

[Bar Code for Scanning Purposes] [123-103B] [5060002091717] [MZ2000104/0000F & 0001F]