

SERFF Tracking Number: IADC-126329616 State: Arkansas  
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 43669  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term  
Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application  
Project Name/Number: /

## Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application SERFF Tr Num: IADC-126329616 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved-Closed State Tr Num: 43669

Sub-TOI: H16G.004 Short Term Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Author: Shellie Howard Disposition Date: 10/06/2009

Date Submitted: 10/05/2009 Disposition Status: Approved-Closed

Implementation Date Requested: Implementation Date:

State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Not Filed  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Overall Rate Impact: Group Market Type: Association  
Filing Status Changed: 10/06/2009 Explanation for Other Group Market Type:  
State Status Changed: 10/06/2009  
Deemer Date: Created By: Shellie Howard  
Submitted By: Shellie Howard Corresponding Filing Tracking Number:  
Filing Description:  
Replacement application for short term medical expense policy issued to out-of-state association.

## Company and Contact

### Filing Contact Information

Shellie Howard, Forms Development & Compliance Specialist howards@iacusa.com

SERFF Tracking Number: IADC-126329616 State: Arkansas

Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 43669

Company Tracking Number:

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application

Project Name/Number: /

2101 W. Peoria Ave 602-861-6070 [Phone]  
Suite 100  
Phoenix, AZ 85029-4925

### Filing Company Information

Standard Security Life Insurance Company of New York CoCode: 69078 State of Domicile: New York

485 Madison Avenue Group Code: 450 Company Type: Life and Health  
New York, NY 10022-4141 Group Name: State ID Number:  
(212) 355-4141 ext. [Phone] FEIN Number: 13-5679267

-----

### Filing Fees

Fee Required? Yes  
Fee Amount: \$20.00  
Retaliatory? No  
Fee Explanation: \$20 per form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Security Life Insurance Company of New York	\$20.00	10/05/2009	31044795

SERFF Tracking Number: IADC-126329616 State: Arkansas  
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 43669  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term  
Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application  
Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/06/2009	10/06/2009

SERFF Tracking Number: IADC-126329616 State: Arkansas  
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 43669  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term  
Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application  
Project Name/Number: /

## Disposition

Disposition Date: 10/06/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: IADC-126329616 State: Arkansas

Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 43669

Company Tracking Number:

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application

Project Name/Number: /

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	3rd party authorization	Approved-Closed	Yes
<b>Supporting Document</b>	Statement of Variability	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Form</b>	Application	Approved-Closed	Yes

SERFF Tracking Number: IADC-126329616 State: Arkansas  
 Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 43669  
 Company Tracking Number:  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term  
 Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application  
 Project Name/Number: /

## Form Schedule

**Lead Form Number: SSL-STM-0909-APP**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/06/2009	SSL-STM-0909-APP	Application/Enrollment Form	Application/Enrollment Form	Revised	Replaced Form #: SSL-STM-0609-APP Previous Filing #: IADC-126208822/42787		SSL-STM-0909-APP (ForFiling 092709).pdf

**STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK  
SHORT TERM MEDICAL INSURANCE APPLICATION**

[Plan Name]

**COMPLETE THE FOLLOWING TO INSURE YOURSELF:**

**Applicant:**  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Billing Address (if different) \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail address \_\_\_\_\_

**COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE/DOMESTIC PARTNER AND/OR CHILDREN:**

**Spouse/Domestic Partner:**  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Child(ren)Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Child(ren)Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Child(ren)Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Social Security Number \_\_\_\_\_

**COMPLETE THE FOLLOWING PLAN CHOICES:**

**Coverage Effective Date:**  
 Day after US Post Office Date Stamp  
 Later Effective Date: \_\_\_\_\_  
 • No more than [60] days in advance]

**Coverage Length:**  
 **Single Payment:** *Specify number of days of coverage*  
 \_\_\_\_\_ days (*minimum [30] days, maximum [365] days*) or  
 **Monthly Payment:**  
 Up to [6] Months  
 Up to [12] Months]

**[Secure] STM Plan Coinsurance:**  
 80/20 of \$5,000  50/50 of \$5,000  
 80/20 of \$10,000  50/50 of \$10,000  
 100%]\*  
 \*100% not available with \$250 or \$1,000 Deductible]]  
**Deductible:**  
 \$250  \$500  \$1,000  
 \$2,500  \$5,000  \$10,000  
 \$25,000]

**Daily Deductible STM Plan Coinsurance:**  
 Not applicable  
**Deductible:**  
 \$250  \$500  \$750  
 \$1,000]

**Optional Supplemental Accident Benefit**  
 \$500  \$1,000]

**[Method of Payment**  
 Check or Money Order  
 Credit Card  
 Monthly Automatic Bank Withdrawal]

**ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:**

Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

1. Will there be any other group or individual major medical health insurance in force on the policy effective date? .....  Yes  No
2. Are you or any person applying for coverage now pregnant? .....  Yes  No
3. Are you or any person applying for coverage currently eligible for Medicaid? .....  Yes  No
4. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? .....  Yes  No]
- 5.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for: .....  Yes  No

<ul style="list-style-type: none"> <li>■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent</li> <li>■ peripheral vascular disease or carotid artery disease</li> <li>■ stroke or other neurological disorder</li> <li>■ cancer or tumor</li> </ul>	<ul style="list-style-type: none"> <li>■ paraplegia, quadriplegia or multiple sclerosis</li> <li>■ stem cell transplant</li> <li>■ emphysema or COPD (chronic obstructive pulmonary disease)</li> <li>■ insulin-dependent diabetes</li> <li>■ liver disorder</li> </ul>	<ul style="list-style-type: none"> <li>■ kidney disorder other than stones</li> <li>■ degenerative disc disease or herniated disc</li> <li>■ rheumatoid or psoriatic arthritis</li> <li>■ degenerative joint disease of the knees or hips</li> <li>■ alcohol or drug abuse or dependency</li> <li>■ hemophilia</li> </ul>
--	---	---

- 6.] Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS .....  Yes  No
  - 7.] Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months? .....  Yes  No]
- (NOTE: IF "YES IS ANSWERED ON ANY QUESTION 1 THROUGH [7], COVERAGE CANNOT BE ISSUED.)**

**ACCEPTANCE AND ACKNOWLEDGEMENT:**

- A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
- B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
- C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
- D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
- E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
- F. I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I now have or have had within [5] years of my application for coverage.
- G. I understand that cancellation of this coverage within the 10 Day Right to Return the Certificate provision as stated in the Certificate of Insurance will result in a refund of premiums only. [Any administrative fees or other fees that may apply will not be refunded].

**Signature of Applicant or (Legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Spouse/Domestic Partner:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fraud Warning:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalty.

**[Arkansas Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**[District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

**[Kentucky, Ohio and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

**[New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

**[Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

**[Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.]

SERFF Tracking Number: IADC-126329616 State: Arkansas  
 Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 43669  
 Company Tracking Number:  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term  
 Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	10/06/2009
<b>Comments:</b>		
<b>Attachments:</b>		
SSL STM Readability Certification (100509).pdf		
ARCertificate of Compliance 100609.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	10/06/2009
<b>Comments:</b>		
<b>Attachment:</b>		
SSL-STM-0909-APP (ForFiling 092709).pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> 3rd party authorization	Approved-Closed	10/06/2009
<b>Comments:</b>		
<b>Attachment:</b>		
SSL Filing Authorization Letter 0309.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability	Approved-Closed	10/06/2009
<b>Comments:</b>		
<b>Attachment:</b>		
Statement of Variability 100509.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>

SERFF Tracking Number: IADC-126329616 State: Arkansas  
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 43669  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term  
Product Name: SSL SHORT TERM MEDICAL 2009 - Revised Application  
Project Name/Number: /  
**Satisfied - Item:** Cover Letter Approved-Closed 10/06/2009  
**Comments:**  
**Attachment:**  
SSL(AR)filing letter 100509.pdf

**Standard Security Life Insurance Company of New York**  
**485 Madison Avenue**  
**New York, NY 10022-5872**  
**Telephone: (212) 355-4141**

October 5, 2009

**READABILITY CERTIFICATION**

**NAIC Company Number: 69078**  
**NAIC Group Number: 0450**  
**FEIN Number: 13-5679267**

SSL-STM-0909-APP

Application

I hereby certify that the above captioned forms have a minimum Flesch Index Score of 51 and comply with the readability requirements of this State. Schedules, captions, indexes, defined terms and the Company references were deleted prior to determining the Flesch Index Score.



Adam C. Vandervoort  
Secretary

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

Insurer: Standard Security Life Insurance Company of New York (SSL)

Form Number(s):

SSL-STM-0909-APP

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

Signature of Company Officer:



Adam Vandervoort  
Name

Secretary  
Title

10/6/09  
Date

**STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK  
SHORT TERM MEDICAL INSURANCE APPLICATION**

[Plan Name]

**COMPLETE THE FOLLOWING TO INSURE YOURSELF:**

**Applicant:**  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Billing Address (if different) \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail address \_\_\_\_\_

**COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE/DOMESTIC PARTNER AND/OR CHILDREN:**

**Spouse/Domestic Partner:**  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Child(ren)Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Child(ren)Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Child(ren)Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Social Security Number \_\_\_\_\_

**COMPLETE THE FOLLOWING PLAN CHOICES:**

**Coverage Effective Date:**  
 Day after US Post Office Date Stamp  
 Later Effective Date: \_\_\_\_\_  
 • No more than [60] days in advance]

**Coverage Length:**  
 **Single Payment:** *Specify number of days of coverage*  
 \_\_\_\_\_ days (*minimum [30] days, maximum [365] days*) or  
 **Monthly Payment:**  
 Up to [6] Months  
 Up to [12] Months]

**[Secure] STM Plan Coinsurance:**  
 80/20 of \$5,000  50/50 of \$5,000  
 80/20 of \$10,000  50/50 of \$10,000  
 100%]\*  
 \*100% not available with \$250 or \$1,000 Deductible]]  
**Deductible:**  
 \$250  \$500  \$1,000  
 \$2,500  \$5,000  \$10,000  
 \$25,000]

**Daily Deductible STM Plan Coinsurance:**  
 Not applicable  
**Deductible:**  
 \$250  \$500  \$750  
 \$1,000]

**Optional Supplemental Accident Benefit**  
 \$500  \$1,000]

**[Method of Payment**  
 Check or Money Order  
 Credit Card  
 Monthly Automatic Bank Withdrawal]

**ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:**

Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

1. Will there be any other group or individual major medical health insurance in force on the policy effective date? .....  Yes  No
2. Are you or any person applying for coverage now pregnant? .....  Yes  No
3. Are you or any person applying for coverage currently eligible for Medicaid? .....  Yes  No
4. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? .....  Yes  No]
5. Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for: .....  Yes  No

<ul style="list-style-type: none"> <li>■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent</li> <li>■ peripheral vascular disease or carotid artery disease</li> <li>■ stroke or other neurological disorder</li> <li>■ cancer or tumor</li> </ul>	<ul style="list-style-type: none"> <li>■ paraplegia, quadriplegia or multiple sclerosis</li> <li>■ stem cell transplant</li> <li>■ emphysema or COPD (chronic obstructive pulmonary disease)</li> <li>■ insulin-dependent diabetes</li> <li>■ liver disorder</li> </ul>	<ul style="list-style-type: none"> <li>■ kidney disorder other than stones</li> <li>■ degenerative disc disease or herniated disc</li> <li>■ rheumatoid or psoriatic arthritis</li> <li>■ degenerative joint disease of the knees or hips</li> <li>■ alcohol or drug abuse or dependency</li> <li>■ hemophilia</li> </ul>
--	---	---

6. Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS .....  Yes  No
  7. Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months? .....  Yes  No]
- (NOTE: IF "YES IS ANSWERED ON ANY QUESTION 1 THROUGH [7], COVERAGE CANNOT BE ISSUED.)**

**ACCEPTANCE AND ACKNOWLEDGEMENT:**

- A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
- B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
- C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
- D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
- E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
- F. I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I now have or have had within [5] years of my application for coverage.
- G. I understand that cancellation of this coverage within the 10 Day Right to Return the Certificate provision as stated in the Certificate of Insurance will result in a refund of premiums only. [Any administrative fees or other fees that may apply will not be refunded].

**Signature of Applicant or (Legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Spouse/Domestic Partner:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fraud Warning:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalty.

**[Arkansas Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**[District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

**[Kentucky, Ohio and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

**[New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

**[Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

**[Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.]



Standard Security Life Insurance Company of New York  
485 Madison Avenue  
New York, NY 10022-5872  
Telephone: (212) 355-4141

March 23, 2009

**RE: Standard Security Life Insurance Company of New York**  
NAIC Company Number: 69078  
NAIC Group Number: 0450  
FEIN Number: 13-5679267

### **AUTHORIZATION STATEMENT**

Standard Security Life Insurance Company of New York ("SSLICNY") hereby authorizes Insurers Administrative Corporation ("IAC"), to represent us in the submission of accident and health insurance Group Policy Forms, and related forms and rates, and to negotiate with the Department for their approval.

Sincerely,

A handwritten signature in black ink, appearing to read "Adam Vandervoort".

Adam C. Vandervoort  
Secretary

**SHORT TERM MEDICAL PRODUCT  
STATEMENT OF VARIABILITY**

**Variability will never be used if it would conflict with the minimum requirements as mandated by State or Federal law. All state mandated benefits within text that is bracketed would not be changed to an amount below that which is mandated by the state. Variability is provided to offer greater flexibility in plan design by the insurer.**

**All text within brackets is variable as follows:**

**APPLICATION SSL-STM-0909-APP**

Variability in application is for marketing names, and plan options.

The Plan choices (column 2) is based on plan designs being offered by the insurer and as selected by the applicant. The questions #5 (weight question) and #7 (US residency) are both completely variable so that the question(s) can be included in their entirety or completely omitted contingent on the insurer's plan designs and whether the question(s) will be applicable to the plan being marketed. As a result of question #5 being bracketed, question #6 and #7; as well as #9 are bracketed, but only the numbers, not the entire question to allow renumbering if any of the questions are not used due to plan design.



October 5, 2009

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

RE: **Standard Security Life Insurance Company of New York**  
**NAIC #: 69078**  
**NAIC Group #: 0450**  
**FEIN #: 13-5679267**  
**Group Short Term Medical Insurance Policy – SSL-STMP-1104**

**Form List:**

Short Term Medical Insurance Application:      SSL-STM-0909-APP

Dear Commissioner Benafield-Bowman :

We are submitting the above referenced new form for your review and approval. This new form is for use with the above referenced Short Term Medical Insurance Policy. A Filing Letter of Authorization from Standard Security Life Insurance Company of New York authorizing us, Insurers Administrative Corporation {"IAC"}, to represent them in this filing and to work with the Department for the purposes of obtaining Departmental approval is enclosed.

The following is a summary of the form being filed:

**Form #SSL-STM-0909-APP (Short Term Medical Insurance Application).** This form will replace Form #SSL-STM-0609-APP that was filed and approved June 30, 2009 under SERFF Tracking #IADC-126208822/State tracking #42787. The differences are: A) Form number is changed. B) question 5, under the medical history questions, is replacing the word, "diabetes" with the words, "insulin-dependent diabetes", C) Adding the words, "Domestic Partner" after, "Spouse". This change will allow greater availability to the consumer by allowing non-insulin diabetics to qualify for the plan as well as provide for domestic partner benefits. Since this text was not filed variably, we are submitting this change for your approval.

Variable text is bracketed and may vary from case-to-case. Variable text will never exclude or limit provisions required by your jurisdiction.

Your favorable consideration and expeditious approval of these new forms is respectfully requested. Please let me know if you have any questions or if additional information is desired in connection with this filing.

Sincerely,

Shellie Howard  
Form Development & Compliance Specialist  
PH: 602-861-6070