

SERFF Tracking Number: AEGX-126064527 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41773
Company Tracking Number: TL AR0046515C01
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: Term Life
Project Name/Number: Term Life/TL AR0046515C01

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Term Life

SERFF Tr Num: AEGX-126064527 State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-
Closed State Tr Num: 41773

Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life

Co Tr Num: TL AR0046515C01 State Status: Approved-Closed

Filing Type: Form

Author: SPI ADMSLH

Reviewer(s): Linda Bird

Date Submitted: 03/06/2009

Disposition Date: 03/13/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: 04/01/2009

Implementation Date:

State Filing Description:

General Information

Project Name: Term Life

Status of Filing in Domicile:

Project Number: TL AR0046515C01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/13/2009

Explanation for Other Group Market Type:

State Status Changed: 03/13/2009

Deemer Date:

Created By: SPI ADMSLH

Submitted By: SPI ADMSLH

Corresponding Filing Tracking Number:

Filing Description:

Stonebridge Life Insurance Company

NAIC #65021 FEIN #03-0164230

Form Filing

The captioned individual term life insurance policy and related material is submitted for your departmental review and approval. This form is new and is not intended to replace any previously approved form.

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The Product will not be illustrated.

The policy provides term life insurance. The death benefit is level during the term of coverage elected by the insured and pays the face amount in the event of death due to any cause.

The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format. We will use enrollment form SLTL1600IE to solicit this product and conditional coverage will be provided on form SLTL1600IVN.

The premium is payable on a periodic basis by the insured. Coverage is provided on a conditional basis during the initial period. The Policy form SLTL1600IP will be issued when the insured is accepted. Issue ages are 18 - 49.

Bracketed information throughout the policy forms is intended to be variable and explained in the attached Explanation of Variability document. We reserve the right to rearrange the placement of the schedule items on all forms as well as the Company names to accommodate various printing methods and paper sizes. We also reserve the right to correct minor typographical and grammatical errors. We assure the Department that the typeface and size used will always be similar to that shown and will never be smaller than 10 point.

Company and Contact

Filing Contact Information

Cathy Wynn, Filing Specialist cwynn@aegonusa.com
400 Galleria Parkway 678-402-2085 [Phone]
Suite 1000 678-402-2105 [FAX]
Atlanta, GA 30339

Filing Company Information

Stonebridge Life Insurance Company CoCode: 65021 State of Domicile: Vermont
29 South Main Street Group Code: 468 Company Type: Life and Health
Rutland, VT 05701-5014 Group Name: State ID Number:
(410) 685-5500 ext. [Phone] FEIN Number: 03-0164230

Filing Fees

SERFF Tracking Number: AEGX-126064527 State: Arkansas
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Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation:
Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|------------------------------------|----------|----------------|---------------|
| Stonebridge Life Insurance Company | \$100.00 | 03/06/2009 | 26198876 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 03/13/2009 | 03/13/2009 |

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 | Linda Bird | 03/12/2009 | 03/12/2009 | SPI ADMSLH | 03/13/2009 | 03/13/2009 |

SERFF Tracking Number: AEGX-126064527 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41773
 Company Tracking Number: TL AR0046515C01
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration - Fixed/Indeterminate
 Premium - Single Life
 Product Name: Term Life
 Project Name/Number: Term Life/TL AR0046515C01

Disposition

Disposition Date: 03/13/2009

Implementation Date:

Status: Approved-Closed

Comment:

| Company Name: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where required): | Minimum % Change (where required): |
|---------------------------------------|-----------------------------------|---------------------------|--|---|---|--|--|
| Stonebridge Life Insurance Company | % | % | \$ | | \$ | % | % |

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| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Life & Annuity - Actuarial Memo | | No |
| Supporting Document | Application | | No |
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | AR - NAIC FORM FILING | | Yes |
| | ATTACHMENT, AR - NAIC RATE FILING | | |
| | ATTACHMENT, AR - NAIC | | |
| | TRANSMITTAL DOC | | |
| Supporting Document | AR - CONSENT TO SUBMIT RATES AND/OR COST BASES FOR APPROVAL, Statement of Variability | | Yes |
| Form | Individual Term Life Insurance Enrollment Form | | Yes |
| Form | Individual Term Life Insurance Policy | | Yes |
| Form | Individual Term Life Insurance Conditional Receipt Verification Notice | | Yes |
| Rate | Actuarial Rate Sheet | | No |

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 03/12/2009

Submitted Date 03/12/2009

Respond By Date

Dear Cathy Wynn,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Term Life Insurance Policy, SLTL1600IP (Form)

Comment: We did not find a provision in the contract that provide for the payment of interest on delayed claim payments as described in Ark. Code Ann. 23-81-118.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/13/2009
Submitted Date 03/13/2009

Dear Linda Bird,

Comments:

Thank you for your letter acknowledging receipt of my filing.

Response 1

Comments: Pursuant to our telephone conversation just now, please reference Page 4 of 4, H. Interest At Settlement. I believe this provision satisfies ARK. Code Ann. 23-81-118.

Related Objection 1

Applies To:

- Individual Term Life Insurance Policy, SLTL1600IP (Form)

Comment:

We did not find a provision in the contract that provide for the payment of interest on delayed claim payments as described in Ark. Code Ann. 23-81-118.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Your continued review and approval of our filing is appreciated. Please contact me if you have additional questions.

Sincerely,

Cathy L. Wynn
Filing Specialist
(800) 521-1670 ext. 2404

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Sincerely,
SPI ADMSLH

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Form Schedule

Lead Form Number:

| Schedule Item Status | Form Number | Form Type Form Name | Action | Action Specific Data | Readability | Attachment |
|----------------------|-------------|--|--------------------------|----------------------|-------------|-----------------|
| | SLTL1600IE | Application/ Individual Term Life Enrollment Form | Initial Enrollment | | 54.600 | SLTL1600IE.PDF |
| | SLTL1600IP | Policy/Contract/ Fraternal Certificate | Initial Insurance Policy | | 51.300 | SLTL1600IP.PDF |
| | SLTL1600IVN | Other Individual Term Life Insurance Conditional Receipt Verification Notice | Initial | | 50.100 | SLTL1600IVN.PDF |

INDIVIDUAL TERM LIFE INSURANCE ENROLLMENT FORM

Yes

Please enroll me for this Protection

I understand that in order to enroll for this coverage, I, the applicant, must:

- [1. be a [customer] of [Destination Maternity Corporation];]
- [2. be between the ages of [[18] through [49]], and reside in a state in which this insurance plan may legally be offered;]
- [3.] be pregnant at the time of enrollment.]

Name _____ Insured's Date of Birth ____/____/____
mo day yr
Address _____ [Gender Female Male]
City, ST ZIP Code _____ Home Telephone # (_____) _____
E-mail Address: _____
Amount of Insurance Requested: \$ _____ Term of Coverage Requested: _____ yrs.

[Will this coverage replace, discontinue or change an existing policy or contract? Yes No]
[If yes, please provide the company name, the policy number and the amount of coverage below.]

[Beneficiary designation: Unless you specify below, benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any; otherwise equally to your then living parents or parent, otherwise to your estate.]

Beneficiary _____ Relationship _____

If accepted and premiums of \$X.XX are paid, an Insurance Policy will be sent to me and will be effective on the date stated on my Policy Schedule Page. [I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

[AUTHORIZATION FOR DISCLOSURES OF MEDICAL INFORMATION TO STONEBRIDGE LIFE INSURANCE COMPANY

I understand that I am not required to sign this Authorization; however without it Stonebridge Life Insurance Company ("Stonebridge") can not achieve two purposes, (1) underwriters cannot determine my eligibility for insurance; and (2) its claims adjuster may not be able to pay my claim. I authorize any medical practitioner, medical related institution, government agency, paramedic facility, medical record retrieval services, or pharmaceutical services to disclose to Stonebridge all of my medical records except psychotherapy notes (e.g. my medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS). I understand that entities to which this information may be disclosed may not be covered by Federal privacy rules and if this information is re-disclosed, it may no longer be protected by those rules. I understand this Authorization or a copy: (1) expires 24 months from the date signed or if earlier, upon completion of any claim for benefits; and (2) I may revoke it in writing at any time by sending written notice to [Stonebridge Life Insurance Company, 2700 West Plano Parkway, Plano Texas 75075] except to the extent it is already relied upon.]

[Your Doctor's Name _____]
[Doctor's Address _____] [BAR CODE]
[Doctor's Tel # _____]

X _____ Date ____/____/____
Insured's Signature - Required month day year

Stonebridge Life Insurance Company
Home Office: Rutland, Vermont /Administrative Offices: [2700 West Plano Parkway, Plano, Texas 75075-8200]

[Residents of ARKANSAS, NEW MEXICO, and OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

[Residents of DISTRICT OF COLUMBIA: 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.]

[Residents of FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[Residents of KENTUCKY: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.]

[Residents of LOUISIANA: 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.]

[Residents of MAINE and TENNESSEE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]

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

[Residents of NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[Residents of NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

[Residents of PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.]

STONEBRIDGE LIFE INSURANCE COMPANY

A STOCK COMPANY

Home Office: Rutland, Vermont

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

Toll Free Number [1-800-527-9027]

SCHEDULE OF INSURANCE

INSURED:

FACE AMOUNT: \$

POLICY NUMBER:

EFFECTIVE DATE:

EXPIRATION DATE:

AGE AT ISSUE:

SEX:

ISSUE DATE:

TERM OF COVERAGE:

years

INITIAL PREMIUM: \$

POLICY ANNIVERSARY:

RENEWAL PREMIUM:

\$
MONTHLY

\$
QUARTERLY

\$
SEMI-ANNUALLY

\$
ANNUALLY

GUARANTEED MAXIMUM [ANNUAL] PREMIUM: \$

FOR YOUR INFORMATION

Stonebridge Life Insurance Company (herein called "we," "our," or "us") has issued this Policy to the Insured shown in the Schedule which provides non-renewable, term life insurance for the Term of Coverage shown in the Schedule.

We agree to pay the benefits provided with respect to the Insured (herein called "you", "your" or "yours"), subject to the terms of the Policy.

This Policy supersedes any Policy previously issued to you. You may qualify under one Policy only. If you are insured under more than one Policy, we will consider you to be insured under the Policy which provides the greatest amount of coverage. Upon discovery of the duplication, we will refund any payments which may have been made on your behalf.

YOUR RIGHT TO EXAMINE THE POLICY: You may return this Policy for any reason within [30] days of the date you receive your Policy. The Policy is treated as if it never existed. No benefits are paid.

TO OBTAIN INFORMATION OR TO MAKE A COMPLAINT: You may call our toll-free telephone number at [1-800-732-1821.]

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| What Benefits We Pay..... | [2] | How You Pay Your Premiums..... | [3] |
| Who Receives the Benefits..... | [2] | General Provisions..... | [3] |

**INDIVIDUAL TERM LIFE INSURANCE POLICY
PREMIUMS ARE NOT GUARANTEED AND ARE
SUBJECT TO CHANGE AFTER THE FIRST POLICY YEAR
CONVERTIBLE -- NON-PARTICIPATING**

PART I – DEFINITIONS

POLICY ANNIVERSARY means any anniversary of the date this Policy takes effect.

POLICY YEAR means the 12 month period ending on any Policy Anniversary.

POLICY EFFECTIVE DATE means the date your coverage starts.

INSURED means you, the Insured named on the Policy Schedule, who is eligible for coverage and whose coverage has become effective.

LOSS means loss of life.

PREMIUM means the payment required to keep your insurance in force.

PART II –WHEN COVERAGE STARTS AND STOPS

WHEN COVERAGE STARTS – Your coverage takes effect on the Policy Effective Date shown on the Policy Schedule, and while you are alive.

WHEN COVERAGE STOPS – Coverage stops on the earliest of:

- a. the Expiration Date stated on the Policy Schedule; or
- b. the date you convert to an individual permanent life policy;
- c. the date the 31 day Grace Period ends if you fail to pay the Premium when due, or
- d. the date we receive your request to cancel this coverage.

Only you may cancel this Policy. You may cancel it upon notice to us. Notice is deemed given when made in writing, [communicated verbally by telephone or in person,] or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made. Any unearned premium is pro-rated from the date of cancellation and refunded to you. Cancellation is without prejudice to any claim originating prior to the date of cancellation. No benefits are paid for any loss which occurs after the date your coverage stops.

PART III – WHAT BENEFITS WE PAY

AMOUNT OF COVERAGE – We pay the Face Amount when you die while covered under this Policy. The Face Amount is shown on the Policy Schedule. Before we pay, we must be given proof of death.

SUICIDE – A benefit will not be paid if Loss is a result of suicide, whether sane or insane, within two years of the Policy Effective Date. In such event, we will limit the amount payable to the total premium paid under the Policy.

PART IV – WHO RECEIVES THE BENEFITS

BENEFICIARY: At your death, unless you specify otherwise, any benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any; otherwise equally to your then living parents or parent, otherwise to your estate. Any payment made under this section will fully release us to the extent of the payment.

CHANGING THE BENEFICIARY: You can change your beneficiary at any time by writing to us at our Administrative Office. Once we record the change, it will take effect as of the day you signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable.

PART V – WHAT ARE THE CONDITIONS FOR RENEWING COVERAGE

RENEWAL CONDITIONS – You may keep your coverage in force until the Expiration Date stated on the Policy Schedule, or the Anniversary Date on or after you reach age [50], whichever comes first. Prior to that time, we do not have the right to:

1. cancel your coverage; or
2. place any restriction on your coverage while it is in force; or
3. refuse a premium paid on or before the due date or within the Grace Period.

Premiums are not guaranteed and are subject to change after the first Policy Year. After the first Policy Year, we have the right to change the table of rates on any premium due date. We will provide you written notice at least 60 days before the date of change. The premium rates may also be changed at any time the terms of this Policy are changed.

All renewal premiums will be based on our rates in effect for this Policy on the date such premiums are due. The Table of Renewal Premiums shows the maximum renewal premiums. There will be no change in the Premium Class of the Insured due to any physical impairment or claim incurred. Renewal premiums are due on the first day of each renewal period. Your coverage will expire if premium is not paid on or before the end of the Grace Period.

PART VI – HOW YOU CAN CONVERT TO PERMANENT LIFE

Upon written request, you may convert this Policy, while in force and premiums are being paid, at any time until the end of the Term of Coverage shown in the Schedule. This is subject to what individual permanent life policy we then have available, if any. The conversion must be to any form of individual permanent life insurance issued by us on the date of conversion. It may be converted without medical exam or other evidence of insurability. However, any application attached to this Policy may be made part of the permanent life policy. It may be used to contest benefits under the permanent life policy during the balance of the time that it may be contested under this Certificate. The amount of new coverage must not be less than our minimum then required for the plan selected, and up to a maximum Face Amount of **[\$50,000]**. The new premium will be based on your age and class at the time you convert to the new policy.

PART VII – HOW YOU PAY YOUR PREMIUMS

All premiums due by the terms of the Policy are stated on the Policy Schedule. The premiums shall be paid to our Administrative Office on or before the day they are due.

- A. PREMIUM PAYMENTS:** You keep coverage in force by paying the premiums. Your first premium is due prior to the Policy Effective Date. All premiums after the first premium must be paid in advance.
- B. GRACE PERIOD:** We allow a grace period of 31 days to pay each Premium due after the first Premium. Coverage continues during this grace period. If you die during the grace period, any Premium due is deducted from the death benefit.
- C. REINSTATEMENT:** If your coverage stops because Premiums have not been paid, it may be reinstated. This happens if you:
 - 1. make written request for reinstatement;
 - 2. send satisfactory evidence of insurability;
 - 3. are alive on the date of reinstatement; and
 - 4. make your request within 5 years of when the Premium was due and prior to the end of the Term of Coverage shown in the Schedule.

Reinstatement is subject to payment of all overdue Premiums. We charge 6% interest compounded annually on overdue Premiums.

The Incontestability period will start again on the effective date of Reinstatement.

- D. UNEARNED PREMIUM REFUND:** A refund of unearned Premium is payable to your Beneficiary at the time of your death. You are also entitled to a refund of unearned Premium upon cancellation of the Policy. Unearned Premium is any amount paid by you beyond the date of your death or cancellation of this Policy.

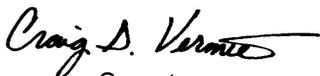
PART VIII – GENERAL PROVISIONS

- A. INCONTESTABILITY:** This Policy is “incontestable” after it has been in effect while you are alive for 2 years from its Issue Date, subject to the “Misstatement of Age” provision. “Incontestable” means we may not deny benefits except for non-payment of Premiums when due. Benefits may be denied during the first two years of your coverage if you fail to give, to the best of your knowledge and belief, true and complete answers in your application.

If your Policy is reinstated, benefits may be denied during the first 2 years after your reinstatement date. This happens if you failed to give, to the best of your knowledge and belief, true and complete answers in your reinstatement application.

- B. THE CONTRACT:** Your Policy is issued in consideration of the enrollment form and payment of the premiums. The policy and the copy of the enrollment form attached to it form the entire contract. All statements made by you shall be deemed representations and not warranties. No statement made by you shall be used in any contest or in defense of a claim hereunder unless a copy of the instrument containing the statement is or has been furnished to you or to your beneficiary. No agent has the authority to change or waive any provisions of the Policy under which this coverage is provided.
- C. MISSTATEMENT OF AGE:** If your age has been misstated, the benefits will be those which the premiums 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 of all premiums paid for such period.
- D. ASSIGNMENT:** You may give your rights under this Policy to someone else. This is called an "Assignment." We take no responsibility for the validity or effect of your actions. In order for us to honor your directions, we must receive a copy of any Assignment at our offices.
- E. NON-PARTICIPATING:** There are no dividends payable under this Policy. It does not share in our surplus earnings.
- F. PROOF OF LOSS:** A certified copy of the death certificate showing the date and cause of death must be given to us as soon as possible after the date of Loss.
- G. TIME PAYMENT OF CLAIMS:** We will pay all benefits covered under the Policy as soon as we receive proper Proof of Loss sufficient to determine liability.
- H. INTEREST AT SETTLEMENT:** If required, we pay interest on death proceeds according to the requirements of your state. The rate of interest is not less than that required by law.
- I. PAYMENT OF CLAIMS:** Benefits are payable in accordance with the beneficiary designation in effect at the time of payment.
- J. AUTOPSY:** At our expense, we may have an autopsy done where it is not forbidden by law.
- K. 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.

IN WITNESS, this Policy is signed by our President and Secretary.


Secretary


President

**INDIVIDUAL TERM LIFE INSURANCE POLICY
PREMIUMS ARE NOT GUARANTEED AND ARE
SUBJECT TO CHANGE AFTER THE FIRST POLICY YEAR
CONVERTIBLE -- NON-PARTICIPATING**

[SIGN AND RETURN

[FUTURE TRUST INSURANCE]

Customer Name _____
Customer Address _____
Policy Number _____

**AUTHORIZATION FOR DISCLOSURES OF MEDICAL INFORMATION TO
STONEBRIDGE LIFE INSURANCE COMPANY**

I understand that I am not required to sign this Authorization; however without it Stonebridge Life Insurance Company ("Stonebridge") can not achieve two purposes, (1) underwriters cannot determine my eligibility for insurance; and (2) its claims adjuster may not be able to pay my claim. I authorize any medical practitioner, medical related institution, government agency, paramedic facility, medical record retrieval services, or pharmaceutical services to disclose to Stonebridge all of my medical records except psychotherapy notes (e.g. my medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS). I understand that entities to which this information may be disclosed may not be covered by Federal privacy rules and if this information is re-disclosed, it may no longer be protected by those rules. I understand this Authorization or a copy: (1) expires 24 months from the date signed or if earlier, upon completion of any claim for benefits; and (2) I may revoke it in writing at any time by sending written notice to [Stonebridge Life Insurance Company, 2700 West Plano Parkway, Plano Texas 75075] except to the extent it is already relied upon.

Your Signature _____ Date _____

[Your Doctor's Name]
[Doctor's Address] [BAR CODE]
[Doctor's Tel #]

Underwritten by Stonebridge Life Insurance Company
Home Office: Rutland, Vermont /Administrative Offices: [2700 West Plano Parkway, Plano Texas 75075]

Detach and return above

RETAIN FOR YOUR RECORDS

[FUTURE TRUST INSURANCE]

INDIVIDUAL TERM LIFE INSURANCE – CONDITIONAL RECEIPT VERIFICATION NOTICE

[Customer Name _____]
[Customer Address _____]
[Call/Issue Date _____]
[Policy Number _____]

This Conditional Receipt Verification Notice confirms the information you provided to us along with your electronic signature. As disclosed [in our phone conversation], in order to continue the process of providing you with the insurance coverage you have requested, we need you to review and sign the Authorization For Disclosures of Medical Information attached to this document and return it to us [in the enclosed postage paid return envelope].

Conditions of Conditional Receipt: While the process of reviewing your information continues, you are provided insurance protection (in the same amount as the insurance coverage you have requested) as long as the following conditions are met:

- Any premium payment provided must be honored when first presented.
- You sign, date and return the Authorization For Disclosures of Medical Information attached to this document within [30] days from the call date indicated above. We need you to complete this step so that we can continue to process your request for insurance coverage. If we do not receive the signed Authorization within the noted timeframe, the application process will stop and your premium payment will be refunded in full.
- As part of the application process, we need to review your medical information [related to your pregnancy] to determine if you qualify for the insurance coverage you have requested. In order to obtain that information, submission of the Authorization form allows your [OB-GYN/physician] to provide us your medical information [related to your pregnancy]. Your [OB-GYN/physician] will be sent a copy of your signed Authorization and will be required to release the information to us within [60] days of the Call Date noted above. When we receive the information from your [OB-GYN/physician] we will be able to determine your insurability and finalize the application process. And similar to step 2, if we do not receive this information within the noted timeframe, the application process will stop and your premium payment will be refunded in full.

If all of the above conditions are met and you qualify for the insurance, your insurance in the amount requested will become effective on the Call Date noted above. If you do not qualify for the insurance coverage you requested or if you should die before we are able to determine your insurability and we are unable to complete the application process, we assume no liability under the request for coverage or the Conditional Receipt other than the return of your premium payment in full.

NOTE: We reserve the right to limit the amount of coverage you have with us.

Underwritten by Stonebridge Life Insurance Company
Home Office: Rutland, Vermont /Administrative Offices: [2700 West Plano Parkway, Plano Texas 75075]

SERFF Tracking Number: AEGX-126064527 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41773
 Company Tracking Number: TL AR0046515C01
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: Term Life
 Project Name/Number: Term Life/TL AR0046515C01

Rate Information

Rate data applies to filing.

Filing Method: Prior Approval
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

| Company Name: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where required): | Minimum % Change (where required): |
|------------------------------------|-----------------------------|------------------------|--|--|-----------------------------------|------------------------------------|------------------------------------|
| Stonebridge Life Insurance Company | % | % | | | | % | % |

SERFF Tracking Number: AEGX-126064527 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41773
 Company Tracking Number: TL AR0046515C01
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: Term Life
 Project Name/Number: Term Life/TL AR0046515C01

Rate/Rule Schedule

| Schedule Item Status: | Document Name: | Affected Form Numbers: (Separated with commas) | Rate Action: | Rate Action Information: | Attachments |
|-----------------------|----------------------|---|--------------|--------------------------|--------------------------|
| | Actuarial Rate Sheet | SLTL1600IP | New | | Actuarial Rate Sheet.PDF |

ACTUARIAL RATE SHEET
Stonebridge Life Insurance Company
SLTL1600IP

GUARANTEED
Term Monthly Gross Premium Rates per \$1,000 Face
(Add \$2.50 Monthly Policy Fee)
Female NonTobacco

| Term Period | Issue Age: | 18-24 | 25-29 | 30-34 | 35-39 | 40 |
|-------------|------------|--------|--------|--------|--------|--------|
| 10 | | 0.1275 | 0.1375 | 0.1575 | 0.1950 | 0.2425 |
| 11 | | 0.1300 | 0.1400 | 0.1625 | 0.2050 | 0.2575 |
| 12 | | 0.1300 | 0.1425 | 0.1650 | 0.2125 | 0.2700 |
| 13 | | 0.1325 | 0.1450 | 0.1700 | 0.2250 | 0.2850 |
| 14 | | 0.1350 | 0.1475 | 0.1750 | 0.2375 | 0.3000 |
| 15 | | 0.1350 | 0.1525 | 0.1800 | 0.2475 | 0.3175 |
| 16 | | 0.1375 | 0.1550 | 0.1875 | 0.2600 | 0.3375 |
| 17 | | 0.1400 | 0.1575 | 0.1950 | 0.2725 | 0.3575 |
| 18 | | 0.1425 | 0.1625 | 0.2025 | 0.2875 | 0.3750 |
| 19 | | 0.1475 | 0.1675 | 0.2125 | 0.3050 | 0.3975 |
| 20 | | 0.1525 | 0.1725 | 0.2225 | 0.3225 | 0.4200 |
| 21 | | 0.1550 | 0.1800 | 0.2350 | 0.3400 | 0.4400 |

| | | | | |
|--|---------------|--------------------|------------------|----------------|
| | <u>Annual</u> | <u>Semi-Annual</u> | <u>Quarterly</u> | <u>Monthly</u> |
| Mode Factors | 12.00 | 6.00 | 3.00 | 1.00 |
| Sum of all benefits, & round to the near quarter. Multiply by mode factor. | | | | |

SERFF Tracking Number: AEGX-126064527 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41773
 Company Tracking Number: TL AR0046515C01
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: Term Life
 Project Name/Number: Term Life/TL AR0046515C01

Supporting Document Schedules

| | | |
|-------------------------------------|---------------------|---------------------|
| | Item Status: | Status Date: |
| Bypassed - Item: Application | | |
| Bypass Reason: See Forms Tab | | |
| Comments: | | |

| | | |
|---|---------------------|---------------------|
| | Item Status: | Status Date: |
| Satisfied - Item: Flesch Certification | | |
| Comments: | | |
| Attachment: | | |
| AR - READABILITY CERTIFICATION.PDF | | |

| | | |
|--|---------------------|---------------------|
| | Item Status: | Status Date: |
| Satisfied - Item: AR - NAIC FORM FILING ATTACHMENT, AR - NAIC RATE FILING ATTACHMENT, AR - NAIC TRANSMITTAL DOC | | |
| Comments: | | |
| Attachments: | | |
| AR - NAIC FORM FILING ATTACHMENT.PDF | | |
| AR - NAIC RATE FILING ATTACHMENT.PDF | | |
| AR - NAIC TRANSMITTAL DOC.PDF | | |

| | | |
|--|---------------------|---------------------|
| | Item Status: | Status Date: |
| Satisfied - Item: AR - CONSENT TO SUBMIT RATES AND/OR COST BASES FOR APPROVAL, Statement of Variability | | |
| Comments: | | |

SERFF Tracking Number: AEGX-126064527 *State:* Arkansas
Filing Company: Stonebridge Life Insurance Company *State Tracking Number:* 41773
Company Tracking Number: TL AR0046515C01
TOI: L04I Individual Life - Term *Sub-TOI:* L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life

Product Name: Term Life
Project Name/Number: Term Life/TL AR0046515C01

Attachments:

AR - CONSENT TO SUBMIT RATES AND_OR COST BASES FOR APPROVAL.PDF
Statement of Variability.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.

| Form Number | Score |
|-------------|-------|
| SLTL1600IE | 54.6 |
| SLTL1600IP | 51.3 |
| SLTL1600IVN | 50.1 |
| | |
| | |

Signed: 
Name: Cathy L. Wynn
Title: Filing Specialist
Date: 03/03/2009

| | | |
|---|-------------------------------|--|
| 17. | Form Filing Attachment | |
| This filing transmittal is part of company tracking number | TL AR0046515C01 | |
| This filing corresponds to rate filing company tracking number | | |

| | Document Name | Form Number | | Replaced Form Number |
|----|--|--------------------|--|-------------------------------------|
| | Description | | | Previous State Filing Number |
| 01 | Individual Term Life Insurance Enrollment Form | SLTL1600IE | <input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____ | |
| 02 | Individual Term Life Insurance Policy | SLTL1600IP | <input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____ | |
| 03 | Individual Term Life Insurance Conditional Receipt Verification Notice | SLTL1600IVN | <input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____ | |
| 04 | | | <input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____ | |
| 05 | | | <input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____ | |
| 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 _____ | |
| 11 | | | <input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____ | |

LIFE, ACCIDENT & HEALTH, ANNUITY, CREDIT RATE FILING ATTACHMENT

Rate Filing Attachment

| This filing transmittal is part of company tracking number | | TL AR0046515C01 | |
|---|----------------------|------------------------------|--|
| This filing corresponds to form filing company tracking number | | | |
| Overall percentage rate indication (when applicable) | | | |
| Overall percentage rate impact for this filing | | Not Applicable % | |
| | Document Name | Affected Form Numbers | Previous State Filing Number |
| | Description | | |
| 01 | Actuarial Rate Sheet | SLTL1600IP | <input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request + _____ % - _____ % <input type="checkbox"/> Other |
| 02 | | | <input type="checkbox"/> New <input type="checkbox"/> Revised Request + _____ % - _____ % <input type="checkbox"/> Other |
| 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 |
| 11 | | | <input type="checkbox"/> New <input type="checkbox"/> Revised Request + _____ % - _____ % <input type="checkbox"/> Other |
| 12 | | | <input type="checkbox"/> New <input type="checkbox"/> Revised Request + _____ % - _____ % <input type="checkbox"/> Other |

Life, Accident & Health, Annuity, Credit Transmittal Document

| | | |
|-----------|----------------------------------|----------|
| 1. | Prepared for the State of | Arkansas |
|-----------|----------------------------------|----------|

| | | |
|-----------|----------------------------|--|
| 2. | Department Use Only | |
| | State Tracking ID | |
| | | |

| 3. Insurer Name & Address | Domicile | Insurer License Type | NAIC Group # | NAIC # | FEIN # | State # |
|---|----------|----------------------|--------------|--------|------------|---------|
| Stonebridge Life Insurance Company 29 South Main Street Rutland VT 05701-5014 | VT | L&H | 468 | 65021 | 03-0164230 | |

| 4. Contact Name & Address | Telephone # | Fax # | E-mail Address |
|---|--------------|--------------|--------------------|
| Cathy L. Wynn, HIA, FLMI, ACS, ALHC 400 Galleria Parkway, Suite 1000 Atlanta GA 30339 | 800-521-1670 | 678-402-2105 | cwynn@aegonusa.com |

| | |
|---------------------------------|--|
| 5. Requested Filing Mode | <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): _____ |
|---------------------------------|--|

| | |
|-----------------------------------|-----------------|
| 6. Company Tracking Number | TL AR0046515C01 |
|-----------------------------------|-----------------|

| | | |
|--|---------------------------------------|-----------------------|
| 7. <input checked="" type="checkbox"/> New Submission | <input type="checkbox"/> Resubmission | Previous file # _____ |
|--|---------------------------------------|-----------------------|

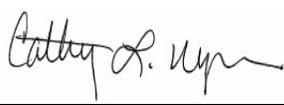
| | | | | |
|------------------|--|--|--------------------------------------|--|
| 8. Market | <input checked="" type="checkbox"/> Individual | <input type="checkbox"/> Franchise | | |
| | Group | <input type="checkbox"/> Small | <input type="checkbox"/> Large | <input type="checkbox"/> Small and Large |
| | | <input type="checkbox"/> Employer | <input type="checkbox"/> Association | <input type="checkbox"/> Blanket |
| | | <input type="checkbox"/> Discretionary | <input type="checkbox"/> Trust | |
| | | <input type="checkbox"/> Other: _____ | | |

| | |
|-----------------------------|-----------------------------|
| 9. Type of Insurance | L04I Individual Life - Term |
|-----------------------------|-----------------------------|

| | |
|--|--|
| 10. Product Coding Matrix Filing Code | L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life |
|--|--|

| | |
|--------------------------------|--|
| 11. Submitted Documents | <input checked="" type="checkbox"/> FORMS <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input checked="" type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input checked="" type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____ |
|--------------------------------|--|

| | | |
|---|-------------------------------------|---|
| 12. | Filing Submission Date | 03/03/2009 |
| 13. | Filing Fee (If required) | Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number _____ |
| 14. | Date of Domiciliary Approval | |
| 15. | Filing Description: | |
| <p>Stonebridge Life Insurance Company NAIC #65021 FEIN #03-0164230 Form Filing</p> <p>The captioned individual term life insurance policy and related material is submitted for your departmental review and approval. This form is new and is not intended to replace any previously approved form.</p> <p>The Product will not be illustrated.</p> <p>The policy provides term life insurance. The death benefit is level during the term of coverage elected by the insured and pays the face amount in the event of death due to any cause.</p> <p>The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format. We will use enrollment form SLTL1600IE to solicit this product and conditional coverage will be provided on form SLTL1600IVN.</p> <p>The premium is payable on a periodic basis by the insured. Coverage is provided on a conditional basis during the initial period. The Policy form SLTL1600IP will be issued when the insured is accepted. Issue ages are 18 - 49.</p> <p>Bracketed information throughout the policy forms is intended to be variable and explained in the attached Explanation of Variability document. We reserve the right to rearrange the placement of the schedule items on all forms as well as the Company names to accommodate various printing methods and paper sizes. We also reserve the right to correct minor typographical and grammatical errors. We assure the Department that the typeface and size used will always be similar to that shown and will never be smaller than 10 point.</p> | | |

| | | |
|---|------------------------------------|--|
| 16. | Certification (If required) | |
| <p>I HEREBY CERTIFY 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>.</p> | | |
| <p>Print Name <u>Cathy L. Wynn, HIA, FLMI, ACS, ALHC</u> Title <u>Filing Specialist</u></p> | | |
| <p>Signature <u></u> Date <u>03/03/2009</u></p> | | |

STATE OF ARKANSAS

Certification

Name of Company: Stonebridge Life Insurance Company

The above named company certifies that Individual Term Life Insurance Enrollment Form
Form No. SLTL1600IE has been reviewed and complies with Arkansas
Insurance Department Guidelines identified in its Bulletin No. 11-83.



Signature

Cathy L. Wynn
Print or Type Name

Filing Specialist
Title

STATE OF ARKANSAS

Certification

Name of Company: Stonebridge Life Insurance Company

The above named company certifies that Individual Term Life Insurance Policy
Form No. SLTL1600IP has been reviewed and complies with Arkansas
Insurance Department Guidelines identified in its Bulletin No. 11-83.



Signature

Cathy L. Wynn

Print or Type Name

Filing Specialist

Title

STATE OF ARKANSAS

Certification

Name of Company: Stonebridge Life Insurance Company

The above named company certifies that Individual Term Life Insurance Conditional Receipt Verification Notice
Form No. SLTL1600IVN has been reviewed and complies with Arkansas Insurance Department Guidelines identified in its Bulletin No. 11-83.



Signature

Cathy L. Wynn

Print or Type Name

Filing Specialist

Title

Explanation of Variable Items

Page 1 of 4

Form SLTL1600IP – Individual Term Life Insurance Policy

Page 1

- * *Administrative Office* address and *Toll Free Number* will appear as shown. These items may vary depending on the location and phone number of the office that will administer the policy.

Page 1

Policy Schedule Data

- * The *INSURED, FACE AMOUNT, POLICY NUMBER, EFFECTIVE DATE, EXPIRATION DATE, AGE AT ISSUE, SEX, ISSUE DATE, TERM OF COVERAGE INITIAL PREMIUM POLICY ANNIVERSARY, RENEWAL PREMIUM, MONTHLY, QUARTERLY, SEMI-ANNUALLY, and ANNUALLY* schedule data will vary to reflect the insured's unique information.

Page 1

Policy Schedule Items

GUARANTEED MAXIMUM [ANNUAL] PREMIUM:

- * The renewal premium period stated in this schedule item can be Monthly, Quarterly, Semi-Annual or Annual.

Page 1

3rd Introductory Paragraph

[Participating Group /]

- * When the Participating Group provision applies for the governing group policy, the language Participating Group will appear as shown, otherwise it will be deleted in its entirety.

Page 1

Table of Contents Page Numbers

- * The page number references will vary to accurately reflect the appropriate page number where the provision appears.

Page 2

Part II - When Coverage Starts and Stops

[communicated verbally by telephone or in person,]

- * As approved by the Company for the group policy, this text within this provision will appear as shown or be removed.

Part V – What Are The Conditions For Renewing Coverage

[50]

- * The age range after which coverage expires will vary as approved by the Company and may be and age up to 50

Explanation of Variable Items

Page 2 of 4

Form SLTL1600IE – Individual Term Life Enrollment Form

- * The declarative statements will appear as shown and will be consistent with the program of insurance offered under a group policy and approved by the Company.
- * The check boxes to indicate gender will appear as shown or will be removed in their entirety when not indicated.
- * *Administrative Office* address at the bottom of the form will appear as shown. This item may vary depending on the location and phone number of the office that will administer the policy.

Beneficiary Designation

[Beneficiary designation: Unless you specify below, benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any; otherwise equally to your then living parents or parent, otherwise to your estate.]

- * The Beneficiary designation definition will appear as shown or will be deleted in its entirety when indicated.

Statement made by the enrollee

[I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

- * This statement will appear when a fraud warning applies to the enrollee.

Fraud Warning paragraph

- * Fraud Warning paragraph will appear as shown as the apply to the enrollee state of residence or may be deleted in their entirety.

HIPPA Notice section

- * When required for the program of insurance offered, the entire section will print as shown below. When it does not apply, the section will be deleted in its entirety.

[AUTHORIZATION FOR DISCLOSURES OF MEDICAL INFORMATION TO STONEBRIDGE LIFE INSURANCE COMPANY

I understand that I am not required to sign this Authorization; however without it Stonebridge Life Insurance Company (“Stonebridge”) can not achieve two purposes, (1) underwriters cannot determine my eligibility for insurance; and (2) its claims adjuster may not be able to pay my claim. I authorize any medical practitioner, medical related institution, government agency, paramedic facility, medical record retrieval services, or pharmaceutical services to disclose to Stonebridge all of my medical records except psychotherapy notes (e.g. my medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS). I understand that entities to which this information may be disclosed may not be covered by Federal privacy rules and if this information is re-disclosed, it may no longer be protected by those rules. I understand this Authorization or a copy: (1) expires 24 months from the date signed or if earlier, upon completion of any claim for benefits; and (2) I may revoke it in writing at any time by sending written notice to [Stonebridge Life Insurance Company, 2700 West Plano Parkway, Plano Texas 75075] except to the extent it is already relied upon.]

[Your Doctor’s Name

]

[Doctor’s Address

]

[BAR CODE]

[Doctor’s Tel #

]

Explanation of Variable Items

Page 3 of 4

Form SLTL1600IVN – Conditional Receipt Verification Notice

- * The *CUSTOMER NAME, CUSTOMER ADDRESS, POLICY NUMBER, YOUR DOCTOR'S NAME, DOCTOR'S ADDRESS, DOCTOR'S TEL #, BAR CODE, CALL DATE, AND OTHER INFORMATION OBTAINED DURING THE CALL* schedule data will vary to reflect the insured's unique information.
- * *Administrative Office* address in the middle and at the bottom of the form will appear as shown. This item may vary depending on the location and phone number of the office that will administer the policy.

Program of insurance Marketing Name

[FUTURE TRUST INSURANCE]

- * The marketing name will vary based on the for the program of insurance offered.

HIPPA Notice section

- * When required for the program of insurance offered, the entire section will print as shown below. When it does not apply, or when the notice is made a part of the enrollment form, the section will be deleted in its entirety.

[SIGN AND RETURN

[FUTURE TRUST INSURANCE]

Customer Name _____
 Customer Address _____
 Policy Number _____

**AUTHORIZATION FOR DISCLOSURES OF MEDICAL INFORMATION TO
STONEBRIDGE LIFE INSURANCE COMPANY**

I understand that I am not required to sign this Authorization; however without it Stonebridge Life Insurance Company ("Stonebridge") can not achieve two purposes, (1) underwriters cannot determine my eligibility for insurance; and (2) its claims adjuster may not be able to pay my claim. I authorize any medical practitioner, medical related institution, government agency, paramedic facility, medical record retrieval services, or pharmaceutical services to disclose to Stonebridge all of my medical records except psychotherapy notes (e.g. my medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS). I understand that entities to which this information may be disclosed may not be covered by Federal privacy rules and if this information is re-disclosed, it may no longer be protected by those rules. I understand this Authorization or a copy: (1) expires 24 months from the date signed or if earlier, upon completion of any claim for benefits; and (2) I may revoke it in writing at any time by sending written notice to [Stonebridge Life Insurance Company, 2700 West Plano Parkway, Plano Texas 75075] except to the extent it is already relied upon.

Your Signature _____ Date _____

Your Doctor's Name _____
 Doctor's Address _____
 Doctor's Tel # _____

[BAR CODE]

Underwritten by **STONEBRIDGE LIFE INSURANCE COMPANY**
 Home Office: Rutland, Vermont /Administrative Offices: [2700 West Plano Parkway, Plano Texas 75075]

Explanation of Variable Items

Page 4 of 4

1st Paragraph

[in our phone conversation]

- * This text will appear as shown when the program of insurance is telemarketed. Otherwise this text will be deleted in its entirety.

[in the enclosed postage paid return envelope]

- * This text will appear as shown when the program of insurance is marketed via telephone or mail channels. Otherwise this text will be deleted in its entirety.

[30] appearing in the second bulleted item

- * The range for the period within which the authorization must be return will vary depending on the marketing method and may be a number between 15 and 60.

[related to your pregnancy]

- * This text will appear as shown when the program of insurance is marketed to member or customers who are pregnant.

[related to your pregnancy] and [OB-GYN/physician]

- * This text will appear as shown when the program of insurance is marketed to member or customers who are pregnant.

[60] appearing in the second bulleted item

- * The range for the period within which the information must be released will vary depending on the marketing method and may be a number between 30 and 90.