

SERFF Tracking Number: IADC-126160130 *State:* Arkansas
Filing Company: Standard Security Life Insurance Company of New York *State Tracking Number:* 42460
Company Tracking Number: SHORT TERM MEDICAL 2009
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.004 Short Term
Product Name: SSL STMP 1104, ET AL
Project Name/Number: /

Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: SSL STMP 1104, ET AL	SERFF Tr Num: IADC-126160130	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 42460
Sub-TOI: H16G.004 Short Term	Co Tr Num: SHORT TERM MEDICAL 2009	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Shellie Howard	Disposition Date: 05/28/2009
	Date Submitted: 05/20/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		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: 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: 05/28/2009	Explanation for Other Group Market Type:
	State Status Changed: 05/28/2009
Deemer Date:	Corresponding Filing Tracking Number:
Filing Description:	
Group Short Term medical insurance product filing with situs state of DC - new forms. Please see cover letter for detailed explanation.	

Company and Contact

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Filing Contact Information

Shellie Howard, Forms Development & Compliance Specialist
 2101 W. Peoria Ave (602) 861-6070 [Phone]
 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: \$80.00
 Retaliatory? Yes
 Fee Explanation: \$20 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Security Life Insurance Company of New York	\$80.00	05/20/2009	28017609

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/28/2009	05/28/2009

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Disposition

Disposition Date: 05/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	3rd Party Authorization	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Original Approval Letter	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Accident Rider	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SSL-STM-0409

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SSL-STM-0409	Schedule Pages	Schedule of Benefits	Initial			SSL-STM-0409(Schedule)ForFiling(041509).pdf
Approved-Closed	SSL-STM-0109-APP	Application/ Enrollment Form	Application	Initial			SSL-STM-0109-APP (ForFiling{041409}.pdf
Approved-Closed	SSL-ADB-0409	Application/ Enrollment Form	Accident Rider	Revised	Replaced Form #: SSL-ADB-1104 Previous Filing #: Paper filing approved 01/18/05		SSL-ADB-0409(Supp Acc Rider)ForFiling(041409).pdf
Approved-Closed	SSL-STM-AE-0409	Certificate Amendment, Insert Page, Endorsement or Rider	Amendatory Endorsement	Initial			SSL-STM-AE-0409 (ForFiling{041509}.pdf

SCHEDULE

[HOSPITAL PRECERTIFICATION NOTICE

This plan requires a Precertification by a Professional Review Organization prior to in-patient Hospitalization or surgery. A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed Hospitalization;
2. Within 48-hours of an emergency admission; or
3. Within 48-hours of delivery for complicated childbirth.

Non-compliance with the Pre-Admission Certification procedure will result in a **reduction in benefits of 50%**, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. You have been provided with information and procedures necessary for Pre-Admission Certification. You may obtain more information regarding Pre-Certification and its procedures from the Company.]

SECTION I

The [Daily Deductible] [Deductible], [Copay,] Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount for Covered Expenses apply to each Covered Person, unless otherwise stated for a specific benefit, including any maximum benefits for each Covered Person, in SECTION II.

THE FOLLOWING SHALL APPLY TO COVERED EXPENSES FOR EACH COVERED PERSON

[DEDUCTIBLE: [\$250 - \$25,000] as elected]

[Deductible Family Maximum: [\$2,000] [When [2-5] Covered Persons each satisfy their individual Deductible, the Deductibles for any remaining Covered Persons are deemed satisfied for the remainder of the Coverage Period.]

[DAILY DEDUCTIBLE: [\$250-\$2,000] as elected]

[Daily Deductible Family Maximum: [[\$2,000] [When [2-5] Covered Persons each satisfy their individual Daily Deductible, the Daily Deductible is deemed satisfied for the remainder of the Coverage Period.]]

COINSURANCE:

Coinsurance Percentage: [50% -100%] [as elected] after payment by the Covered Person of the [Daily Deductible] [Deductible], [up to the Coinsurance Limit]

[Coinsurance Limit: [\$4,000 - \$20,000] of Covered Expenses] [per Covered Person] [Satisfied when [2-5] Covered Persons each satisfy their individual Coinsurance Limit] [Satisfied when 1 Covered Person satisfies his/her individual Coinsurance Limit]]

[Coinsurance Percentage Thereafter: [50%-100%]]

COVERAGE PERIOD MAXIMUM BENEFIT AMOUNT: [\$100,000 - \$2,000,000] per Covered Person

[LIFETIME MAXIMUM AMOUNT: [\$100,000 - \$2,000,000] per Covered Person]

SECTION II

MAXIMUM BENEFITS FOR COVERED EXPENSES FOR EACH COVERED PERSON:

Covered Expenses are subject to the Usual, Reasonable and Customary charge and the following Maximum Benefit, if applicable.

HOSPITAL COVERED EXPENSES:

Hospital Room, Board and General Nursing Care:

[Not Applicable] [Up to the most common Average Semi-Private Room Rate] [up to \$[1,000-\$2,000 per day [and up to the Inpatient Miscellaneous Medical Expense Services maximum benefit]]

Intensive or Specialized Care Unit:

[Not Applicable] [Up to [2-4] times the most common Average Semi-Private Room Rate] [up to \$[1,250-\$2,500] per day [and up to the Inpatient Miscellaneous Medical Expense Services maximum benefit]]

[Emergency Room Treatment:

[Not Applicable] [Up to \$[500-\$1,000] per day [including the emergency room Doctor charge], [24 hour observation and up to the Inpatient Miscellaneous Medical Expense Services maximum benefit]]]

[Inpatient Doctor Visits:

[Not Applicable] [Up to \$[500-\$1,500] per each Hospital confinement [and up to the Inpatient Miscellaneous Medical Expense Services maximum benefit.]]

[Inpatient Miscellaneous Medical Expense Services:

[Not Applicable] [Up to \$[500-\$2,500] per day for all Inpatient Covered Expenses combined]]

OTHER COVERED EXPENSES:

Doctor Office Visits:

[Not Applicable] [After \$[25-\$100] Copay] [Up to \$[25-\$100] per office visit [charge] [not to exceed [2-8] visits per Coverage Period.] [The Copay applies to each doctor office visit charge] [Additional Covered Expenses incurred during the office visit including Expenses for laboratory and diagnostic tests, [and Covered Expenses incurred after [2-8] office visits] will be subject to the [Daily Deductible] [Deductible] and Coinsurance] [Once this limit is exceeded [Covered Expenses will be subject to the [Daily Deductible] [Deductible] and Coinsurance, [up to a maximum benefit of \$[1,000-\$2,000] per Covered Person for each Coverage Period]] [expenses incurred for Doctor Office Visits will not be considered Covered Expenses for the balance of that Coverage Period.]

[Outpatient Hospital Surgery or Ambulatory Surgical Center:

[Not Applicable] [Up to \$[1,000-\$2,000] per day [and up to the Outpatient Miscellaneous Medical Expense Services maximum benefit]]

Surgeon Services

[Not Applicable] [Up to \$[\$2,000-\$5,000] per surgery] [and up to the Outpatient Miscellaneous Medical Expense Services maximum benefit]]

SCHEDULE (Continued)

Doctor Administering Anesthetics: [Not Applicable] [Up to [20%-40%] of the surgeon's benefit]

Assistant Surgeon: [Not Applicable] [Up to [20%-40%] of the surgeon's benefit]

Surgeon's Assistant: [Not Applicable] [Up to [15%-25%] of the surgeon's benefit]

[The Covered Expenses incurred for [Surgeon Services], [Doctor Administering Anesthetics], [Assistant Surgeon] and [Surgeon's Assistant] are limited to a combined maximum benefit of \$[2,500-\$5,000] per surgery, [not to exceed \$[5,000-\$10,000] per Coverage Period]]

Surgery: [Not Applicable] [Up to \$[10,000-\$100,000] per [surgery] [Coverage Period]

Ambulance [Ground or Air] Services: [Not Applicable] [Up to \$[250-\$2,500] per [occurrence] [Coverage Period] [up to \$[250-\$500] per [occurrence] [Coverage Period] for ground ambulance and \$[500-\$2,500] per [occurrence] [Coverage Period] for air ambulance]

[Acquired Immune Deficiency Syndrome (AIDS)] [Not Applicable] [Up to \$[10,000-\$20,000] per Coverage Period]]

[Knee Injury or Disorder] [Not Applicable] [Up to \$[2,500-\$5,000] per [Coverage Period] [surgery combined for both left and right knees]]

[Gallbladder Surgery: [Not Applicable] [Up to \$[2,500-\$5,000] per Coverage Period]]

[Organ, Tissue, Bone Marrow Transplants] [Not Applicable] [Up to \$[50,000-\$200,000] for all Covered Expenses] per Coverage Period]]

Outpatient Miscellaneous Medical Expense Services:

[Not Applicable] [Up to \$[1,000-\$100,000] per Coverage Period for all Covered Expenses combined].

**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 AND/OR CHILDREN:

Spouse:

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. Is the proposed insured, spouse, or any dependent child now pregnant? Yes No
3. Have you or any person applying for coverage been declined for health insurance for a condition that is still present? Yes No
4. Are you or any person applying for coverage currently eligible for Medicaid? Yes No
5. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? Yes No
- 6.] 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:

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

..... Yes No

- 7.] 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
- [[8.]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 [8], 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: _____ **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]

[Optional] Supplemental Accidental Injury Benefit Rider

The following is hereby made a part of the Policy and Certificate to which it is attached and is subject to all the provisions of the Policy and Certificate which are not in conflict with the provisions of this Rider. **[This Rider will only be effective if the required premium for these benefits has been paid.]**

Supplemental Accident Benefit..... [100% of the first [\$300] of inpatient or outpatient Covered Expenses Incurred due to Accidental Injury, payable per accident.]

The Company will pay for Covered Expenses incurred due to an Accidental Injury, up to the maximum amount shown above. This benefit is not subject to the Deductible or Coinsurance amounts, The Covered Expenses must be incurred during the Coverage Period and within [90 days] of the accident and the Covered Person must receive the first medical treatment within [72 hours] of the accident and while the Covered Person's coverage is continuously inforce under this Rider. Covered Expenses incurred in excess of the maximum amount shown above and Covered Expenses incurred during the Coverage Period but after [90 days] following the date of the covered Accidental Injury, are payable as any other Covered Expense under the Policy, subject to the Deductible and Coinsurance amounts.

For the purposes of the Rider, Accidental Injury means accidental bodily Injury sustained by a Covered Person, on or after the Effective Date of coverage under this Rider, caused by an outside agent or force, that happens solely, directly, and independently of all other causes.

This Rider is endorsed and made part of the Group Policy and Certificate as of [its Effective Date] [[October 1, 2009] or] [Your Effective Date of coverage] [whichever is later].

Coverage under the Rider will end on the earliest of: the date coverage under the Policy ends; or the end of the Coverage Period; or the date We receive a written request to terminate the Rider].

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK



Rachel Lipari
President



Adam C. Vandervoort
Secretary

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
[485 Madison Avenue, New York, NY 10022]

AMENDATORY ENDORSEMENT

This Amendatory Endorsement made a part of the Group Policy and Certificate to which it is attached. The provisions of this Amendatory Endorsement are effective on the Effective Date stated herein and will expire concurrently with the Group Policy and Certificate unless otherwise terminated. In consideration of issuance, the Group Policy and Certificate is hereby amended and modified, as follows:

Under the Section entitled "Definitions" the following change[s] [is] [are] hereby made:

[1.] The definition of "Deductible" is deleted and replaced with the following:

Deductible. The Deductible means the amount of Covered Expenses that each Covered Person must pay before benefits will be payable. The Deductible amount must be satisfied each Coverage Period. The daily Deductible amount must be satisfied each day, and applies per calendar day regardless of the number of providers rendering services on that day. The applicable Deductible or daily Deductible, as elected by You, is shown in the Schedule.

[2.] The following definition is added:

Copay/Copayment. The Copay/Copayment means the amount the Covered Person must pay to each provider for each service or each supply as specified in the Schedule. If the Covered Person has a Copay, the Copay amount is specified in the Schedule. [Copayments [do not] apply toward the Deductible, Coinsurance or Coinsurance Limit.]

This Rider is endorsed and made part of the Group Policy and Certificate as of [its Effective Date] [[October 1, 2009] or] [Your Effective Date of coverage] [whichever is later].

This Rider is subject to all provisions of the Policy and Certificate which are not in conflict with the provisions of this Amendatory Endorsement. Nothing in this Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK



Rachel Lipari
President



Adam C. Vandervoort
Secretary

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Flesch Certification	Review Status: Approved-Closed	05/28/2009
Comments:		
Attachments:		
SSL STM Readability Certification (041509).pdf		
ARCertificate of Compliance.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	05/28/2009
Comments:		
Attachment:		
SSL-STM-0109-APP (ForFiling{041409}).pdf		
Satisfied -Name: 3rd Party Authorization	Review Status: Approved-Closed	05/28/2009
Comments:		
Attachment:		
SSL Filing Authorization Letter 0309.pdf		
Satisfied -Name: Explanation of Variables	Review Status: Approved-Closed	05/28/2009
Comments:		
Attachment:		
STM Explanation of Variables (General).pdf		
Satisfied -Name: Cover Letter	Review Status: Approved-Closed	05/28/2009
Comments:		
Attachment:		
SSL(AR)filing letter 052009.pdf		

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Product Name: SSL STMP 1104, ET AL
Project Name/Number: /

Satisfied -Name: Original Approval Letter **Review Status:** Approved-Closed 05/28/2009
Comments:
Attachment:
Original Policy Approval.pdf

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

April 15, 2009

READABILITY CERTIFICATION

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

SSL-STM-AE-0409
SSL-ADB-0409

Amendatory Endorsement
Supplemental Accidental Injury Benefit Rider

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-0409

SSL-STM-0109-APP

SSL-ADB-0409

SSL-STM-AE-0409

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

05/20/09
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 AND/OR CHILDREN:

Spouse:

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. Is the proposed insured, spouse, or any dependent child now pregnant? Yes No
3. Have you or any person applying for coverage been declined for health insurance for a condition that is still present? Yes No
4. Are you or any person applying for coverage currently eligible for Medicaid? Yes No
5. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? Yes No
- 6.] 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:

<ul style="list-style-type: none"> ■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent ■ peripheral vascular disease or carotid artery disease ■ stroke or other neurological disorder ■ cancer or tumor 	<ul style="list-style-type: none"> ■ paraplegia, quadriplegia or multiple sclerosis ■ stem cell transplant ■ emphysema or COPD (chronic obstructive pulmonary disease) ■ diabetes ■ liver disorder 	<ul style="list-style-type: none"> ■ kidney disorder other than stones ■ degenerative disc disease or herniated disc ■ rheumatoid or psoriatic arthritis ■ degenerative joint disease of the knees or hips ■ alcohol or drug abuse or dependency ■ hemophilia
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..... Yes No

- 7.] 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
- [[8.]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 [8], 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: _____ **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
EXPLANATION OF VARIABLES**

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:

SCHEDULE OF BENEFITS

Deductible OR Daily Deductible	Range from \$250 - \$25,000 based on the insurer's Plan design
Deductible OR Daily Deductible Family Maximum	a specific monetary amount ranging from \$1,000-\$4,000 OR a range from 1-3x individual (when 2-5 insured individuals in a family satisfy their deductibles, the deductibles for the remaining covered persons are deemed satisfied for the remainder of the coverage period)
Coinsurance Percentage	50% - 100% as elected after payment by the covered person of of either Daily Deductible OR Deductible (depending on election) up to the Coinsurance Limit
Coinsurance Limit	\$4,000 – \$20,000 of covered expenses per covered person or satisfied when 2-5 covered persons each satisfy their individual coinsurance limit.
Coinsurance Percentage Thereafter	50%-100%
Coverage Period Maximum Benefit Amount:	\$100,000 - \$2,000,000
Lifetime Maximum Amount	\$100,000-\$2,000,000 – will either be included or not included, depending on the specific product's plan designs developed by the insurer prior to marketing
Hospital Room, Board and General Nursing Care	Maximum is Not Applicable OR it is applicable Up to the most common Average Semi-Private Room Rate] [up to \$[1,000-\$2,000 per day [and up to the Inpatient Miscellaneous Medical Expense Services maximum benefit]]
Intensive or Specialized Care Unit:	Maximum is Not Applicable OR it is applicable Up to [2-4] times the most common Average Semi-Private Room Rate] [up to \$[1,250-\$2,500] per day [and up to the Inpatient Miscellaneous Medical Expense Services maximum benefit]]
[Emergency Room Treatment:	Maximum is Not Applicable OR it is applicable [Up to \$[500-\$1,000] per day [including the emergency room Doctor charge], [24 hour observation and up to the Inpatient Miscellaneous Medical Expense Services maximum benefit]]]
[Inpatient Doctor Visits:	Maximum is Not Applicable OR it is applicable [Up to \$[500-\$1,500] per each Hospital confinement [and up to the Inpatient Miscellaneous Medical Expense Services maximum benefit.]]

[Inpatient Miscellaneous Medical Expense Services	Maximum is Not Applicable OR it is applicable [Up to \$[500-\$2,500] per day for all Inpatient Covered Expenses combined]]
Doctor Office Visits:	Maximum is Not Applicable OR it is applicable [After \$[25-\$100] Copay] [Up to \$[25-\$100] per office visit [charge] [not to exceed [2-8] visits per Coverage Period.] [The Copay applies to each doctor office visit charge] [Additional Covered Expenses incurred during the office visit including Expenses for laboratory and diagnostic tests, [and Covered Expenses incurred after [2-8] office visits] will be subject to the [Daily Deductible] [Deductible] and Coinsurance] [Once this limit is exceeded [Covered Expenses will be subject to the [Daily Deductible] [Deductible] and Coinsurance, [up to a maximum benefit of \$[1,000-\$2,000] per Covered Person for each Coverage Period]] [expenses incurred for Doctor Office Visits will not be considered Covered Expenses for the balance of that Coverage Period.]
[Outpatient Hospital Surgery or Ambulatory Surgical Center:	Maximum is Not Applicable OR it is applicable [Up to \$[1,000-\$2,000] per day [and up to the Outpatient Miscellaneous Medical Expense Services maximum benefit]]
Surgeon Services	Maximum is Not Applicable OR it is applicable [Up to \$[2,000-\$5,000] per surgery] [and up to the Outpatient Miscellaneous Medical Expense Services maximum benefit]]
Doctor Administering Anesthetics:	Maximum is Not Applicable OR it is applicable [Up to [20%-40%] of the surgeon's benefit]
Assistant Surgeon:	Maximum is Not Applicable OR it is applicable [Up to [20%-40%] of the surgeon's benefit]
Surgeon's Assistant:	Maximum is Not Applicable OR it is applicable [Up to [15%-25%] of the surgeon's benefit]
[The Covered Expenses incurred for [Surgeon Services], [Doctor Administering Anesthetics], [Assistant Surgeon] and [Surgeon's Assistant] are limited to a combined maximum benefit of \$[2,500-\$5,000] per surgery, [not to exceed \$[5,000-\$10,000] per Coverage Period]] – will either be included or not included, depending on the specific product's plan designs developed by the insurer prior to marketing	
Surgery:	Maximum is Not Applicable OR it is applicable [Up to \$[10,000-\$100,000] per [surgery] [Coverage Period]
Ambulance [Ground or Air] Services:	Maximum is Not Applicable OR it is applicable [Up to \$[250-\$2,500] per [occurrence] [Coverage Period] [up to \$[250-\$500] per [occurrence] [Coverage Period] for ground ambulance and \$[500-\$2,500] per [occurrence] [Coverage Period] for air ambulance]
[Acquired Immune Deficiency Syndrome (AIDS)	Maximum is Not Applicable OR it is applicable [Up to \$[10,000-\$20,000] per Coverage Period]]

[Knee Injury or Disorder

Maximum is Not Applicable **OR** it is applicable [Up to \$[2,500-\$5,000] per [Coverage Period] [surgery combined for both left and right knees]]

[Gallbladder Surgery:

Maximum is Not Applicable **OR** it is applicable [Up to \$[2,500-\$5,000] per Coverage Period]]

[Organ, Tissue, Bone
Marrow Transplants

Maximum is Not Applicable **OR** it is applicable [Up to \$[50,000-\$200,000] for all Covered Expenses] per Coverage Period]]

Outpatient Miscellaneous Medical
Covered Expenses

Maximum is Not Applicable **OR** it is applicable [Up to \$[1,000-\$100,000] per Coverage Period or all Covered Expenses combined]. – will either be included or not included, depending on the specific product's plan designs developed by the insurer prior to marketing



May 20, 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, et al

Forms:

Schedule:	SSL-STM-0409
Amendatory Endorsement:	SSL-STM-AE-0409
Supplemental Accidental Injury Benefit Rider:	SSL-ADB-0409
Short Term Medical Insurance Application:	SSL-STM-0109-APP

Dear Commissioner Benafield-Bowman :

The above referenced Short Term Medical Insurance Policy et al, was approved by your Department on January 18, 2005. For your convenience and confirmation, attached is a copy of the Department's January 18, 2005 stamped approval.

We are submitting the above referenced new forms for your review and approval. These four new forms are 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 each form being filed:

Form #SSL-STM-0409 (Schedule). This form is new and will replace the previously filed Schedule. When the Short Term Medical Insurance Policy [form #SSL-STMP-1104] was originally filed, the Schedule was included in the Certificate [form #SSL-STM-1104] as pages 3 and 4. It was necessary to update the Schedule to accommodate additional deductible options and other benefits as requested by the Policyholder and the Insurer and to allow more flexibility for the applicant to select a plan design that best meets his/her needs and budget. The changes were made to the Schedule, including updating the form number for the Schedules to reflect the current date for the updated Schedule. No other changes were made to the original filed Certificate. Although the Certificate has the same form number as the original filed Schedules, the Certificate is not being withdrawn or replaced. Only the Schedule is being replaced.

Form #SSL-STM-AE-0409 (Amendatory Endorsement). This form is new and does not replace any existing form. The Amendatory Endorsement amends the Policy to address the additional deductible and other benefit designs.

Form #SSL-ADB-0409 (Supplemental Accidental Injury Benefit Rider). This form is new and will replace the Supplemental Accidental Rider (#SSL-ADB-1104) previously approved by your Department on January 18, 2005. The original filed/approved Benefit Rider provided a benefit of 100% of coverage up to a benefit maximum for covered expenses received within a specific period (i.e., 90 days) of the accident provided the first treatment is received within a specified time period of the accident. The new Rider was enhanced to clarify that additional covered charges incurred after the Rider's maximum benefit is reached or incurred after the specific time period, that such charges are covered under the Policy, on the same basis as any other covered charge, subject to the insured's selected deductible and coinsurance. It is important to note that while benefits were always processed in this manner, the original Rider did not address how the additional charges were paid. We feel the enhancements to this Rider will be beneficial the insureds.

Form #SSL-STM-0109-APP (Short Term Medical Insurance Application). This form is new and is not intended to replace any form previously approved by your Department.

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

Shellie Howard
Form Development & Compliance Specialist
PH: 602-861-6070
Email: howards@iacusa.com



INSURANCE
COMPLIANCE
CONSULTANTS, INC.

519 Colman Center Drive
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 316-6720

January 4, 2005

Honorable Mike Pickens
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RECEIVED

JAN - 6 2005

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

RE: STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK - NAIC# 69078
FEIN# 13-5679267

Group Short Term Medical Insurance Product Filing

Enclosed Forms:

Group Policy	SSL-STMP-1104
Certificate	SSL-STM-1104
Variable Endorsement	SSL-AE-1104
Accident Rider	SSL-ADB-1104
Application	SSL-STM-1104-APP
Reenrollment Application	SSL-STM-1104-REAPP
Policyholder Application	SSL-STMP-1104-APP
Authorization Letter	

APPROVED

JAN 18 2005

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Dear Commissioner Pickens:

The enclosed forms are being submitted for approval as a Group Short Term Medical product for a group situated outside your state's jurisdiction. The situated state of the group is DC and the forms are being filed simultaneously with your state. These are new forms and not intended to replace any forms previously filed with your Department.

Insurance Compliance Consultants, Inc. has been retained by Standard Security Life Insurance Company of New York to file the above mentioned filing in your state. Please address any future correspondence and/or approvals to my attention at the address shown above.

This product provides short term medical expense coverage to insured members and their dependents. As you know, the Health Insurance Portability and Accountability Act (HIPAA) specifically exempts short-term medical contracts from compliance with any such requirements. Additionally, this product will not be issued to employer groups. Premiums will be paid solely by the individual insured.

The coverage period is for 12-months or less and is non-renewable. The specific benefit design will be elected by the Policyholder. The Policyholder will apply for coverage via the Policyholder Application. Person's who are members of the association will complete the Application and be issued the Certificate.

The Variable Endorsement will be used to make changes within the bracketed areas of the Policy and Certificate after it becomes effective. For example, a benefit maximum may be changed. This would be shown in the Endorsement to add that change to the Policy and Certificate.

Variable text is bracketed and may vary from case-to-case. Amounts may vary, or provisions may be modified, to fit a specific policyholder's request. The bracketed text shows the most restrictive provision that would be offered to the insured. Variable text will never exclude or limit provisions required by your jurisdiction. If a change in a non-variable area is needed, the section will be refiled. We intend to refile only the section being changed and not the entire product.

Please note the following:

- Standard Security Life Insurance Company of New York is domiciled in New York.
- This product will be solicited through properly licensed agents and brokers and/or mass marketed.
- Forms are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, position and format. Printing standards will never be less than that required by your state. We would like to reserve the option of using these forms electronically.

If you have any questions, or need additional information, please contact me by telephone at 815-316-6714 or email at brendadawson@inscompliance.com. My fax number is 815-316-6720. Your immediate consideration of this filing is appreciated.

Sincerely,



Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.

Enclosures