

SERFF Tracking Number: AEGX-126182139 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 42603
Company Tracking Number: TL AR0049515F01
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 AR0049515F01

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Term Life

SERFF Tr Num: AEGX-126182139 State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-
Closed State Tr Num: 42603

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

Co Tr Num: TL AR0049515F01 State Status: Approved-Closed

Filing Type: Form

Author: SPI ADMSLH

Reviewer(s): Linda Bird

Date Submitted: 06/08/2009

Disposition Date: 06/15/2009

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Term Life

Status of Filing in Domicile: Not Filed

Project Number: TL AR0049515F01

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: 06/15/2009

Explanation for Other Group Market Type:

State Status Changed: 06/15/2009

Deemer Date:

Created By: SPI ADMSLH

Submitted By: SPI ADMSLH

Corresponding Filing Tracking Number:

Filing Description:

RE: Application Verification Form SL-T20-0604 APPVER

NAIC # 0468-65021

FEIN: 03-0164230

Dear Analyst:

Attached for your review and approval is a copy of the above captioned form. This form is new and does not replace

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any form previously approved by your Department. This form has been completed in "John Doe" fashion. Variable information is bracketed and printed in red.

Individual Application Verification Form SL-T20-0604 APPVER will be used to solicit Individual term life policies SL-T20-0604 approved by your Department on July 14, 2004 and SL-BT20-1204 AR approved by your Department on January 19, 2005. A copy of the completed application verification form will be issued with a policy when an Insured applies via telemarketing methods.

We request approval of this form in various formats, dimensions, shading and colors. We certify that no dimension, format, shading or color change will affect the text content or product unacceptable print. Completed filing forms are attached.

Sincerely,
 Iris B. Cruver

Company and Contact

Filing Contact Information

Iris Cruver, Filing Specialist icruver@aegonusa.com
 400 Galleria Parkway 678-402-2402 [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

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$20.00	06/08/2009	28434912

SERFF Tracking Number: AEGX-126182139 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	06/15/2009	06/15/2009

SERFF Tracking Number: AEGX-126182139 *State:* Arkansas
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Disposition

Disposition Date: 06/15/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-126182139 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT		Yes
Form	Standard individual application		Yes

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Form Schedule

Lead Form Number: SLA-T20-0604 APPVER

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SLA-T20-0604 APPVER	Application/ Enrollment Form	Standard individual application	Initial		50.100	SLA-T20-0604 APPVER .PDF

**Twenty Year Term Life Insurance
Application Verification**

Keep this form with your insurance Policy. Your acceptance of this offer is on file at our Administrative Office.

This document is a verification record of your telephone-recorded application for the Twenty Year Term Life Insurance plan. It is designed to help you verify that we have correctly recorded your name, address, [date of birth], [gender], [height] and [weight] and the answers and information you provided to the health questions which qualified you for this plan.

Our records indicate the following information:

Name/Address: [John Q. Public]
[1000 Anywhere Street]
[Any Town, USA 75000]

Date of Birth: [01/05/1968] [Gender:] [Male]

[Height:] [5'10"] [Weight:] [185 lbs.]

Will this insurance replace or change any life insurance or annuity contract that you now have? Yes No

Health Questions

1. Have you used any tobacco or nicotine based products within the last 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. In the past 3 years, have you had a driver's license suspended and/or revoked or been cited or arrested for driving while intoxicated (DWI)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. In the past 10 years, has a licensed medical doctor diagnosed you with or treated you for: any disease or disorder of the heart, blood, lungs, liver, kidneys; Acquired Immune Deficiency Syndrome (AIDS); any mental, nervous, circulatory, digestive or immune disorder; high blood pressure, stroke, hepatitis, cancer or tumor, diabetes, drug or alcohol abuse?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Other than those conditions covered in Question 3 during the last three years have you had an examination that was caused by an illness, injury, or abnormal physical condition, or follow-up of a diagnosed condition?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

FULL DETAILS YOU PROVIDED TO QUESTIONS 2, 3, or 4 THAT YOU ANSWERED "YES"

QUES. NO.	REASON OR CONDITION	DATE(S)	RESULTS	NAMES, COMPLETE ADDRESSES AND TELEPHONE NUMBERS OF DOCTORS AND MEDICAL FACILITIES

STONEBRIDGE LIFE INSURANCE COMPANY
Administrative Offices: [Valley Forge, Pennsylvania 19493]

I understand and affirm by my signature below that, to the best of my knowledge and belief, the information in this entire application is true and complete. I understand that if I fail to give true and complete answers on this application, benefits may be denied during the first 2 Policy Years. **I have read the fraud notices on this application and the NOTICE TO APPLICANT enclosed with this form as required by the Fair Credit Reporting Act.** I understand that no insurance is in effect unless the following happens while I am alive. Stonebridge Life: (1) approves this application; and (2) receives the first premium before the effective date.

Authorization for disclosures of medical information to Stonebridge Life Insurance Company

I understand I am not required to sign this authorization; however, without it Stonebridge can not achieve two purposes, (1) its underwriters can not determine my eligibility for insurance; and (2) its claim adjusters may not be able to pay my claim. I authorize any medical practitioner, medical related institution, government agency, paramedic facility, medical record retrieval services, pharmaceutical services, insurance company, reinsurer, plan administrator, the Medical Information Bureau, or any Consumer Reporting Agency, 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 redisclosed, 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; (2) a copy will be sent to me; and (3) I may revoke it in writing at any time by sending written notice to Stonebridge [Valley Forge, Pa. 19493] except to the extent it is already relied upon.

FAILURE TO DISPUTE ANY OF THE STATEMENTS ABOVE IS AN ADMISSION THAT THE STATEMENTS ARE CORRECT. THE FALSITY OF ANY ANSWER MAY BAR YOUR BENEFICIARIES' RIGHT TO RECOVER BENEFITS.

If any of the information is incorrect, contact our Customer Service Department at: [1-800-XXX-XXXX]

[Application signed electronically. Signature on file with the Company] [____ 01/06/2009 ____]
[Applicant's Signature] [Date Application signed]

FOR OHIO RESIDENTS ONLY: Any person who submits an application or files a claim containing a false or deceptive statement with intent to defraud or knowing that he is facilitating a fraud against an insurer is guilty of insurance fraud.

FOR ARKANSAS and LOUISIANA RESIDENTS ONLY: 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.

FOR MAINE RESIDENTS ONLY: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

STONEBRIDGE LIFE INSURANCE COMPANY
Administrative Offices: [Valley Forge, Pennsylvania 19493]

SLA-T20-0604 APPVER

<i>SERFF Tracking Number:</i>	<i>AEGX-126182139</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42603</i>
<i>Company Tracking Number:</i>	<i>TL AR0049515F01</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Term Life</i>		
<i>Project Name/Number:</i>	<i>Term Life/TL AR0049515F01</i>		

Supporting Document Schedules

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

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Not applicable.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: Not applicable.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT		
Comments: NAIC Transmittal		
Attachments: AR - NAIC TRANSMITTAL DOCUMENT.PDF AR - NAIC FORM FILING ATTACHMENT.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
SLA-T20-0604 APPVER	50.1

Signed: 
Name: Iris B. Cruver
Title: Filing Specialist
Date: June 8, 2009

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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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		468	65021	03-0164230	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Iris B. Cruver, AIRC, ACS 400 Galleria Parkway, Suite 1000 Atlanta GA 30339	800-521-1670	678-402-2105	icruver@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): _____
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6. Company Tracking Number	TL AR0049515F01
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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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	L041 Individual Life - Term
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10. Product Coding Matrix Filing Code	L041.213 Specified Age or Duration – Fixed/Indeterminate Premium - Single Life
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11. Submitted Documents	<input checked="" type="checkbox"/> FORMS <input 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 type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	June 8, 2009
13.	Filing Fee (If required)	Amount <u>20.00</u> Check Date <u>EFT</u> Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u>EFT</u>
14.	Date of Domiciliary Approval	N/A
15.	Filing Description:	
	See filing description tab.	

16.	Certification (If required)	
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> .		
Print Name <u>Iris B. Cruver, AIRC, ACS</u>		Title <u>Filing Specialist</u>
Signature <u></u>	Date <u>June 8, 2009</u>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	TL AR0049515F01	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Standard individual application	SLA-T20-0604 APPVER	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input 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 _____	