

SERFF Tracking Number: SNLF-126206563 State: Arkansas
Filing Company: Sun Life Assurance Company of Canada State Tracking Number: 42766
Company Tracking Number: XGR-2775
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: revised AR stop loss application
Project Name/Number: revised AR stop loss application/revised AR stop loss application

Filing at a Glance

Company: Sun Life Assurance Company of Canada

Product Name: revised AR stop loss application SERFF Tr Num: SNLF-126206563 State: ArkansasLH
TOI: H21 Health - Other SERFF Status: Closed State Tr Num: 42766
Sub-TOI: H21.000 Health - Other Co Tr Num: XGR-2775 State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Authors: James Crowley, Lori Disposition Date: 06/29/2009
Chilcote
Date Submitted: 06/26/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: revised AR stop loss application
Project Number: revised AR stop loss application
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type:
Overall Rate Impact:
Filing Status Changed: 06/29/2009

Deemer Date:

Filing Description:

RE: Sun Life Assurance Company of Canada
NAIC #80802 FEIN 38-1082080

Stop Loss Policy Application Form XGR/2775

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Employer
Explanation for Other Group Market Type:
State Status Changed: 06/29/2009
Corresponding Filing Tracking Number:

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Dear Commissioner:

The above form is being submitted for your review and approval. It is a new form and replaces our recently approved application form XGR/2748, approved by your department on June 2, 2009.

As a result of the special Arkansas notice required on the application, our marketing department has asked us to use a different form number for Arkansas, even though the content is identical to that approved recently by your department, so we are filing this form for approval. This application is used to apply for aggregate and specific stop loss coverage to employers who self fund their employees' health benefit plan.

This form is unique to the State of Arkansas, so it has not been filed for approval in our domiciliary state (Michigan).

The filing does not contain any unusual or potentially controversial items from normal entity or industry standards.

The forms submitted:

- are in final print form, subject only to minor variations in color, paper stock, duplexing, shading, fonts and positioning; and
- meet the requirements of the Flesch Readability Test. Enclosed is a certification signed by an officer of our company.

Should you have any questions regarding this filing, please do not hesitate to contact me.

Company and Contact

Filing Contact Information

James Crowley, Compliance Consultant James.Crowley@sunlife.com
175 Addison Road (800) 451-2513 [Phone]
Windsor, CT 06095-0725 (860) 737-6598[FAX]

Filing Company Information

Sun Life Assurance Company of Canada CoCode: 80802 State of Domicile: Michigan
175 Addison Road Group Code: 549 Company Type:
Windsor, CT 06095 Group Name: State ID Number:
(860) 737-1000 ext. [Phone] FEIN Number: 38-1082080

SERFF Tracking Number: SNLF-126206563 *State:* Arkansas
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Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sun Life Assurance Company of Canada	\$20.00	06/26/2009	28828316

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/29/2009	06/29/2009

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Disposition

Disposition Date: 06/29/2009

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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Group Application for Stop Loss	Approved-Closed	Yes

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Form Schedule

Lead Form Number: XGR-2775

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	XGR/2775	Application/Group Enrollment Form	Application for Initial Stop Loss			51	XGR-2775.pdf

Sun Life Assurance Company of Canada

Application for Stop-Loss Insurance



1 Plan Sponsor Information

Full legal name of Plan Sponsor		Policy number (office use only)	
Street address		Policy effective date	
City	State	Zip code	

2 Subsidiaries, Affiliates, Divisions and Locations

Please list all subsidiaries, affiliates, divisions and locations to be covered under the Stop-Loss policy.

Subsidiaries, Affiliates, Divisions and Locations to be covered under this policy:

1.
2.
3.
4.
5.
6.
7.
8.

3 Requested Coverage

Please select the coverages you are applying for.

Specific Benefit

Specific benefit deductible \$	<input type="checkbox"/> Individual <input type="checkbox"/> Family
Specific benefit lifetime maximum eligible expenses \$	
<input type="checkbox"/> Aggregating Specific (if applicable)	Aggregating Specific deductible \$

Aggregate Benefit

Aggregate benefit maximum \$	Aggregate benefit maximum eligible expenses per covered person* \$
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* Individual or family option applies to all selected coverages.

Domiciliary State - Michigan

Continued on next page

4 Proposed Benefits: Rates, Covered Lives and ADFs

Specific benefit premium rates:

Single \$	Family \$	Other \$
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Specific covered benefits:

- Medical including Prescription Drug Medical excluding Prescription Drug

Specific covered employees:

Single	Family	Other
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Aggregate benefit premium rates:

<input type="checkbox"/> Monthly rate \$	<input type="checkbox"/> Other: _____ \$
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Aggregate covered employees:

Single	Family	Other
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Aggregate deductible factors (ADFs):

Covered Benefit	ADF
<input type="checkbox"/> Medical.....	\$
<input type="checkbox"/> Prescription drug plan	\$
<input type="checkbox"/> Dental	\$
<input type="checkbox"/> STD	\$
<input type="checkbox"/> Vision	\$
<input type="checkbox"/> Other	\$

- Monthly Aggregate Accommodation (MAA)

5 Claims Basis

Contract Basis	Specific Benefit	Aggregate Benefit
12/12 Incurred and Paid	<input type="checkbox"/>	<input type="checkbox"/>
15/12 3 Month Run-In.....	<input type="checkbox"/>	<input type="checkbox"/>
18/12 6 Month Run-In.....	<input type="checkbox"/>	<input type="checkbox"/>
24/12 12 Month Run-In.....	<input type="checkbox"/>	<input type="checkbox"/>
12/15 3 Month Run-Out	<input type="checkbox"/>	<input type="checkbox"/>
12/18 6 Month Run-Out	<input type="checkbox"/>	<input type="checkbox"/>
12/24 12 Month Run-Out	<input type="checkbox"/>	<input type="checkbox"/>
Incurred	<input type="checkbox"/>	NA
Paid	NA	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Terminal Liability Option:	<input type="checkbox"/>	<input type="checkbox"/> 3 Months <input type="checkbox"/> Other _____

Continued on next page

6 For Employers Who are Providers of Medical Services Only (i.e., hospitals)

Provide a list of Related Providers in a separate attachment.

The Related Provider Reimbursement Percentage applied to Eligible Claims Expenses for Related Provider Services will be _____ % for the Specific Benefit and _____ % for the Aggregate Benefit.

Note: Any facility, service provider, pharmacy or other vendor which is owned, operated or controlled by the Plan Sponsor, including owned divisions/subsidiaries, will be deemed a Related Provider of the Plan Sponsor.

7 Retiree Information

1. Specific Benefit: Is retiree coverage included?..... No Yes

2. Aggregate Benefit: Is retiree coverage included?..... No Yes

8 Additional Benefits (Must be Underwriting Approved)

These are programs and enhancements to your Stop-Loss coverage.

Clinical Trials Benefit

Elect Decline

No New Special Conditions Rider (i.e., No New Lasers at Renewal)

Elect Decline

9 Medical Management Vendor Information

Note: Any policy issued pursuant to this application is contingent upon the continued administration of the plan by the medical management vendors named below. If you wish to change medical management vendors, you must notify Sun Life Assurance Company of Canada at least 31 days before the effective date of the change. Our prior written agreement is required before the insurance under the Stop-Loss policy will apply to such changes. We reserve the right to recalculate any benefit provisions whenever there is a change in vendors.

List the names of all vendors that provide any form of medical management services to your plan.

Precertification/Utilization review vendor	Neo-natal management program
Case management vendor	PPO network(s)
Pregnancy management vendor	Other(s)

10 Administration Information

Provide contact information for your TPA/ASO provider for claim submissions.

Name of provider			
Provider street address	City	State	Zip code
Name of TPA/ASO claims provider contact			
TPA/ASO claims provider email address		Phone number	

Continued on next page

11 Certification and Signature

Please return this form and all additional required documentation to your Sun Life Financial Group Office.

This Application does not bind coverage. The applicant agrees to provide Sun Life Assurance Company of Canada with a current census of all eligible individuals, disclosure of all special risks on the Special Risk Questionnaire and a complete Plan document no later than the effective date specified in Section 1. Upon approval of this application, Sun Life Assurance Company of Canada will issue a Stop-Loss insurance policy with insurance coverage to become effective on the effective date. This Application will be attached to and made a part of the Stop-Loss policy.

The policy will be void if the applicant has concealed or misrepresented any material fact or circumstance concerning the subject of this application.

I have read the applicable fraud warning shown on page 5.

Name of authorized representative of Plan Sponsor	
Title	
Signature of authorized representative X	Date

Print name of Agent/Broker	
Signature of Agent/Broker X	
Florida agent/broker license ID number (required in Florida only)	Amount paid with this application
Countersigned by licensed resident agent (when required by law) X	\$

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop-loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop-loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop-loss carrier may deny the reimbursement under the stop-loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop-loss policy.

Continued on next page

Fraud Warning

Please read the fraud warning before signing this application.

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 that person to criminal and civil penalties.

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Rate Information

Rate data does NOT apply to filing.

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 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
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Supporting Document Schedules

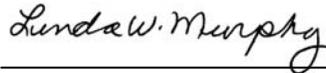
Satisfied -Name:	Flesch Certification	Review Status:	Approved-Closed	06/29/2009
Comments:				
Attachment:	Flesch certification.pdf			
Satisfied -Name:	Application	Review Status:	Approved-Closed	06/29/2009
Comments:				
Attachment:	XGR-2775.pdf			
Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	06/29/2009
Bypass Reason:	n/a. No rate impact			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	06/29/2009
Bypass Reason:	not applicable to this filing.			
Comments:				

CERTIFICATION

This is to certify that the Form Numbers listed below have achieved the following Flesch Reading Ease Scores and comply with the requirements of Arkansas Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form Number</u>	<u>Flesch Readability Score</u>
XGR/2775	50.7

SUN LIFE ASSURANCE COMPANY OF CANADA



Linda W. Murphy
Compliance Officer

June 26, 2009

Sun Life Assurance Company of Canada

Application for Stop-Loss Insurance



1 Plan Sponsor Information

Full legal name of Plan Sponsor		Policy number (office use only)	
Street address		Policy effective date	
City	State	Zip code	

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Please list all subsidiaries, affiliates, divisions and locations to be covered under the Stop-Loss policy.

Subsidiaries, Affiliates, Divisions and Locations to be covered under this policy:

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3 Requested Coverage

Please select the coverages you are applying for.

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Specific benefit deductible \$	<input type="checkbox"/> Individual <input type="checkbox"/> Family
Specific benefit lifetime maximum eligible expenses \$	
<input type="checkbox"/> Aggregating Specific (if applicable)	Aggregating Specific deductible \$

Aggregate Benefit

Aggregate benefit maximum \$	Aggregate benefit maximum eligible expenses per covered person* \$
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--	--

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Covered Benefit	ADF
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12/18 6 Month Run-Out	<input type="checkbox"/>	<input type="checkbox"/>
12/24 12 Month Run-Out	<input type="checkbox"/>	<input type="checkbox"/>
Incurred	<input type="checkbox"/>	NA
Paid	NA	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Terminal Liability Option:	<input type="checkbox"/>	<input type="checkbox"/> 3 Months <input type="checkbox"/> Other _____

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Name of TPA/ASO claims provider contact			
TPA/ASO claims provider email address		Phone number	

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The policy will be void if the applicant has concealed or misrepresented any material fact or circumstance concerning the subject of this application.

I have read the applicable fraud warning shown on page 5.

Name of authorized representative of Plan Sponsor	
Title	
Signature of authorized representative X	Date

Print name of Agent/Broker	
Signature of Agent/Broker X	
Florida agent/broker license ID number (required in Florida only)	Amount paid with this application \$
Countersigned by licensed resident agent (when required by law) X	

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop-loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop-loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop-loss carrier may deny the reimbursement under the stop-loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop-loss policy.

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