

<i>SERFF Tracking Number:</i>	<i>AEGX-126459121</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44611</i>
<i>Company Tracking Number:</i>	<i>HH AR0052415F01</i>		
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Hospital Indemnity</i>		
<i>Project Name/Number:</i>	<i>Hospital Indemnity/HH AR0052415F01</i>		

## Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Hospital Indemnity

SERFF Tr Num: AEGX-126459121 State: Arkansas

TOI: H02G Group Health - Accident Only

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44611

Sub-TOI: H02G.000 Health - Accident Only

Co Tr Num: HH AR0052415F01 State Status: Approved-Closed

Filing Type: Form

Author: SPI ADMSLH

Reviewer(s): Rosalind Minor

Date Submitted: 01/15/2010

Disposition Date: 01/22/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Hospital Indemnity

Status of Filing in Domicile: Not Filed

Project Number: HH AR0052415F01

Date Approved in Domicile:

Requested Filing Mode: Informational

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Discretionary

Filing Status Changed: 01/22/2010

Explanation for Other Group Market Type:

State Status Changed: 01/22/2010

Deemer Date:

Created By: SPI ADMSLH

Submitted By: SPI ADMSLH

Corresponding Filing Tracking Number:

Filing Description:

We are filing for your review and acknowledgement new forms. These forms do not replace any forms previously acknowledged by your Department. The forms have been completed in "John Doe" fashion. Variable information is printed and bracketed in red.

Group Certificate SLHI3000GC is a Group Accident Hospital Confinement Certificate. It provides a benefit for hospital confinement due to an accident resulting in an injury. Other additional benefits include an Accident Intensive Care and Burn Unit Benefit that pays if the covered person is confined to an intensive care or burn unit and an Accident Emergency Facility Benefit that pays for necessary emergency treatment in a hospital emergency room or other emergency facility.

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SLHI3000GP is the Master Policy under which SLHI3000GC certificates will be issued. We plan to issue the Master Policy to various discretionary groups that are situated in Missouri. These forms were approved by Missouri, our Situs State, on December 7, 2009.

Group enrollment forms SLHI3000GE and SLHI3001GE will be used to solicit the Group Hospital Indemnity Certificate. SLHI3000GE will be used for enrollees who are not Medicare eligible and SLHI3001GE will be used for those who are Medicare eligible.

The Flesch scores for SLHI3000GP and SLHI3000GC are 41.6 and 44.3, respectively. The combined scores for SLHI3000GE and SLHI3001GE are 42.9 and 42.8, respectively. Microsoft Word was used to obtain these scores.

We request acknowledgement of the submitted forms in various dimensions, format, shading and colors. No dimension/format/shading/color change would produce unacceptable print.

These forms will be mass marketed by direct mail, telemarketing and possibly on the Internet through our website.

We ask that this filing become effective upon the date of your acknowledgement.

## Company and Contact

### Filing Contact Information

Deborah Yates, Product Filing & Compliance Analyst  
dyates@aegonusa.com  
520 Park Avenue  
Baltimore, MD 21201  
410-209-5269 [Phone]  
410-209-5910 [FAX]

### Filing Company Information

Stonebridge Life Insurance Company  
29 South Main Street  
Rutland, VT 05701-5014  
(410) 685-5500 ext. [Phone]

CoCode: 65021  
Group Code: 468  
Group Name:  
FEIN Number: 03-0164230

State of Domicile: Vermont  
Company Type: Life and Health  
State ID Number:

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No

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Fee Explanation: \$50.00 per filing.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$50.00	01/15/2010	33578176

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/22/2010	01/22/2010



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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Supporting Document	Sample Enrollment Form	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group Accident Hospital Confinement Insurance Policy	Approved-Closed	Yes
Form	Group Accident Hospital Confinement Insurance Certificate of Insurance	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: SLHI3000GP

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/22/2010	SLHI3000G P	Policy/Cont ract/Fratern al	Group Accident Hospital Confinement Insurance Policy Certificate	Initial		41.600	SLHI3000GP. PDF
Approved-Closed 01/22/2010	SLHI3000G C	Certificate	Group Accident Hospital Confinement Insurance Certificate of Insurance	Initial		44.300	SLHI3000GC. PDF
Approved-Closed 01/22/2010	SLHI3000G E	Application/ Enrollment Form	Enrollment Form	Initial		0.000	SLHI3000GE. PDF
Approved-Closed 01/22/2010	SLHI3001G E	Application/ Enrollment Form	Enrollment Form	Initial		0.000	SLHI3001GE. PDF

# Stonebridge Life Insurance Company

A STOCK COMPANY

Home Office: Rutland, Vermont

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

Stonebridge Life Insurance Company  
(Herein called the Company)

Having issued this Policy to

[XYZ Corporation]  
(Herein called Policyholder)

Agrees to pay the benefits herein provided with respect to  
persons Insured hereunder, subject to all terms of this Policy.

This Policy is issued in consideration of the payment of premium [and statements made in the application] herein provided, and shall take effect on [MARCH 1, 2010] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR].

This Policy is issued in the State of Missouri, and its terms shall be construed in accordance with the laws of the State of Missouri.

## RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return the Certificate of Insurance within [30] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded. The certificate will be treated as if it never existed. No benefits will be paid.

The provisions and conditions of this Policy shall form a part of the contract as fully as if recorded in detail above the signatures hereunder affixed.



Secretary



President

Policy No. [XXXXXXXXXX]

GROUP ACCIDENT HOSPITAL CONFINEMENT INSURANCE POLICY

## DEFINITIONS

**INSURED** means each eligible person who has enrolled for coverage as an Insured and whose coverage has become effective.

**COVERED PERSON** means, for coverage purposes only, the Insured and the following persons, provided coverage has become effective:

1. the Insured's spouse; and
2. each of the Insured's children including step-children, children born to the Insured or legally adopted by the Insured, 18 years of age or younger, unmarried and dependent upon the Insured for support and maintenance (An adopted child is a child who is in the Insured's custody pursuant to an interim court order of adoption or placement of adoption); and
3. the Insured's unmarried child 19 years of age but less than 26 years of age if the child is dependent upon the Insured for support and maintenance.

**HOSPITAL** means an institution which meets the following requirements:

1. It is operated pursuant to law; and
2. It is primarily engaged in providing or operating either on its premises or in facilities available to the hospital on a prearranged basis and under supervision of a staff of one or more duly licensed physicians, medical, diagnostic, and major surgery facilities for medical care and treatment of sick and Injured persons on an inpatient basis; and
3. It provides 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

**HOSPITAL** does not include an institution operated primarily as:

1. a convalescent home, convalescent, rest, or nursing facility; or
2. a facility primarily affording custodial or educational care; or
3. a facility for the aged, drug addicts, or alcoholics.

**HOSPITAL** also does not include that part of an institution operated primarily as:

1. a convalescent home, convalescent, rest, or nursing facility; or
2. a facility primarily affording custodial or educational care; or
3. a facility for the aged.

**HOSPITAL CONFINEMENT/CONFINEMENT/CONFINED** means being an inpatient in a Hospital for the necessary care and treatment of an Injury or sickness. Such confinement must be prescribed by a Physician.

Confinement does not include outpatient care and treatment, including outpatient surgery or outpatient observation received in a Hospital.

**INTENSIVE CARE UNIT** means a facility in a Hospital which:

1. provides room and board;
2. provides registered graduate nursing care;
3. requires constant audio visual observation;
4. provides special equipment or supplies at all times on a standby basis; and
5. charges a daily Intensive Care fee.

**BURN UNIT** means a facility in a Hospital which:

1. provides room and board;
2. provides registered graduate nursing care;
3. provides special equipment or supplies at all times on a standby basis; and
4. charges a daily Burn Unit fee.

**PHYSICIAN** means a person who is duly licensed and legally qualified to diagnose and treat sickness and Injuries. Such person must be providing services within the scope of his or her license. A Physician may not be the Insured or a member of the Insured's immediate family.

**INJURY** means bodily harm caused by an accident which occurs while an Insured's Certificate is in force. The Injury must be the direct cause of loss, independent of all other causes. Injury must not be caused by or contributed to by sickness, disease or bodily or mental infirmity.

**INJURED** means having suffered a bodily Injury or trauma in an accident.

**EMERGENCY FACILITY** means a facility licensed, if a license is required, to provide emergency care and staffed by a Physician. The facility can be a clinic, Hospital emergency room, or similar outpatient emergency facility.

**NECESSARY TREATMENT** means medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment or service or expense in connection therewith, which is experimental in nature, is considered Necessary Treatment.

The Company may use peer review organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

If services do not meet these criteria, expenses related to those services will not be deemed "Necessary Treatment".

**[PARTICIPATING GROUP** means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by the Company. The name of such group is shown in the Certificate Schedule of Insurance.]

**[AEGON AFFILIATE** includes Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and Monumental Life Insurance Company.]

## ELIGIBILITY

Each natural person **[AGE 18 THROUGH 64 WHO IS A CREDIT CARDHOLDER (OR THE SPOUSE OF A CREDIT CARDHOLDER AGE 18 THROUGH 64) OF THE POLICYHOLDER]** is eligible to become an Insured. Such persons are herein called eligible persons.

**[No person shall be covered under more than one Certificate of Insurance under this Policy. Each Certificate may cover only one Insured. If a person is recorded by the Company as an Insured under more than one Certificate, such person shall be deemed to be Insured only under the Certificate which affords that person the greatest amount of coverage. Upon discovery of the duplication of coverage, any premium for the duplicate coverage made by, or on behalf of, the Insured will be refunded.]**

In no event will a corporation, partnership, or business entity, other than a natural person, be eligible for insurance.

## WHEN A PERSON BECOMES INSURED

Each Insured will be issued a Certificate of Insurance which will indicate the coverage, the effective date of coverage, and the persons covered.

Each eligible person shall become insured on the effective date shown on the Certificate Schedule of Insurance.

## WHEN A PERSON'S INSURANCE ENDS

An Insured's insurance ends on the last day of the period covered by the last premium contribution.

The Insured may cancel his or her coverage upon notice to the Company. Notice is deemed to be due or given when made in writing or communicated verbally by telephone, in person, or by any other means acceptable to the Company. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

## AMOUNTS OF INSURANCE - SCHEDULE OF INSURANCE

When an eligible person enrolls as an Insured under this Policy, he or she will receive coverage as described in the Coverage section of this Policy. The amounts of insurance for each Covered Person shall be the amount shown on the Certificate Schedule of Insurance issued to each individual Insured.

## COVERAGE

### A. ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT

The Company will pay the Accident Daily Hospital Confinement Benefit stated on the Certificate Schedule of Insurance for each day a Covered Person is Confined to a Hospital for at least 24 hours, provided: 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) such Confinement occurs while the Insured's Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury. The Accident Daily Hospital Confinement Benefit will begin with the first day of Confinement and continue up to the Maximum Accident Daily Hospital Confinement Benefit Period stated on the Schedule of Insurance.

Recurrent Confinements – To be covered, additional Confinements for the same Injury must take place within 90 days of a previously covered Confinement.

### B. ACCIDENT DAILY INTENSIVE CARE/BURN UNIT BENEFIT

In addition to the Daily Hospital Confinement Benefit, the Company will pay the Daily Intensive Care/Burn Unit Benefit stated on the Certificate Schedule of Insurance for each day a Covered Person is Confined to an Intensive Care Unit or a Burn Unit of a Hospital for at least 24 hours, provided: 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) such Confinement occurs while the Insured's Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury. The Accident Daily Intensive Care/Burn Unit Benefit will continue up to the Maximum Accident Daily Intensive Care/Burn Unit Benefit Period stated on the Schedule of Insurance.

Any transfer from an Intensive Care Unit to a Burn Unit or from a Burn Unit to an Intensive Care Unit will not entitle a Covered Person to receive double benefits.

Recurrent Confinements – To be covered, additional Confinements for the same Injury must take place within 90 days of a previously covered Confinement.

### C. ACCIDENT EMERGENCY FACILITY BENEFIT

The Company will pay the Accident Emergency Facility Benefit stated on the Certificate Schedule of Insurance for a visit to a Hospital emergency room or other Emergency Facility for an unlimited number of accidents per Covered Person per year for an Injury. Only one Accident Emergency Facility Benefit is payable for each accident. Treatment must be for necessary emergency treatment of an Injury, and treatment must occur within 72 hours of the accident causing the Injury.

## EXCLUSIONS

No benefit shall be paid for loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane;
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Covered Person's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Covered Person's blood alcohol level being [.08] percent weight by volume or higher;
5. the Covered Person operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Covered Person committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, disease, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

## RENEWAL CONDITIONS

The Insured may keep his or her Certificate in force for as long as he or she lives. The Company does not have the right to:

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

Renewal premiums may not be increased.

When a person is added to or dropped from coverage, the premium amount due as of the next premium due date may be adjusted to reflect the change in coverage. Renewal premiums are due on the first day of each renewal period. The Certificate will expire if the premium is not paid by the end of the Grace Period.

## PREMIUM

[For the [ first month] of coverage, the premium [of \$1.00] will be paid by the Policyholder.] Renewal premiums for Covered Persons are included on the attached rate sheet.

Rates do not increase because of age.

## CONTINUATION OF COVERAGE

In the event of the Insured's death, the covered spouse, if any, shall be deemed the Insured. Otherwise, the coverage will terminate on the next renewal date. If a covered spouse ceases to be the spouse of the Insured for reasons other than the Insured's death, the spouse will no longer be covered as of the next monthly renewal date.

Coverage for any covered child insured under this Policy shall terminate as of the next renewal date after the covered child's marriage or 19<sup>th</sup> birthday. If any covered child is unmarried and dependent upon the Insured for support and maintenance, coverage under this Policy shall terminate as of the next renewal date after the covered child's 26<sup>th</sup> birthday.

A covered child may continue to be covered if upon reaching the limiting age the covered child is, and continues thereafter to be, both:

1. incapable of self-sustaining employment by reason of mental or physical handicap; and
2. dependent upon the Insured for support and maintenance.

The Insured must write and tell the Company a covered child meets the above requirements for Continuation of Coverage. The Company may require periodic proof of continued eligibility for Continuation of Coverage.

## **CONVERSION**

The covered child or spouse whose coverage ceases may apply for his or her own certificate within 31 days after coverage ceases. No evidence of insurability will be required. The new certificate will be issued:

1. on the Company's form at that time with benefits most like but not greater than those of the current Certificate; and
2. at the adult rate for the attained age of the person at that time.

The effective date of Coverage under the new certificate will be the same as the effective date of the conversion. The Company will not pay under the new certificate for any loss for which benefits have been paid under the current Certificate.

## **NEWBORN CHILDREN**

If the Insured's spouse or any children are already covered under the Insured's Certificate and a child is born to the Insured, the benefit amount for the newborn child will be the same as for other children. If no other child is covered under the Insured's Certificate, the benefit will be the amount which would have been issued to children as of the effective date of the Insured's Certificate.

If neither the Insured's spouse nor another child is covered under the Certificate, the Insured must notify the Company of the birth of a child if the Insured wishes to add child coverage. There will be an increase in the premium as of the next monthly renewal date after the Company has been notified of the child's birth. The child is covered free from the time of notification until that date. The child will be dropped from coverage if the increased premium is not paid within 31 days after that due date. The child's benefit will be the amount which would have been issued to children as of the effective date of the Insured's Certificate.

## **GENERAL PROVISIONS**

### **ENTIRE CONTRACT**

This Policy is issued in consideration of the application and payment of the premium. Insureds' Certificates are furnished in accordance with and subject to the terms of the Policy. Certificates are not part of the Policy, but are evidence of the insurance provided under this Policy. This Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

Any change in this Policy must be in the form of an amendment or endorsement signed by one of the officers of the Company. Agreements made by the Policyholder and the Company in this manner will be binding on all persons insured. Certificate anniversaries are measured from the Certificate effective date.

### **INCONTESTABILITY**

The Company cannot contest an Insured's Certificate except for fraud or for not paying premiums.

## **INFORMATION TO BE FURNISHED**

The Policyholder shall furnish the Company with any information required to administer this Policy. The Company shall have the right to inspect any record of the Policyholder or in possession of the Policyholder which relates to this Policy.

## **CLERICAL ERROR**

A clerical error in the records relative to this insurance shall not invalidate insurance or cause insurance to be in force or to continue in force. Upon discovery of such error, an equitable adjustment shall be made in the premium.

## **INSURED'S CERTIFICATE**

The Company will issue an individual Certificate to each Insured. The Certificate will describe the insurance coverage and state to whom the benefits will be paid.

## **PAYMENT OF PREMIUM**

All premiums due by the terms of this Policy shall be paid by the Policyholder to the Administrative Office of the Company on or prior to the day they are due.

[For the first month of coverage, the premium [of \$1.00] will be paid by the Policyholder.]

Insureds are required to contribute 100 percent of the premium payable under this Policy for their Certificates [after the first month]. If at any time the Policyholder refuses to accept such contributions and pay the premium for the Insured, the Insured may pay such premium directly to the Administrative Office of the Company on or prior to the day it is due.

## **GRACE PERIOD**

If a premium is not paid when due, the insurance shall be in default. The Company will allow a 31 day Grace Period to pay each premium after the first one. If a premium is not paid on or before the end of the Grace Period, the insurance shall terminate effective the last day of the period covered by the last premium contribution.

## **REINSTATEMENT**

The Insured's Certificate will lapse if the Insured does not pay his or her premium before the end of the Grace Period. If the Company later accepts a premium and does not require an application for reinstatement, that payment will put the Certificate back in force. If the Company requires an application for reinstatement, the Certificate will be put back in force when the Company approves it. If the Company does not approve it, the Certificate will be put back in force on the 45<sup>th</sup> day after the date of application for reinstatement, unless the Company gives the Insured prior written notice of its disapproval.

The reinstated Certificate covers only loss due to an Injury caused by an accident that occurs after the date of reinstatement. In all other respects, the Company and the Insured have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

## **NOTICE OF CLAIM**

Written Notice of Claim must be given to the Company within 30 days after any loss covered under this Policy occurs or as soon as possible thereafter. The Insured may give the notice or may have someone do it for him or her. The notice should include the Insured's name and Certificate number as shown on the Certificate Schedule of Insurance. Notice should be mailed to the Company at its administrative office.

## **CLAIM FORMS**

When the Company receives the Notice of Claim, the Company will send the claimant forms for filing Proof of Loss. If the Company does not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing the Company with a written statement describing what happened. The Company must receive this statement within the time given for filing Proof of Loss.

## **PROOF OF LOSS**

Written Proof of Loss must be given to the Company within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

## **MISSTATEMENT OF AGE**

If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, the Company accepts a premium for any period when coverage would not normally have been in effect, then the Company's liability for such period shall be a refund, upon request, of all premiums paid for such period.

## **TIME OF PAYMENT OF CLAIMS**

The Company will pay all benefits covered by this Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

## **PAYMENT OF CLAIMS**

Any benefits payable will be paid to the Insured, if living. Any other benefits unpaid at death may be paid as follows:

1. At the Insured's death
  - a. to the Insured's spouse, if living;
  - b. otherwise, equally to the Insured's then living lawful children, including adopted children, if any;
  - c. otherwise, equally to the Insured's then living parents or parent;
  - d. otherwise, to the Insured's estate.
2. At the death of any other Covered Person
  - a. to the Insured, if then living;
  - b. otherwise, as though it were payable under (1) above.

## **PHYSICAL EXAM AND AUTOPSY**

The Company, at its own expense, shall have the right to examine a Covered Person when and as often as is reasonable while a claim is pending. The Company may also have an autopsy done in case of death where it is not forbidden by law.

## **LEGAL ACTIONS**

No action can be brought to recover on this 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.

## **[OTHER INSURANCE**

If a Covered Person is insured under more than one [accident hospital confinement] policy or certificate in effect with this Company or any Aegon Affiliates at any one time, the Company's maximum liability is limited to [a total of [ten] certificates and policies with all Aegon Affiliates.] [the lesser of the total amount of benefits payable under all such policies and certificates or [\$1,000,000]]. Upon discovery of duplication in excess of the Company's maximum liability, the Company will refund all premiums paid for all such policies or certificates. The excess will be voided and all premiums paid for such excess shall be returned to the Insured or to the Insured's beneficiary.]

# Stonebridge Life Insurance Company

A STOCK COMPANY  
Home Office: Rutland, Vermont  
Administrative Office: [2700 West Plano Parkway  
Plano, Texas 75075]

## CERTIFICATE OF INSURANCE

Person(s) insured and benefits are shown on the Schedule of Insurance of this Certificate.

Stonebridge Life Insurance Company (herein called "we," "us" or "our") has issued Policy No. [XXXXXX] to [XYZ COMPANY] (herein called "Policyholder") which makes available accident hospital insurance for eligible persons.

We agree to pay the benefits herein provided with respect to the person(s) insured hereunder, subject to all terms of the Policy.

### RIGHT TO EXAMINE CERTIFICATE

If you are not satisfied with this insurance, you may void it by returning this Certificate within [30] days after you receive it to our Administrative Office. You will receive a full refund of any premium you have paid. The Certificate will be treated as if it never existed. No benefits will be paid.

[This Certificate supersedes any Certificate previously issued to you under the Policy. You and any Covered Person may qualify under one Certificate only. If any person is insured under more than one Certificate, we will consider that person to be insured under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, we will refund any duplicated payments which may have been made on behalf of that person.]

The records maintained by the [Policyholder/Participating Group] shall determine the insurance provided under the Policy for any Insured. Important provisions of the Policy are outlined herein.



Secretary



President

### INSURED:

[John Doe  
123 Any Street  
Anytown, USA 12345]

### CERTIFICATE NUMBER:

[12345678]

### GROUP ACCIDENT HOSPITAL CONFINEMENT INSURANCE

## DEFINITIONS

**INSURED** (herein called "you," "your," or "yours") means you, the Insured named on the Schedule of Insurance, provided coverage has become effective.

**COVERED PERSON** means, for coverage purposes only, you and the following persons, provided coverage has become effective:

1. your spouse; and
2. each of your children including step-children, children born to you or legally adopted by you, 18 years of age or younger, unmarried and dependent upon you for support and maintenance (An adopted child is a child who is in your custody pursuant to an interim court order of adoption or placement of adoption); and
3. your unmarried child 19 years of age but less than 26 years of age if the child is dependent upon you for support and maintenance.

**HOSPITAL** means an institution which meets the following requirements:

1. It is operated pursuant to law; and
2. It is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a prearranged basis and under supervision of a staff of one or more duly licensed Physicians, medical, diagnostic, and major surgical facilities for medical care and treatment of sick and Injured persons on an inpatient basis; and
3. It provides 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s)

**HOSPITAL** does not include an institution operated primarily as:

1. a convalescent home, convalescent, rest, or nursing facility; or
2. a facility primarily affording custodial or educational care; or
3. a facility for the aged, drug addicts, or alcoholics.

**HOSPITAL** also does not include that part of an institution operated primarily as:

1. a convalescent home, convalescent, rest, or nursing facility; or
2. a facility primarily affording custodial or educational care; or
3. a facility for the aged.

**HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED** means being an inpatient in a Hospital for necessary care and treatment of an Injury. Such Confinement must be prescribed by a Physician.

Confinement does not include outpatient care and treatment, including Outpatient surgery or Outpatient observation received in a Hospital.

**INTENSIVE CARE UNIT** means a facility in a Hospital which:

1. provides room and board;
2. provides registered graduate nursing care;
3. requires constant audio visual observation;
4. provides special equipment or supplies at all times on a standby basis; and
5. charges a daily Intensive Care fee.

**BURN UNIT** means a facility in a Hospital which:

1. provides room and board;
2. provides registered graduate nursing care;
3. provides special equipment or supplies at all times on a standby basis; and
4. charges a daily Burn Unit fee.

**PHYSICIAN** means a person who is duly licensed and legally qualified to diagnose and treat sickness and Injuries. Such person must be providing services within the scope of his or her license. A Physician may not be you or a member of your immediate family.

**INJURY** means bodily harm caused by an accident which occurs while this Certificate is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by sickness, disease or bodily or mental infirmity.

**INJURED** means having suffered a bodily Injury or trauma in an accident.

**EMERGENCY FACILITY** means a facility licensed, if a license is required, to provide emergency care and staffed by a Physician. The facility can be a clinic, Hospital emergency room, or similar outpatient emergency facility.

**NECESSARY TREATMENT** means medical treatment which is consistent with currently accepted medical practice. Any Confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment or service or expense in connection therewith, which is experimental in nature, is considered Necessary Treatment.

We may use peer review organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

If services do not meet these criteria, expenses related to those services will not be deemed Necessary Treatment.

**[PARTICIPATING GROUP** means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by us. The name of such group is shown in the Schedule of Insurance.]

**AFFILIATE** includes Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and Monumental Life Insurance Company.]

## **WHEN YOUR INSURANCE BEGINS**

Issuance of a Certificate is not a waiver of any of the following conditions:

Each eligible person will become insured under this Certificate at 12:01 a.m., Standard Time on the Certificate Effective Date following acceptance by us of the enrollment form, if required, and upon receipt of the first premium [before][within 21 days of] the Certificate Effective Date. The premium and the Effective Date of Coverage are shown on the Certificate Schedule of Insurance.

Newborn children are covered immediately from birth. Any required premium must be paid within 31 days. See the Newborn Children provision.

## **WHEN YOUR INSURANCE ENDS**

Your insurance ends on the last day of the period covered by your last premium contribution.

You may cancel your coverage 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.

## **COVERAGE**

### **A. ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT**

We will pay the Accident Daily Hospital Confinement Benefit stated on the Schedule of Insurance for each day a Covered Person is Confined to a Hospital for at least 24 hours, provided: 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) such Confinement occurs while this Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury. The Accident Daily Hospital Confinement Benefit will begin with the first day of Confinement and continue up to the Maximum Accident Daily Hospital Confinement Benefit Period stated on the Schedule of Insurance.

Recurrent Confinements – To be covered, additional Confinements for the same Injury must take place within 90 days of a previously covered Confinement.

### **B. ACCIDENT DAILY INTENSIVE CARE/BURN UNIT BENEFIT**

In addition to the Accident Daily Hospital Confinement Benefit, we will pay the Accident Daily Intensive Care/Burn Unit Benefit stated on the Schedule of Insurance for each day a Covered Person is Confined to an Intensive Care Unit or a Burn Unit of a Hospital for at least 24 hours, provided: 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) such Confinement occurs while this Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury. The Accident Daily Intensive Care/Burn Unit Benefit will continue up to the Maximum Accident Daily Intensive Care/Burn Unit Benefit Period stated on the Schedule of Insurance.

Any transfer from an Intensive Care Unit to a Burn Unit or from a Burn Unit to an Intensive Care Unit will not entitle a Covered Person to receive double benefits.

Recurrent Confinements – To be covered, additional Confinements for the same Injury must take place within 90 days of a previously covered Confinement.

### **C. ACCIDENT EMERGENCY FACILITY BENEFIT**

We will pay the Accident Emergency Facility Benefit stated on the Schedule of Insurance for a visit to a Hospital emergency room or other Emergency Facility for an unlimited number of accidents per Covered Person per year for an Injury. Only one Accident Emergency Facility Benefit is payable for each accident. Treatment must be for necessary emergency treatment of an Injury, and treatment must occur within 72 hours of the accident causing the Injury.

## **EXCLUSIONS**

No benefit shall be paid for loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane;
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Covered Person's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Covered Person's blood alcohol level being [.08] percent weight by volume or higher;
5. the Covered Person operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Covered Person committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, disease, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

## **RENEWAL CONDITIONS**

You may keep this Certificate in force for as long as you live. 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 date due or within the Grace Period.

Renewal premiums may not be increased.

If a person is added to or removed from coverage, the premium amount may be adjusted to reflect the change in coverage. Renewal premiums are due on the first day of each renewal period. Your coverage will expire if the premium is not paid by the end of the Grace Period.

## **CONTINUATION OF COVERAGE**

In the event of your death, your covered spouse, if any, shall be deemed the Insured. Otherwise, the coverage will terminate on the next renewal date. If your spouse ceases to be your spouse for reasons other than your death, your spouse will no longer be covered as of the next monthly renewal date.

Coverage for any covered child insured under this Certificate shall terminate as of the next renewal date after the covered child's marriage or 19<sup>th</sup> birthday. If any covered child is unmarried and dependent upon you for support and maintenance, coverage under this Certificate shall terminate as of the next renewal date after the covered child's 26<sup>th</sup> birthday.

A covered child may continue to be covered if upon reaching the limiting age the covered child is, and continues thereafter to be, both:

1. incapable of self-sustaining employment by reason of mental or physical handicap; and
2. chiefly dependent upon you for support and maintenance.

You must write and tell us a covered child meets the above requirements for Continuation of Coverage. We may require periodic proof of continued eligibility for Continuation of Coverage.

## **CONVERSION**

The covered child or spouse whose coverage ceases may apply for his or her own Certificate within 31 days after coverage ceases. No evidence of insurability will be required. The new Certificate will be issued:

1. on a form available at that time with benefits most like but not greater than those of this Certificate; and
2. at the adult rate for the attained age of the person at that time.

The effective date of coverage under the new Certificate will be the same as the effective date of the conversion. We will not pay under the new Certificate for any loss for which benefits have been paid under this Certificate.

## **NEWBORN CHILDREN**

If your spouse or any children are already covered under this Certificate and a child is born to you, the benefit amount for the newborn child will be the same as for other children. If no other child is covered under this Certificate, the benefit will be the amount which would have been issued to children as of the effective date of this Certificate.

If neither your spouse nor another child is covered under this Certificate, you must notify us of the birth of a child if you wish to add child coverage. There will be an increase in the premium as of the next monthly renewal date after we have been notified of the child's birth. The child is covered free from the time of notification until that date. The child will be dropped from coverage if the increased premium is not paid within 31 days after that due date. The child's benefit will be the amount which would have been issued to children as of the effective date of this Certificate.

## GENERAL PROVISIONS

### ENTIRE CONTRACT

Your Certificate is furnished in accordance with and subject to the terms of the Policy. It is not part of the Policy, but it is evidence of the insurance provided under the Policy. The Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

### INCONTESTABILITY

We cannot contest this Certificate except for fraud or for not paying premiums.

### PAYMENT OF PREMIUM

All premiums due by the terms of the Policy shall be paid by the [Policyholder/Participating Group] to our Administrative Office on or prior to the day they are due.

[For the first month of coverage, the premium will be paid by the Policyholder/Participating Group.]

You are required to contribute 100 percent of the premium payable under this Certificate [after the [first] month]. If at any time the [Policyholder/Participating Group] refuses to accept such contributions and pay the premium for you, you may pay such premium directly to our Administrative Office on or prior to the day it is due.

### GRACE PERIOD

If a premium is not paid when due, the insurance shall be in default. We will allow a 31 day Grace Period to pay each premium after the first one. If a premium is not paid on or before the end of the Grace Period, the insurance shall terminate, effective the last day of the period covered by your last premium contribution.

### MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium 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, upon request, of all premiums paid for such period.

### REINSTATEMENT

Your Certificate will lapse if you do not pay your premium before the end of the Grace Period. If we later accept a premium and do not require an application for reinstatement, that payment will put the Certificate back in force. If we require an application for reinstatement, this Certificate will be put back in force when we approve it and the required premium is received. If we do not approve it, the Certificate will be put back in force on the 45<sup>th</sup> day after the date of application for reinstatement, unless we give you prior written notice of its disapproval.

The reinstated Certificate only covers loss due to an Injury caused by an accident that occurs after the date of reinstatement. In all other respects, you and we have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

### NOTICE OF CLAIM

Written Notice of Claim must be given to us within 30 days after any loss covered under the Policy occurs or as soon as possible thereafter. You may give the notice or may have someone do it for you. The notice should include your name and Certificate Number as shown on the Schedule of Insurance. Notice should be mailed to us at our Administrative Office.

### CLAIM FORMS

When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing us with a written statement describing what happened. We must receive this statement within the time given for filing Proof of Loss.

## **PROOF OF LOSS**

Written Proof of Loss must be given to us within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

## **TIME OF PAYMENT OF CLAIMS**

We will pay all benefits covered by the Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

## **PAYMENT OF CLAIMS**

Any benefits payable will be paid to you, if living. Any other benefits unpaid at death will be paid as follows:

1. At your death
  - a. to your spouse, if living;
  - b. otherwise, equally to your then living lawful children, including adopted children, if any;
  - c. otherwise, equally to your then living parents or parent;
  - d. otherwise, to your estate.
2. At the death of any other Covered Person
  - a. to you, if then living;
  - b. otherwise, as though it were payable under (1) above.

## **PHYSICAL EXAM AND AUTOPSY**

At our expense, we shall have the right to examine a Covered Person when and as often as is reasonable while a claim is pending. We may also have an autopsy done in case of death where it is not forbidden by law.

## **LEGAL ACTIONS**

No action can be brought to recover on this Certificate 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.

## **[OTHER INSURANCE**

If a Covered Person is insured under more than one [accidental hospital confinement] policy or certificate in effect with us or any Aegon Affiliate at any one time, our maximum liability is limited to [a total of [ten] certificates and policies with all Aegon Affiliates.] [the lesser of the total amount of benefits payable under all such policies and certificates or [\$1,000,000]]. Upon discovery of duplication in excess of our maximum liability, we will refund all premiums paid for all such policies or certificates. The excess will be voided and all premiums paid for such excess shall be returned to you or to your beneficiary.]



## Group Accident Hospital Confinement Indemnity Plan

\$8.95 per month for me only].     \$11.95 per month for me and my eligible family members.]

I understand that in order to enroll for Group Accident Hospital Confinement coverage under the Group Policy issued to [XYZ Corporation., I must be a XYZ Corporation Credit Cardholder or the spouse of a XYZ Corporation Credit Cardholder, age 18 through-64], and reside in a state in which this product may legally be offered. My coverage can never be canceled as long as I pay my premiums. My coverage will become effective on the date stated on my Certificate Schedule of Insurance. By signing below, I certify that I am not currently eligible to receive Medicare benefits [I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

[By signing below, I certify that I understand coverage for Accident Hospital Confinement Indemnity Insurance is limited to the lesser of the total amount of benefits payable under all policies and certificates with this Company, Monumental Life Insurance Company, Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company or [\$1,000,000].

By signing below, I certify that I am not currently eligible to receive Medicare benefits.

Name: [Joan Q. Public] Date of Birth: [01/01/1955]  
Address: [123 Any State] Home Telephone: [123-456-7890]  
[Any City, IL 12345] [ Email: \_\_\_\_\_ ]  
 Male     Female

X| \_\_\_\_\_ |  
Required Signature

| \_\_\_\_\_ |  
Date Month    Day    Year

SLHI3000GE

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

[01G  
NAA99  
]

**[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, 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 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.]

## Group Accident Hospital Confinement Indemnity Plan

\$8.95 per month for me only].    [  \$11.95 per month for me and my eligible family members].

I understand that in order to enroll for Group Accident Hospital Confinement coverage under the Group Policy issued to [XYZ Corporation., I must be a XYZ Corporation Cardholder or the spouse of a XYZ Corporation Cardholder, age 18 through 64], and reside in a state in which this product may legally be offered. My coverage can never be canceled as long as I pay my premiums. My coverage will become effective on the date stated on my Certificate Schedule of Insurance. By signing below, I certify that I am currently eligible to receive Medicare benefits and have received a special notice regarding this product and Medicare benefits. [I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

[By signing below, I certify that I understand coverage for Accident Hospital Confinement Indemnity Insurance is limited to the lesser of the total amount of benefits payable under all policies and certificates with this Company, Monumental Life Insurance Company, Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company or [\$1,000,000].

Name: [Joan Q. Public] Date of Birth: [01/01/1955]  
Address: [123 Any State] Home Telephone: [123-456-7890]  
[Any City, IL 12345] [ Email: \_\_\_\_\_ ]  
 Male     Female

\_\_\_\_\_  
Required Signature

\_\_\_\_\_  
Date    Month    Day    Year

SLHI3001GE

**Stonebridge Life Insurance Company**

Home Office: Rutland, Vermont

Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

[01G  
NAA99]

**[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, 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 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.]

SERFF Tracking Number: AEGX-126459121  
Filing Company: Stonebridge Life Insurance Company  
Company Tracking Number: HH AR0052415F01  
TOI: H02G Group Health - Accident Only  
Product Name: Hospital Indemnity  
Project Name/Number: Hospital Indemnity/HH AR0052415F01

State: Arkansas  
State Tracking Number: 44611  
Sub-TOI: H02G.000 Health - Accident Only

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> AR - READABILITY CERTIFICATION <b>Attachment:</b> AR - READABILITY CERTIFICATION.PDF	Approved-Closed	01/22/2010
<b>Satisfied - Item:</b> AR - NAIC TRANSMITTAL DOCUMENT <b>Comments:</b> AR - NAIC TRANSMITTAL DOCUMENT <b>Attachment:</b> AR - NAIC TRANSMITTAL DOCUMENT.PDF	Approved-Closed	01/22/2010
<b>Satisfied - Item:</b> AR - NAIC FORM FILING ATTACHMENT <b>Comments:</b> AR - NAIC FORM FILING ATTACHMENT <b>Attachment:</b> AR - NAIC FORM FILING ATTACHMENT.PDF	Approved-Closed	01/22/2010
<b>Satisfied - Item:</b> Cover Letter <b>Comments:</b> Cover Letter <b>Attachment:</b> Cover Letter.PDF	Approved-Closed	01/22/2010

SERFF Tracking Number: AEGX-126459121 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 44611  
 Company Tracking Number: HH AR0052415F01  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Hospital Indemnity  
 Project Name/Number: Hospital Indemnity/HH AR0052415F01

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Explanation of Variables <b>Comments:</b> Explanation of Variables <b>Attachment:</b> Explanation of Variables.PDF	Approved-Closed	01/22/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Sample Enrollment Form <b>Comments:</b> Sample Enrollment Form <b>Attachment:</b> Sample Enrollment Form.PDF	Approved-Closed	01/22/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> Attached to Forms Schedule	Approved-Closed	01/22/2010

**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.

<b>Form Number</b>	<b>Score</b>
SLHI3000GP	41.6
SLHI3000GC	44.3
SLHI3000GE	0
SLHI3001GE	0

Signed:   
Name: Cheryl Penner  
Title: Assistant Secretary  
  
Date: January 15, 2010

**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

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	Life, Accident and Health	468	65021	03-0164230	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Deborah A. Yates 520 Park Avenue Baltimore MD 21201	800-233-4624	410-209-5910	dyates@aegonusa.com

5. Requested Filing Mode	<input type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input checked="" type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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<b>6. Company Tracking Number</b>	HH AR0052415F01
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<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b> Previous file # _____
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<b>8. Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input checked="" type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

<b>9. Type of Insurance</b>	H02G Group Health - Accident Only
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<b>10. Product Coding Matrix Filing Code</b>	H02G.000 Health - Accident Only
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<b>11. Submitted Documents</b>	<input type="checkbox"/> <b>FORMS</b> <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" 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"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate
	<input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____
	<b>SUPPORTING DOCUMENTATION</b> <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 type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____

<b>12.</b>	<b>Filing Submission Date</b>	January 15, 2010
<b>13.</b>	<b>Filing Fee (If required)</b>	Amount <u>\$50.00</u> Check Date <u>N/A - EFT</u> Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u>N/A - EFT</u>
<b>14.</b>	<b>Date of Domiciliary Approval</b>	Not Filed
<b>15.</b>	<b>Filing Description:</b>	
	<p>We are filing for your review and acknowledgement new forms. These forms do not replace any forms previously acknowledged by your Department. The forms have been completed in "John Doe" fashion. Variable information is printed and bracketed in red.</p> <p>Group Certificate SLHI3000GC is a Group Accident Hospital Confinement Certificate. It provides a benefit for hospital confinement due to an accident resulting in an injury. Other additional benefits include an Accident Intensive Care and Burn Unit Benefit that pays if the covered person is confined to an intensive care or burn unit and an Accident Emergency Facility Benefit that pays for necessary emergency treatment in a hospital emergency room or other emergency facility.</p> <p>SLHI3000GP is the Master Policy under which SLHI3000GC certificates will be issued. We plan to issue the Master Policy to various discretionary groups that are situated in Missouri. These forms were approved by Missouri, our Situs State, on December 7, 2009.</p> <p>Group enrollment forms SLHI3000GE and SLHI3001GE will be used to solicit the Group Hospital Indemnity Certificate. SLHI3000GE will be used for enrollees who are not Medicare eligible and SLHI3001GE will be used for those who are Medicare eligible.</p> <p>The Flesch scores for SLHI3000GP and SLHI3000GC are 41.6 and 44.3, respectively. The combined scores for SLHI3000GE and SLHI3001GE are 42.9 and 42.8, respectively. Microsoft Word was used to obtain these scores.</p> <p>We request acknowledgement of the submitted forms in various dimensions, format, shading and colors. No dimension/format/shading/color change would produce unacceptable print.</p> <p>These forms will be mass marketed by direct mail, telemarketing and possibly on the Internet through our website.</p> <p>We ask that this filing become effective upon the date of your acknowledgement.</p>	

<b>16.</b>	<b>Certification (If required)</b>	
	<p><b>I HEREBY CERTIFY</b> 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>Deborah A. Yates</u> Title <u>Product Filing &amp; Compliance Analyst</u></p> <p>Signature <u></u> Date <u>January 15, 2010</u></p>	

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>	HH AR0052415F01	
<b>This filing corresponds to rate filing company tracking number</b>	N/A	

	<b>Document Name</b>	<b>Form Number</b>		<b>Replaced Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	Group Accident Hospital Confinement Insurance Policy	SLHI3000GP	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	N/A - new
02	Group Accident Hospital Confinement Insurance Certificate of Insurance	SLHI3000GC	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	N/A - new
03	Enrollment Form	SLHI3000GE	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	N/A - new
04	Enrollment Form	SLHI3001GE	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	N/A - new
05			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
06			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
07			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
08			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
09			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
10			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
11			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	



Insurance Company

2700 West Plano Parkway • Plano, Texas 75075-8200

January 15, 2010

Honorable Jay Bradford  
Commissioner of Insurance  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904

Re: Stonebridge Life Insurance Company  
NAIC #: 65021 FEIN: 03-0164230  
SLHI3000GP- Group Accident Hospital Confinement Master Policy  
SLHI3000GC - Group Accident Hospital Confinement Certificate  
SLHI3000GE – Group Enrollment Form  
SLHI3001GE – Group Enrollment Form

Dear Commissioner:

The above-captioned forms are attached for your review and acknowledgement. These forms are new and do not replace any forms previously acknowledged by your Department. The forms have been completed in “John Doe” fashion. Variable information is printed and bracketed in red.

Group Certificate SLHI3000GC is a Group Accident Hospital Confinement Certificate. It provides a benefit for hospital confinement due to an accident resulting in an injury. Other additional benefits include an Accident Intensive Care and Burn Unit Benefit that pays if the covered person is confined to an intensive care or burn unit and an Accident Emergency Facility Benefit that pays for necessary emergency treatment in a hospital emergency room or other emergency facility.

SLHI3000GP is the Master Policy under which SLHI3000GC certificates will be issued. We plan to issue the Master Policy to various discretionary groups that are situated in Missouri. These forms were approved by Missouri, our Situs State, on December 7, 2009.

Group enrollment forms SLHI3000GE and SLHI3001GE will be used to solicit the Group Hospital Indemnity Certificate. SLHI3000GE will be used for enrollees who are not Medicare eligible and SLHI3001GE will be used for those who are Medicare eligible.

The Flesch scores for SLHI3000GP and SLHI3000GC are 41.6 and 44.3, respectively. The combined scores for SLHI3000GE and SLHI3001GE are 42.9 and 42.8, respectively. Microsoft Word was used to obtain these scores.

We request acknowledgement of the submitted forms in various dimensions, format, shading and colors. No dimension/format/shading/color change would produce unacceptable print.

These forms will be mass marketed by direct mail, telemarketing and possibly on the Internet through our website.

We ask that this filing become effective upon the date of your acknowledgement.

We respectfully request your favorable review and acknowledgement. Should you have any questions, please contact us.

Sincerely,

Deborah Yates  
Product Filing & Compliance Analyst  
Product Filing and Compliance Department  
Phone: 410-209-5269  
Toll Free: 800-233-4624, Extension 5269  
Fax 410-209-5910  
Email: dyates@aegonusa.com

## EXPLANATION OF VARIABLES

The following is an explanation of the variables indicated in the submitted forms.

### GROUP ACCIDENT HOSPITAL POLICY SLHI3000GP:

Page 1

1. **COMPANY ADDRESS:** Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

2700 West Plano Parkway  
Plano, Texas 75075-8200

520 Park Avenue  
Baltimore, Maryland 21201

Valley Forge, Pennsylvania 19493

2. Policy effective date, anniversary and policy number will vary according to Policyholder.
3. Right to Examine period may be 30, 60 or 90 days at the determination of the policyholder.

Page 3

1. **DEFINITIONS:** The definition of Participating Group will be included when the coverage is issued to a group that elects to participate in a group trust.
2. **DEFINITIONS:** The definition of Aegon Affiliate may change when companies are added or deleted.
3. **ELIGIBILITY:** Eligibility will vary based on group policyholder to which the policy is issued.

Page 5

1. **ACCIDENTAL DEATH EXCLUSIONS:** Exclusion #4: The percent of the blood alcohol level is variable to enable changes which reflect any changes in legal requirements.
2. **PREMIUM:** Group policyholder chooses the terms of the premium.

Page 7

**PAYMENT OF PREMIUM:** terms of premiums are selected by the group policyholder.

Page 8

**OTHER INSURANCE:** provision will be used based on marketing strategy and limitations. Limits will be either a total of one to ten policies and certificates or a total amount of \$250,000 to \$1,000,000.

## **GROUP ACCIDENT HOSPITAL CERTIFICATE SLHI3000GC:**

Page 1

1. COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

2700 West Plano Parkway  
Plano, Texas 75075-8200

520 Park Avenue  
Baltimore, Maryland 21201

Valley Forge, Pennsylvania 19493

2. Policy number and policyholder name is specific to the entity to which the policy is issued.
3. Right to Examine period may be 30, 60 or 90 days at the determination of the policyholder.
4. The supersedes language will be used when the policyholder wants to limit coverage under the policy.
5. John Doe information will vary according to Certificate holder.
6. the use of the term policyholder or participating group is determined by whether the policy is issued to a participating group.

Page 3

1. DEFINITIONS: The definition of Participating Group will be included when the coverage is issued to a group that elects to participate in a group trust.
2. DEFINITIONS: The definition of Aegon Affiliate may change when companies are added or deleted.
3. WHEN YOUR INSURANCE BEGINS: before or within 21 days of the Certificate effective date – Allows for different system constraints.

Page 4

ACCIDENTAL DEATH EXCLUSIONS: Exclusion #4: The percent of the blood alcohol level is variable to enable changes which reflect any changes in legal requirements.

Page 6

PAYMENT OF PREMIUM: terms of premiums are selected by the group policyholder. Use of the terms Policyholder or Participating Group will be determined by whether the group is a participating group or not.

Page 7

OTHER INSURANCE provision will be used based on marketing strategy and limitations. Limits will be either a total of one to ten policies and certificates or a total amount of \$250,000 to \$1,000,000.

Page 8

1. Schedule of Insurance: information will vary based on John Doe information, coverage selected, and the group policyholder information.

## **GROUP ACCIDENT HOSPITAL OUTLINE OF COVERAGE SLHI3000OC:**

Page 1

COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

2700 West Plano Parkway

Plano, Texas 75075-8200

520 Park Avenue  
Baltimore, Maryland 21201

Valley Forge, Pennsylvania 19493

Benefit amounts vary based on the offer and the requirements of the policyholder

Page 2

Exclusion #4: The percent of the blood alcohol level is variable to enable changes which reflect any changes in legal requirements

Right to Examine period may be 30, 60 or 90 days at the determination of the policyholder.

**GROUP ACCIDENT HOSPITAL ENROLLMENT FORM SLHI3000GE (Not Medicare eligible):**

[Accident Hospital Indemnity Plan]	Title may vary depending on Marketing plan and if used with a different product in the future.
<input checked="" type="checkbox"/> \$8.95 per month for me only]. [ <input checked="" type="checkbox"/> \$11.95 per month for me and my eligible family members.]	Benefit amount and offer is based on the marketing plan and requirements of the policyholder
[Accident Hospital Confinement]	Title may vary depending on Marketing plan and if used with a different product in the future.
[XYZ Corporation., I must be a XYZ Corporation Credit Cardholder or the spouse of a XYZ Corporation Credit Cardholder, age 18 through-64]	Name of policyholder and issue ages are determined by the policyholder and who the group members are.
My coverage can never be canceled as long as I pay my premiums.	This sentence is used when the coverage offered is non cancelable.
[I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]	This sentence is used when the state specific fraud notices are on the back of the enrollment form.
[By signing below, I certify that I understand coverage for Accident Hospital Indemnity Insurance is limited to the lesser of the total amount of benefits payable under all policies and certificates with this Company, Monumental Life Insurance Company, Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company or [\$1,000,000].	This statement is used when the policyholder wants to limit coverage for each Insured. The range of the dollar amount limit is \$250,000 through \$1,000,000. or a number of certificates and policies with a range of one through ten.
Name, address, date of birth, phone, email, male/female, signature, date	Insured information is variable and specific to the prospective insured
[2700 West Plano Parkway, Plano, Texas 75075-8200]	Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market.
[01G NAA99]	Tracking codes used by Marketing to individually identify solicitations
State fraud statements on back of form	Used when the state specific fraud statement is not on the front page of the enrollment form.

**GROUP ACCIDENT HOSPITAL ENROLLMENT FORM SLHI3001GE (Medicare eligible):**

[Accident Hospital Indemnity Plan]	Title may vary depending on Marketing plan and if used with a different product in the future.
<input checked="" type="checkbox"/> \$8.95 per month for me only. [ <input checked="" type="checkbox"/> \$11.95 per month for me and my eligible family members.]	Benefit amount and offer is based on the marketing plan and requirements of the policyholder
[Accident Hospital Confinement]	Title may vary depending on Marketing plan and if used with a different product in the future.
[XYZ Corporation., I must be a XYZ Corporation Credit Cardholder or the spouse of a XYZ Corporation Credit Cardholder, age 18 through-64]	Name of policyholder and issue ages are determined by the policyholder and who the group members are.
My coverage can never be canceled as long as I pay my premiums.	This sentence is used when the coverage offered is non cancelable.
[I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]	This sentence is used when the state specific fraud notices are on the back of the enrollment form.
[By signing below, I certify that I understand coverage for Accident Hospital Indemnity Insurance is limited to the lesser of the total amount of benefits payable under all policies and certificates with this Company, Monumental Life Insurance Company, Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company or [\$1,000,000].	This statement is used when the policyholder wants to limit coverage for each Insured. The range of the dollar amount limit is \$250,000 through \$1,000,000. or a number of certificates and policies with a range of one through ten.
Name, address, date of birth, phone, email, male/female, required signature, date	Insured information is variable and specific to the prospective insured
[2700 West Plano Parkway, Plano, Texas 75075-8200]	Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market.
[01G NAA99]	Tracking codes used by Marketing to individually identify solicitations
State fraud statements on back of form	Used when the state specific fraud statement is not on the front page of the enrollment form.



**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, 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 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.