

SERFF Tracking Number: AEGX-G126853613 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 47018
Company Tracking Number: AR005591500049
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: Hospital Indemnity
Project Name/Number: Hospital Indemnity/AR005591500049

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Hospital Indemnity SERFF Tr Num: AEGX-G126853613 State: Arkansas

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved-Closed State Tr Num: 47018

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AR005591500049 State Status: Approved-Closed

Filing Type: Form
Reviewer(s): Rosalind Minor
Author: SPI ADMSLH Disposition Date: 10/28/2010
Date Submitted: 10/08/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Hospital Indemnity
Project Number: AR005591500049
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/28/2010

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 10/05/2010
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Discretionary
Explanation for Other Group Market Type:
State Status Changed: 10/28/2010
Created By: SPI ADMSLH
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI ADMSLH

Filing Description:

RE: Stonebridge Life Insurance Company
NAIC # 0468-65101 FEIN: 03-0164230
SLHAP1000GE-1.AR- Group Enrollment Form
SLHAP1000GE-1- Group Enrollment Form
SLHAP1000GE-4.AR- Group Enrollment Form
SLHAP1004GE-4 - Group Enrollment Form

SERFF Tracking Number: AEGX-G126853613 State: Arkansas
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Dear Director:

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

These Enrollment Forms will be used to solicit group certificate SLHAP1000GC, approved by your Department on August 3, 2010, and other similar forms approved by your Department. SLHAP1000GE-1.AR and SLHAP1000GE-4.AR will be used when the fraud statement is on the front of the form.

The company has reviewed the enclosed forms and certifies that each form submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.

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

The referenced form may be used in other media formats including translations into (Spanish, Chinese, Korean, Vietnamese, Polish, etc) and in such case, we certify the content will not change.

I respectfully request your favorable review and approval. We appreciate your consideration of these forms. Should you have any questions, please feel free to call us toll free at 1-866-255-8320 Extension 6409 or contact me by e-mail at cpenner@aegonusa.com.

Company and Contact

Filing Contact Information

Cheryl Penner, Manager, Product Filing & Compliance cpenner@aegonusa.com
2700 W Plano Parkway 972-881-6409 [Phone] 6409 [Ext]
Plano, TX 75075 972-881-4097 [FAX]

Filing Company Information

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

SERFF Tracking Number: AEGX-G126853613 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$200.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$200.00	10/08/2010	40467945

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/28/2010	10/28/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/12/2010	10/12/2010	SPI ADMSLH	10/20/2010	10/20/2010

SERFF Tracking Number: AEGX-G126853613 *State:* Arkansas
Filing Company: Stonebridge Life Insurance Company *State Tracking Number:* 47018
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Product Name: Hospital Indemnity
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Disposition

Disposition Date: 10/28/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanation of Variables SLHAP1000GE- 1	Approved-Closed	Yes
Supporting Document	Explanation of Variables SLHAP1004GE- 1	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form (revised)	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/12/2010

Submitted Date 10/12/2010

Respond By Date

Dear Cheryl Penner,

This will acknowledge receipt of the captioned filing.

Objection 1

- Enrollment Form, SLHAP1004GE-1.AR (Form)
- Enrollment Form, SLHAP1004GE-1 (Form)

Comment:

These two enrollment forms do not have the Arkansas Fraud Notice on them.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 10/20/2010
 Submitted Date 10/20/2010

Dear Rosalind Minor,

Comments:

Thank you so much for discussing the issues with my filing this morning and again this afternoon. Hopefully, I have it correct this time.

Response 1

Comments: As I pointed out in our last phone conversation, I am revising the last enrollment form number SLHAP1004GE-1 by adding the Arkansas fraud language on the back. All four enrollment forms are submitted for your review.

Related Objection 1

Applies To:

- Enrollment Form, SLHAP1004GE-1.AR (Form)
- Enrollment Form, SLHAP1004GE-1 (Form)

Comment:

These two enrollment forms do not have the Arkansas Fraud Notice on them.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Enrollment Form	SLHAP1004GE-1		Application/Enrollment Form	Initial		0.000	SLHAP1004GE-1.PDF

SERFF Tracking Number: AEGX-G126853613 State: Arkansas
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Previous Version

Enrollment Form	SLHAP10	Application/Enrollment	Initial	0.000	SLHAP10
	04GE-1	Form			04GE-1.PDF

No Rate/Rule Schedule items changed.

Thank you again for your patience and responding so quickly. I hope you will find the submitted forms acceptable. If you have any questions, please email me at cpenner@aegonusa.com or call me toll free at 877-527-6444, ext. 6409.

Sincerely,
SPI ADMSLH

SERFF Tracking Number: AEGX-G126853613 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 47018
 Company Tracking Number: AR005591500049
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 Product Name: Hospital Indemnity
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Form Schedule

Lead Form Number: SLHAP1000GE-1.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 10/28/2010	SLHAP100 0GE-1.AR	Application/ Enrollment Enrollment Form	Form	Initial		0.000	SLHAP1000G E-1_AR.PDF
Approved- Closed 10/28/2010	SLHAP100 0GE-1	Application/ Enrollment Enrollment Form	Form	Initial		0.000	SLHAP1000G E-1.PDF
Approved- Closed 10/28/2010	SLHAP100 4GE-1.AR	Application/ Enrollment Enrollment Form	Form	Initial		0.000	SLHAp1004G E-1.PDF
Approved- Closed 10/28/2010	SLHAP100 4GE-1	Application/ Enrollment Enrollment Form	Form	Initial		0.000	SLHAP1004G E-1.PDF

[Variable Logo]
[Plan Marketing Name]

ENROLLMENT FORM

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

[John Doe]
[Jane Doe (if enrolling)]
[123 Main Street]
[Apartment #X]
[Columbia, SC XXXXX]

[Please respond by: [Month XX, 2010]]

[Bar code for scanning purposes]

[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

1. Personal Information – Please complete all questions

Customer Information

Home Phone (123) 345-6789
Area Code

Date of Birth 1 | 2 | 1960
Month Day Year

Sex Male Female

[Email address: _____]

[Spouse Information (if enrolling)]

Name _____
First Middle Last

Date of Birth _____ | _____ | _____
Month Day Year

Sex Male Female

2. Choose the Coverage You Want

The monthly costs for the first [30] days of coverage will be paid for by [ABC Bank].

Select your plan:

[Plan 1 Name]

- Individual Only (\$[10.40 per month])[(code)]
 Family Protection (\$[20.90 per month])[(code)]

[Plan 2 Name]

- Individual Only (\$[15.60 per month]) [(code)]
 Family Protection (\$[31.35 per month]) [(code)]

Check here if you are eligible to receive Medicare Benefits:

[You] Spouse (if enrolling)

3. Read and Sign – (Then return in the postage paid envelope provided)

I understand that no coverage is in effect until a Certificate is issued and the first premium is received [before][within 21 days of] the Effective Date and during my lifetime. I also understand that only accidental bodily injuries sustained on or after my Certificate Effective Date will be covered. I understand that I can have no more than one Certificate under the Policy. [I have read my state's fraud notice on the back of this enrollment form as it applies to my state of residence.]

I hereby enroll in the [Insurance Plan Name] underwritten by Stonebridge Life Insurance Company. After the first [30] days, I authorize my premium to be deducted monthly and remitted to the Insurance Company from my [ABC Bank] [checking] account. If I sign and return this form without selecting a coverage amount I understand that I will be automatically enrolled for [the Insurance Plan Name] Individual Coverage. This authority is to remain in effect until I cancel it by written notification to the Company at least 30 days in advance of the intended termination date of my coverage. Coverage begins on the Effective Date stated on the Certificate of Insurance provided the first premium is paid. [I understand that benefits reduce by one-half when a Covered Person attains age [80]] . [I acknowledge that I have received, read and understand the insurance disclosures on the reverse side of this form.] [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.]

Signature of Customer [John Doe]
(Required)

Date [10/1/2010]
(Required)

Do not send money. Complete, sign and mail this form in the postage-paid envelope provided.

INSURANCE DISCLOSURES

Certain state insurance departments require that we advise you of the following statements:

[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 applicants.]

[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 LOUISIANA and RHODE ISLAND: 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 KENTUCKY and 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.]

[Variable Logo]
[Plan Marketing Name]

ENROLLMENT FORM

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

[John Doe]
[Jane Doe (if enrolling)]
[123 Main Street]
[Apartment #X]
[Columbia, SC XXXXX]

[Please respond by: [Month XX, 2010]]

[Bar code for scanning purposes]

[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

1. Personal Information – Please complete all questions

Customer Information

Home Phone (123) 345-6789
Area Code

Date of Birth 1 | 2 | 1960
Month Day Year

Sex Male Female

[Email address: _____]

[Spouse Information (if enrolling)]

Name _____
First Middle Last

Date of Birth _____ | _____ | _____
Month Day Year

Sex Male Female

2. Choose the Coverage You Want

The monthly costs for the first [30] days of coverage will be paid for by [ABC Bank].

Select your plan:

[Plan 1 Name]

- Individual Only (\$[10.40 per month])[(code)]
 Family Protection (\$[20.90 per month])[(code)]

[Plan 2 Name]

- Individual Only (\$[15.60 per month]) [(code)]
 Family Protection (\$[31.35 per month]) [(code)]

Check here if you are eligible to receive Medicare Benefits:

[You] Spouse (if enrolling)]

3. Read and Sign – (Then return in the postage paid envelope provided)

I understand that no coverage is in effect until a Certificate is issued and the first premium is received [before][within 21 days of] the Effective Date and during my lifetime. I also understand that only accidental bodily injuries sustained on or after my Certificate Effective Date will be covered. I understand that I can have no more than one Certificate under the Policy. [I have read my state's fraud notice on the back of this enrollment form as it applies to my state of residence.]

I hereby enroll in the [Insurance Plan Name] underwritten by Stonebridge Life Insurance Company. After the first [30] days, I authorize my premium to be deducted monthly and remitted to the Insurance Company from my [ABC Bank] [checking] account. If I sign and return this form without selecting a coverage amount I understand that I will be automatically enrolled for [the Insurance Plan Name] Individual Coverage. This authority is to remain in effect until I cancel it by written notification to the Company at least 30 days in advance of the intended termination date of my coverage. Coverage begins on the Effective Date stated on the Certificate of Insurance provided the first premium is paid. [I understand that benefits reduce by one-half when a Covered Person attains age [80]] . [I acknowledge that I have received, read and understand the insurance disclosures on the reverse side of this form.]

Signature of Customer [John Doe]
(Required)

Date [10/1/2010]
(Required)

Do not send money. Complete, sign and mail this form in the postage-paid envelope provided.

INSURANCE DISCLOSURES

Certain state insurance departments require that we advise you of the following statements:

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[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 applicants.]

[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 LOUISIANA and RHODE ISLAND: 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.]

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[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 KENTUCKY and 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.]

ENROLLMENT FORM FOR GROUP [ACCIDENT HOSPITAL INDEMNITY] INSURANCE

Underwritten by Stonebridge Life Insurance Company

Home Office: Rutland, Vermont Administrative Offices: [2700 West Plano Parkway, Plano, TX 75075]

1. Personal Information: Please complete ALL questions.

• Customer Information

[Sample A. Sample
123 Any Street
City, ST 12345]

Home Phone: [(123) 456-7890]
area code

[Email Address: _____]

Date of Birth: [____/____/____]
Month Day Year

Sex: Male • Female

• [Spouse Information (if enrolling)]

Name: _____
First Middle Last

Date of Birth: ____/____/____ Sex: Male • Female
Month Day Year

2. Choose the Benefits You Want: Select one option in each section.

• CHECK THE PLAN YOU WANT:

(G) Individual Only
• (L) Family Protection]

• AMOUNT OF COVERAGE YOU WANT:

	[Individual only	Family Protection
<input checked="" type="checkbox"/> (01) \$100 per day	[\$4.95]	[\$9.95]
• (02) \$200 per day	[\$9.95]	[\$19.90]
• (01) \$300 per day	[\$14.95]	[\$29.90]
• (02) \$400 per day	[\$19.95]	[\$39.90]

• Check here if you are eligible to receive Medicare benefits: • [You] [• Spouse (if enrolling)]

3. Payment Information:

[In signing the enrollment form, I authorize the monthly premium as shown above for the coverage chosen to be billed as indicated below.

• Please charge my monthly premiums to my JCPenney Credit Card account. (I am an authorized user.)

• Please charge my monthly premiums to my debit/credit card account identified below:
(I am an authorized user.) • American Express® • Discover® Card • MasterCard® • VISA®
Account No: _____ - _____ - _____ - _____ Exp. Date _____

• Please deduct my monthly premiums from my Checking Account: Withdrawal Date: _____
(Attached is a sample check marked VOID) (1st through 28th)

Please bill me direct for my monthly premiums. Enclosed is my first month's premium.]

4. Read and Sign: Then return in the postage paid envelope provided.

I understand that in order to enroll for this insurance coverage, I must be [a J. C. Penney Credit Cardholder or the spouse of a J. C. Penney Credit Cardholder, age 18 through 75,] who resides in a state in which this insurance plan may legally be offered. I understand that if I send in my enrollment form and do not select an option above, I will be enrolled for Individual Coverage at the lowest benefit level. I also understand that benefits reduce by one-half when a covered person attains age [80].

I understand that no coverage is in effect until the Certificate is issued and my first premium is received [before][within 21 days of] the Effective Date and during my lifetime. I also understand that only accidental bodily injuries sustained on or after my Certificate Effective Date will be covered. I understand that I can have no more than one certificate under the Policy. [I have read my state's fraud notice on the back of this enrollment form as it applies to my state of residence.] [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.]

X [Sample A. Sample] [10/1/2010]
YOUR SIGNATURE (Signature Required) DATE (Required)

[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 applicants.]

[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 LOUISIANA and RHODE ISLAND: 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.]

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ENROLLMENT FORM FOR GROUP [ACCIDENT HOSPITAL INDEMNITY] INSURANCE

Underwritten by Stonebridge Life Insurance Company

Home Office: Rutland, Vermont Administrative Offices: [2700 West Plano Parkway, Plano, TX 75075]

1. Personal Information: Please complete ALL questions.

• Customer Information

[Sample A. Sample
123 Any Street
City, ST 12345]

Home Phone: [(123) 456-7890]
area code

[Email Address: _____]

Date of Birth: [____/____/____]
Month Day Year

Sex: Male • Female

• [Spouse Information (if enrolling)]

Name: _____
First Middle Last

Date of Birth: ____/____/____ Sex: Male • Female
Month Day Year

2. Choose the Benefits You Want: Select one option in each section.

CHECK THE PLAN YOU WANT: [(G) Individual Only
• (L) Family Protection]

<u>AMOUNT OF COVERAGE YOU WANT:</u>	[Individual only	Family Protection
<input checked="" type="checkbox"/> (01) \$100 per day	[\$4.95]	[\$9.95]
<input type="checkbox"/> (02) \$200 per day	[\$9.95]	[\$19.90]
<input type="checkbox"/> (01) \$300 per day	[\$14.95]	[\$29.90]
<input type="checkbox"/> (02) \$400 per day	[\$19.95]	[\$39.90]

• Check here if you are eligible to receive Medicare benefits: • [You] [Spouse (if enrolling)]

3. Payment Information:

[In signing the enrollment form, I authorize the monthly premium as shown above for the coverage chosen to be billed as indicated below.

Please charge my monthly premiums to my JCPenney Credit Card account. (I am an authorized user.)

Please charge my monthly premiums to my debit/credit card account identified below:
(I am an authorized user.) • American Express® • Discover® Card • MasterCard® • VISA®
Account No: _____ - _____ - _____ - _____ Exp. Date _____

Please deduct my monthly premiums from my Checking Account: Withdrawal Date: _____
(Attached is a sample check marked VOID) (1st through 28th)

Please bill me direct for my monthly premiums. Enclosed is my first month's premium.]

4. Read and Sign: Then return in the postage paid envelope provided.

I understand that in order to enroll for this insurance coverage, I must be [a J. C. Penney Credit Cardholder or the spouse of a J. C. Penney Credit Cardholder, age 18 through 75,] who resides in a state in which this insurance plan may legally be offered. I understand that if I send in my enrollment form and do not select an option above, I will be enrolled for Individual Coverage at the lowest benefit level. I also understand that benefits reduce by one-half when a covered person attains age [80].

I understand that no coverage is in effect until the Certificate is issued and my first premium is received [before][within 21 days of] the Effective Date and during my lifetime. I also understand that only accidental bodily injuries sustained on or after my Certificate Effective Date will be covered. I understand that I can have no more than one certificate under the Policy. [I have read my state's fraud notice on the back of this enrollment form as it applies to my state of residence.]

X [Sample A. Sample] [10/1/2010]
YOUR SIGNATURE (Signature Required) DATE (Required)

[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 applicants.]

[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 LOUISIANA and RHODE ISLAND: 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 KENTUCKY and 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-G126853613 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 47018
 Company Tracking Number: AR005591500049
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity
 Project Name/Number: Hospital Indemnity/AR005591500049

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/28/2010
Comments:		
Attachment:		
AR - READABILITY CERTIFICATION.PDF		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	10/28/2010
Bypass Reason: The enrollment forms are on the forms schedule since this filing is to obtain approval of the enrollment forms.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Explanation of Variables SLHAP1000GE-1	Approved-Closed	10/28/2010
Comments:		
Attachment:		
Explanation of Variables SLHAP1000GE-1.PDF		

	Item Status:	Status Date:
Satisfied - Item: Explanation of Variables SLHAP1004GE-1	Approved-Closed	10/28/2010
Comments:		
Attachment:		
Explanation of Variables SLHAP1004GE-1.PDF		

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Stonebridge Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
SLHAP1000GE-1.AR	42.1
SLHAP1000GE-1	43.4
SLHAP1004GE-1.AR	52.1
SLHAP1004GE-1	50.3

Signed: 
Name: Laurie A. Renko
Title: Vice President
Date: _____

ENROLLMENT FORM SLHAP1000GE-1

Language will vary based on the offer by the policyholder who will choose whether spouse coverage is offered, options offered; customer information requested. Below is an explanation of the bracketed portions of the form.

Variable Data	Explanation
[Variable Logo]	Marketer may use the company logo
[Plan Marketing Name]	Marketer may use with other accident only policy forms or another plan name resulting in a change in the title
[2700 West Plano Parkway, Plano, Texas 75075-8200]	Stonebridge Life Insurance Company has locations at three administrative offices. Solicitation may originate from one of the three locations, depending on the market.
[John Doe] [Jane Doe (if enrolling)] [123 Main Street] [Apartment #X] [Columbia, SC XXXXX]	Customer name and address will appear here and may be preprinted on the enrollment form.
[Please respond by: [Month XX, 2010]]	If the Policyholder wants to limit the time of the offer, this information and date will be included.
[Bar code for scanning purposes]	This is for managing customer information
[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]	These are company codes used internally to process enrollments and to uniquely identify solicitations.
[Email Address: _____]	Marketer may choose to ask for email address
[Spouse Information (if enrolling), Name, Date of Birth, Sex]	Included in the enrollment form when the policyholder offers coverage for the spouse.
The monthly costs for the first [30] days of coverage will be paid for by [ABC Bank].	The policyholder determines if the coverage will be paid for 30, 60 or 90 days and disclose they are paying for the coverage.
[Plan 1 Name], [Plan 2 Name] [10.40 per month]][(code)]	The Marketer may offer one or more plans and give them a descriptive name such as Basic, Enhanced, Deluxe or Platinum. Premium amounts and frequency of payment will depend on the offer and a benefit code will be associated with each.
<input type="checkbox"/> You] <input type="checkbox"/> Spouse (if enrolling)]	If Spouse coverage is offered, there will be a checkbox for both the customer and the spouse indicating eligibility for Medicare benefits.
[I understand that no coverage is in effect until the Certificate Effective Date [is issued and my first premium is received [before][within 21 days of] the Effective Date and during my lifetime.]	The bracketed language is worded to support the issue system on which the coverage is loaded.
[I have read my state's fraud notice on the back of the enrollment form as is applies to my state of residence Or [Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or	Used when the state specific fraud language is not used on the front of the enrollment form. Fraud language will either be on the front of the enrollment for those states which require it or on the back of the enrollment form, depending on the marketing plan.

files a claim containing a false or deceptive statement is guilty of insurance fraud.]	
I hereby enroll in the [Insurance Plan Name] underwritten by Stonebridge Life Insurance Company	The bracketed information will be a descriptive title for the insurance determined by the Marketer
After the first [30] days,	The number of days will match the number of days the premium is paid by the policyholder.
[ABC Bank] [checking] account.	The name of the policyholder and type of account will be inserted here.
I understand that I will be automatically enrolled for [Insurance Plan Name] Individual Coverage	Plan name determined by Marketer.
[I understand that benefits reduce by one-half when a Covered Person attains age [80]].	Policyholder will determine age of reduction and may or may not include this information.
[I acknowledge that I have received, read and understand the insurance disclosures on the reverse side of this form.]	This sentence will be included when there are disclosures to be acknowledged.

ENROLLMENT FORM SLHAP1004GE-1

Language will vary based on the offer by the policyholder who will choose whether spouse coverage is offered, options offered; customer information requested; beneficiary information requested. Below is an explanation of the bracketed portions of the form.

Variable Data	Explanation
[ACCIDENT HOSPITAL INDEMNITY]	Marketer may use with other accident only policy forms and may change the enrollment form title or use a similar descriptive title.
[2700 West Plano Parkway, Plano, Texas 75075-8200]	Address will be one of the 3 administrative offices where Stonebridge Life is located.
[Sample A. Sample 123 Any Street City, ST 12345]	Customer name and address will appear here and may be preprinted on the enrollment form.
[Email Address: _____]	Marketer may choose to ask for email address.
[Spouse Information (if enrolling), Name, Date of Birth, Age, Sex]	Included in the enrollment form when the policyholder offers coverage for the spouse.
Individual Only, Family Protection, plans and amounts	The policyholder may choose to offer coverage for individuals or families and may provide choices for the customer as to which plan he wants.
[<input type="radio"/> \$100 per day] [<input type="radio"/> \$200 per day] [<input type="radio"/> \$300 per day] [<input type="radio"/> \$400 per day]	Used when the offer includes several choices. Ranges of amounts offered are the same as on the Certificate Schedule of Insurance.
[<input type="checkbox"/> You] [<input checked="" type="checkbox"/> Spouse (if enrolling)]	there will be a checkbox for both the customer and the spouse (If Spouse coverage is offered,) indicating eligibility for Medicare benefits.
<p>[In signing the enrollment form, I authorize the monthly premium as shown above for the coverage chosen to be billed as indicated below.</p> <ul style="list-style-type: none"> • Please charge my monthly premiums to my JCPenney Credit Card account. (I am an authorized user.) • Please charge my monthly premiums to my debit/credit card account identified below: (I am an authorized user.) • American Express® • Discover® Card • MasterCard® • VISA® Account No: _____ - _____ - _____ _____ - _____ Exp. Date _____ • Please deduct my monthly premiums from my Checking Account: Withdrawal Date: _____ (Attached is a sample check marked VOID) (1st through 28th) • Please bill me direct for my monthly premiums. Enclosed is my first month's premium.] 	<p>Marketer may offer any one or all of these billing methods to the customer. The billing methods may or may not be included in the enrollment form.</p>

<p>[a J. C. Penney Credit Cardholder or the spouse of a J. C. Penney Credit Cardholder age 18 through 75]</p>	<p>The description of the group is based on the Policyholder.</p>
<p>I also understand that benefits reduce by one-half when a covered person attains age [80].</p>	<p>If the enrollment form is used with other accident products where the benefit reduces, it may be a different age of reduction or may be determined by the marketing plan.</p>
<p>I understand that no coverage is in effect until the Certificate is issued and my first premium is received [before][within 21 days of] the Effective Date and during my lifetime.</p>	<p>This language is worded to support the issue system on which the coverage is loaded</p>
<p>[I have read my state's fraud notice on the back of this enrollment form as it applies to my state of residence.] Or [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.]</p>	<p>Used when the state specific fraud language is not used on the front of the enrollment form. Fraud language will either be on the front of the enrollment for those states which require it or on the back of the enrollment form, depending on the marketing plan.</p>
<p>[bar code for scanning purposes]</p>	<p>Holds customer information for company processing</p>

SERFF Tracking Number: AEGX-G126853613 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 47018
 Company Tracking Number: AR005591500049
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity
 Project Name/Number: Hospital Indemnity/AR005591500049

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/08/2010	Form	Enrollment Form	10/20/2010	SLHAP1004GE-1.PDF (Superseded)

ENROLLMENT FORM FOR GROUP [ACCIDENT HOSPITAL INDEMNITY] INSURANCE

Underwritten by Stonebridge Life Insurance Company

Home Office: Rutland, Vermont Administrative Offices: [2700 West Plano Parkway, Plano, TX 75075]

1. Personal Information: Please complete ALL questions.

• Customer Information

[Sample A. Sample
123 Any Street
City, ST 12345]

Home Phone: [(123) 456-7890]
area code

[Email Address: _____]

Date of Birth: [_____/_____/_____]
Month Day Year

Sex: X Male • Female

• [Spouse Information (if enrolling)]

Name: _____
First Middle Last

Date of Birth: ____/____/____ Sex: • Male • Female]
Month Day Year

2. Choose the Benefits You Want: Select one option in each section.

CHECK THE PLAN YOU WANT: [X (G) Individual Only
• (L) Family Protection]

AMOUNT OF COVERAGE YOU WANT: [Individual only Family Protection
X (01) \$100 per day [\$4.95] [\$9.95]
• (02) \$200 per day [\$9.95] [\$19.90]
• (01) \$300 per day [\$14.95] [\$29.90]
• (02) \$400 per day [\$19.95] [\$39.90]]

• Check here if you are eligible to receive Medicare benefits: • [You] [• Spouse (if enrolling)]

3. Payment Information:

[In signing the enrollment form, I authorize the monthly premium as shown above for the coverage chosen to be billed as indicated below.

• Please charge my monthly premiums to my JCPenney Credit Card account. (I am an authorized user.)

• Please charge my monthly premiums to my debit/credit card account identified below:
(I am an authorized user.) • American Express® • Discover® Card • MasterCard® • VISA®
Account No: _____ - _____ - _____ - _____ Exp. Date _____

• Please deduct my monthly premiums from my Checking Account: Withdrawal Date: _____
(Attached is a sample check marked VOID) (1st through 28th)

X Please bill me direct for my monthly premiums. Enclosed is my first month's premium.]

4. Read and Sign: Then return in the postage paid envelope provided.

I understand that in order to enroll for this insurance coverage, I must be [a J. C. Penney Credit Cardholder or the spouse of a J. C. Penney Credit Cardholder, age 18 through 75,] who resides in a state in which this insurance plan may legally be offered. I understand that if I send in my enrollment form and do not select an option above, I will be enrolled for Individual Coverage at the lowest benefit level. I also understand that benefits reduce by one-half when a covered person attains age [80].

I understand that no coverage is in effect until the Certificate is issued and my first premium is received [before][within 21 days of] the Effective Date and during my lifetime. I also understand that only accidental bodily injuries sustained on or after my Certificate Effective Date will be covered. I understand that I can have no more than one certificate under the Policy. [I have read my state's fraud notice on the back of this enrollment form as it applies to my state of residence.]

X [Sample A. Sample] [10/1/2010]
YOUR SIGNATURE (Signature Required) DATE (Required)

[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 applicants.]

[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 LOUISIANA and RHODE ISLAND: 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.]

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