

SERFF Tracking Number:	AEGX-126490419	State:	Arkansas
Filing Company:	Stonebridge Life Insurance Company	State Tracking Number:	44770
Company Tracking Number:	HH AR0049315F01		
TOI:	H02G Group Health - Accident Only	Sub-TOI:	H02G.000 Health - Accident Only
Product Name:	Hospital Indemnity		
Project Name/Number:	Hospital Indemnity/HH AR0049315F01		

## Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Hospital Indemnity

SERFF Tr Num: AEGX-126490419 State: Arkansas

TOI: H02G Group Health - Accident Only

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44770

Sub-TOI: H02G.000 Health - Accident Only

Co Tr Num: HH AR0049315F01

State Status: Approved-Closed

Filing Type: Form

Author: SPI ADMSLH

Reviewer(s): Rosalind Minor

Date Submitted: 02/05/2010

Disposition Date: 02/10/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Hospital Indemnity

Status of Filing in Domicile:

Project Number: HH AR0049315F01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 02/10/2010

Explanation for Other Group Market Type:

State Status Changed: 02/10/2010

Deemer Date:

Created By: SPI ADMSLH

Submitted By: SPI ADMSLH

Corresponding Filing Tracking Number:

Filing Description:

RE: Stonebridge Life Insurance Company

NAIC # 0468-65021

FEIN: 03-0164230

GM559: Group Accident Emergency Room Home Recovery Policy

GC559AR: Group Accident Emergency Room Home Recovery Certificate

GGA159(99)AR: Enrollment Form

GGA160AR: Enrollment Form

Actuarial Memorandum

SERFF Tracking Number: AEGX-126490419 State: Arkansas  
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 44770  
Company Tracking Number: HH AR0049315F01  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Hospital Indemnity  
Project Name/Number: Hospital Indemnity/HH AR0049315F01

Dear Commissioner:

Attached for your review and approval are copies of the above captioned forms. 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 bracketed and printed in red.

GC559AR is a Group Accident Emergency Room Home Recovery Certificate. It provides emergency treatment and home recovery benefits for any insured who suffers a loss as a result bodily injury caused by an accident.

GM559 is the master policy under which GC559 certificates will be issued.

Enrollment Forms GGA159(99)AR and GGA160AR will be used to solicit this and other similar products.

The Flesch scores for this Policy and Certificate are 43.2 and 48.8, respectively. Microsoft Word was used to obtain these scores.

Illinois, our Situs State, approved the Policy and Certificate on December 29, 2009. Illinois approved the Enrollment Forms on November 4, 1999.

The group policy is contemplated for issue to various discretionary groups that are situated in Illinois. We plan to initially issue the policy to Bank of America N. A. for their account holders.

This product will be mass marketed by direct response and telemarketing methods and possibly on the Internet.

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

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

Completed filing forms are attached. Our filing fee is being sent via EFT.

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 (877) 527-6444, Extension 6289 or contact me by e-mail at [mfrei@aegonusa.com](mailto:mfrei@aegonusa.com).

Sincerely,

SERFF Tracking Number: AEGX-126490419 State: Arkansas  
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STONEBRIDGE LIFE INSURANCE COMPANY  
 Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA

Attachments

## Company and Contact

### Filing Contact Information

Margaret Frei, Senior Product Filing & Compliance Analyst  
 2700 W Plano Parkway  
 Plano, TX 75075  
 mfrei@aegonusa.com  
 972-881-6289 [Phone] 6289 [Ext]  
 972-881-4097 [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  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$50.00	02/05/2010	34010431

SERFF Tracking Number: AEGX-126490419 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/10/2010	02/10/2010

*SERFF Tracking Number:* AEGX-126490419      *State:* Arkansas  
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## **Disposition**

Disposition Date: 02/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-126490419 State: Arkansas  
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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	Actuarial Memorandum	Approved-Closed	No
Supporting Document	Explanation_of_Variables	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Group Accident Only Emergency Room and Home Recovery Certificate	Approved-Closed	Yes
Form	Group Accident Only Emergency Room and Home Recovery Master Policy	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/10/2010	GC559AR	Certificate	Group Accident Only Emergency Room and Home Recovery Certificate	Initial		48.800	GC559AR.PDF
Approved-Closed 02/10/2010	GM559	Policy/Contract/Fraternal Certificate	Group Accident Only Emergency Room and Home Recovery Master Policy	Initial		43.200	GM559.PDF
Approved-Closed 02/10/2010	GGA159(9)AR	Application/Enrollment Form	Enrollment Form	Initial		57.900	GGA159(9)AR.PDF
Approved-Closed 02/10/2010	GGA160AR	Application/Enrollment Form	Enrollment Form	Initial		55.200	GGA160AR.PDF

# 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 in the Schedule of Insurance.

Stonebridge Life Insurance Company (herein called "we," "us" or "our") has issued Policy No. [25517 GC559] to [BANK OF AMERICA, N.A.] (herein called Policyholder) which makes available accident only emergency room and home recovery 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 [30/60/90] days after you receive it to our Administrative Office. You will receive a full refund of any premium you have 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 [Participating Group / Policyholder] shall determine the insurance provided under the Policy for any Insured. Important provisions of the Policy are outlined below.



Secretary



President

### INSURED:

[JOHN DOE]  
[1234 ANY STREET]  
[ANY TOWN, AR 12345]

### CERTIFICATE NUMBER:

[74A3000000]

GROUP ACCIDENT ONLY INSURANCE  
PROVIDING EMERGENCY ROOM AND HOME RECOVERY BENEFITS

# STONEBRIDGE LIFE INSURANCE COMPANY

## SCHEDULE OF INSURANCE

This Schedule Page is part of your Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Master Policy No. [25517 GC559 ] to [BANK OF AMERICA, N.A.]

[PARTICIPATING GROUP NUMBER: XXXXX] PARTICIPATING GROUP: XXXXXXXXXXXX]  
[CERTIFICATE NUMBER:] [74A3000000] [EFFECTIVE DATE:] [7-01-09]  
[INSURED:] [JOHN SMITH] [MONTHLY PREMIUM:] [\$4.45]  
[1234 ANY STREET]  
[ANYTOWN, AR 12345]

[FAMILY COVERAGE:] [YES]

[INITIAL PREMIUM: \$ 1.00]

[PREMIUM CONTRIBUTION: 100% AFTER THE FIRST [1][2][3] MONTH[S]

[For the first [1][2][3] month[s], your premium will be paid by the Policyholder / Participating Group.]

## [SCHEDULE OF INSURANCE

BENEFIT	OPTIONAL FAMILY COVERAGE		
	<u>INSURED</u>	<u>SPOUSE</u>	<u>EACH CHILD</u>
ACCIDENT ONLY DAILY HOME RECOVERY BENEFIT	\$ 100.00 PER DAY	\$ 100.00 PER DAY	\$ 100.00 PER DAY
EMERGENCY TREATMENT BENEFIT	\$ 100.00 PER ACCIDENT	\$ 100.00 PER ACCIDENT	\$ 100.00 PER ACCIDENT]

BENEFITS ARE [ONE-HALF (50%)] OF THE ABOVE AMOUNTS IF, BEFORE THE DATE OF INJURY RESULTING IN A COVERED LOSS, THE COVERED PERSON HAS ATTAINED AGE [70].

## DEFINITIONS

**INSURED** (herein called "you," "your," or "yours") means you, the Insured named on the Schedule Page, 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 who is 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 or newborns to be adopted if the petition for adoption is filed within 60 days after the birth); and
  - a. who is under the age of [26] or
  - b. who is under the age of [30] and is:
    1. an Illinois resident; 2. served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and 3. has received a release or discharge other than a dishonorable discharge. To be eligible for coverage, the dependent shall submit a form approved by the Illinois Department of Veteran's Affairs stating the date on which the dependent was released from service.

**POLICY** means the contract issued to the Policyholder providing the benefits described.

**POLICYHOLDER** means the legal entity in whose name the Policy is issued, as shown on the Schedule of Insurance.

**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. 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.

**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 disease or bodily infirmity.

**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.]**

### 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 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 to be due or 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/COVERED LOSSES

#### ACCIDENT ONLY DAILY HOME RECOVERY BENEFIT

We will pay the Accident Only Daily Home Recovery Benefit stated on the Schedule of Insurance after discharge from a Hospital for accidental Injury provided:

1. the Confinement began within 90 days of the accident causing the Injury;
2. the Confinement was for the Necessary Treatment of a covered Injury;
3. the Covered Person was under the professional care of a Physician;
4. Confinement was for at least 24 hours; and
5. such Confinement occurred while this Certificate was in force.

The Accident Only Daily Home Recovery Benefit will be paid for a period equal to the number of days of Hospital Confinement.

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

### EMERGENCY TREATMENT BENEFIT

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

### EXCLUSIONS

No benefit shall be paid for Injury that is caused by or results from:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, 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 being engaged in an illegal occupation;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except infections which result from an accidental Injury or infections which result from an accidental, involuntary or unintentional ingestion of a contaminated substance) 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.

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. Your coverage will expire if the premium is not paid by the end of the Grace Period.

## REDUCTION

All benefits will reduce by one-half (50%) of that otherwise payable if, before the date of Injury resulting in a covered loss, the Covered Person attains age [70].

## 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 renewal date.

Coverage for any covered child insured under this Certificate shall terminate as of the next renewal date after: a. the covered child's marriage or whichever occurs first of; b. the covered child's [26<sup>th</sup>] birthday or c. the covered child's [30<sup>th</sup>] birthday, if the child is 1. an Illinois resident and 2. has served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States and 3. has received a release or discharge other than a dishonorable discharge

A covered child may continue to be covered if upon reaching the limiting age as described above 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 you for support and maintenance.

You must write and tell us a 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 our form 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 new 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 the Certificate.

If neither your spouse nor another child is covered under this Certificate, you must notify us of the birth of a child. 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 the monthly renewal date. The child will be dropped from coverage if the increased premium is not paid within 31 days after the monthly renewal 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.

### PAYMENT OF PREMIUM

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

[For the first [1][2][3] month[s] 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 [1][2][3] month[s]]. If at any time the [Participating Group / Policyholder] 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.

[If no initial premium is requested by us with your enrollment, you shall have 21 days from the Effective Date shown on the Schedule to pay the first premium. If the first premium is not paid within such 21-day period, the Certificate shall be considered void from the beginning and no benefits will be paid for any loss.]

### **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.

### **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 that is sustained 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 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 Page. 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.

## **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 of all premiums paid for such period.

## **TIME OF PAYMENT OF CLAIMS**

We will pay all benefits covered by the Policy within 30 days after 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 your death will be as follows:

1. it will be paid to your living lawful spouse; or if you do not have one,
2. in equal shares to your living lawful children; or if there are none,
3. in equal shares to your living lawful parents; or if there are none,
4. in equal shares to your living lawful brothers and sisters; or if there are none,
5. to your estate.

Spouse means only the one to whom you are lawfully married on the date of your death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

## **PHYSICAL EXAM**

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.

## **LEGAL ACTIONS**

No action can be brought to recover on the 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.

# 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

**[BANK OF AMERICA, N.A.]**

(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 [July 1, 2009] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR].

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

## RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] 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 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: [25517 GC559]

**GROUP ACCIDENT ONLY INSURANCE  
PROVIDING EMERGENCY ROOM AND HOME RECOVERY BENEFITS**

## 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 who is 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
  - a. who is under the age of [26] or
  - b. who is under the age of [30] and is:
    1. an Illinois resident;
    2. served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and
    3. has received a release or discharge other than a dishonorable discharge. To be eligible for coverage, the dependent shall submit a form approved by the Illinois Department of Veteran's Affairs stating the date on which the dependent was released from service.

**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. 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.

**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 the Certificate is in force. The Injury must be the direct cause of loss, independent of disease or bodily infirmity.

**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."

**POLICY** means the contract issued to the Policyholder providing the benefits described.

**POLICYHOLDER** means the legal entity in whose name the Policy is issued, as shown in the Certificate Schedule of Insurance.

**[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.]

#### **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 of Insurance Schedule Page.

An Insured's Certificate will terminate 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.

#### **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.

## 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 benefit amount shown on the Certificate of Insurance Schedule Page issued to each individual Insured.

## COVERAGE/COVERED LOSSES

**ACCIDENT ONLY DAILY HOME RECOVERY BENEFIT** - The Company will pay the Accident Only Daily Home Recovery Benefit stated on the Insured's Certificate Schedule of Insurance after discharge from a Hospital for accidental Injury provided: 1) the Confinement began within 90 days of the accident causing the Injury; 2) the Confinement was for the Necessary Treatment of a covered Injury; 3) the Covered Person was under the professional care of a Physician; 4) Confinement was for at least 24 hours; and 5) such Confinement occurred while the Certificate was in force. The Accident Only Daily Home Recovery Benefit will be paid for a period equal to the number of days of Hospital Confinement.

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

**B. EMERGENCY TREATMENT BENEFIT** - The Company will pay the Emergency Treatment Benefit stated on the Insured's Certificate Schedule of Insurance for a covered visit to a Hospital emergency room or other Emergency Facility for an unlimited number of covered visits per Covered Person per year for a covered Injury. Treatment must be for necessary emergency treatment of an Injury, and such treatment must occur within 72 hours of the accident causing the Injury. Only one Emergency Treatment Benefit is payable for each covered accident.

## EXCLUSIONS

No benefit shall be paid for Injury that is caused by or results from:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Covered Person 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 being engaged in an illegal occupation;
7. sickness, bodily or mental infirmity, or their medical or surgical treatment including diagnosis (except infections which result from an accidental Injury or infections which result from an accidental, involuntary or unintentional ingestion of a contaminated substance) 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.

### **REDUCTION**

All Benefits will reduce by one-half (50%) of that otherwise payable if, before the date of Injury resulting in a covered loss, the Covered Person attains age [70].

### **PREMIUMS**

The monthly premium for each Certificate shall be specified in the Certificate Schedule of Insurance. 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 an Insured's 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 :

- a. the covered child's marriage or whichever comes first of;
- b. the covered child's [26<sup>th</sup>] birthday or
- c. the covered child's [30<sup>th</sup>] birthday, if the child is 1. an Illinois resident and 2. has served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States and 3. has received a release or discharge other than a dishonorable discharge

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

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

The Insured must write and tell the Company a 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 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 new 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 Certificate.

If neither the Insured's spouse nor another child is covered under the Insured's Certificate, the Insured must notify the Company of the birth of a child. 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 the monthly renewal date. The child will be dropped from coverage if the increased premium is not paid within 31 days after the monthly 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. The Policy, the copy of the application from the Policyholder, and any attachments form the entire contract.

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.

### 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/Participating Group] to the Administrative Office of the Company on or prior to the day they are due.

[For the [first [1][2][3] month[s]] of coverage, the premium [of \$1.00] will be paid by the [Policyholder/Participating Group]

Insureds are required to contribute 100 percent of the premium payable under this Policy for their Certificates [after the [first [1][2][3] month[s]]. If at any time the [Policyholder/Participating Group] 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.

[If no initial premium is requested by the Company with the Insured's enrollment form, the Insured shall have 21 days from the Effective Date shown on the Certificate Schedule of Insurance to pay the first premium. If the first premium is not paid within such 21 day period, the Certificate shall be considered void from the beginning and no benefits will be paid for any loss.]

### 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 Insured's 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 and the required premium is received. If the Company does not approve it, the Certificate will be put back in force on the 45th 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 that is sustained 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 Page. Notice should be mailed to the Company's 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 within 30 days after 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 the Insured's death will be paid as follows:

1. it will be paid to the Insured's living lawful spouse; or if there is not one,
2. in equal shares to the Insured's living lawful children; or if there are none,
3. in equal shares to the Insured's living lawful parents; or if there are none,
4. in equal shares to the Insured's living lawful brothers and sisters; or if there are none,
5. to the Insured's estate.

Spouse means only the one to whom the Insured is lawfully married on the date of the Insured's death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

**PHYSICAL EXAM**

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.

**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.

# GROUP ACCIDENT ONLY INSURANCE ENROLLMENT FORM

**No Cost To You For The First [90] Days – [THREE] FULL MONTHS!**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_     Male     Female  
Mo    Day    Yr

Home Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

**1.  
Select the  
plan that  
meets your  
needs**

**2.  
Complete, sign  
and date the  
enrollment form.**

**3.  
Mail today!  
The  
postage  
has been  
prepaid.**

Note: Group Rates shown are for automatic renewal after your [90]-day review period.

[01H] [\$X.XX] per month for me and my eligible family members.

[01G] [\$X.XX] per month for me only

I understand that in order to enroll for Group Accident Only Insurance coverage under the Group Policy issued to [Bank of America N.A.], I must be a [Bank of American N.A. Accountholder or the spouse of a Bank of America N.A. Accountholder, age 18-64], and reside in a state in which this product may legally be offered. The first [three] months of coverage will be provided at no cost to me and I may discontinue my coverage at any time. My coverage will become effective on the date stated on my Certificate. By signing below, I certify that I am currently not eligible to receive Medicare benefits. Benefits reduce by one-half when a covered person attains age [70].

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.

Insured's Signature X \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo    Day    Yr

Stonebridge Life Insurance Company  
Group Accident Only Insurance / Home Office: Rutland, VT  
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

[Code]

# GROUP ACCIDENT ONLY INSURANCE ENROLLMENT FORM

**No Cost To You For The First [90] Days – [THREE] FULL MONTHS!**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_       Male       Female  
Mo      Day      Yr

Home Telephone (\_\_\_\_) \_\_\_\_\_

**1.  
Select the  
plan that  
meets your  
needs**

**2.  
Complete, sign  
and date the  
enrollment form.**

**3.  
Mail today!  
The  
postage  
has been  
prepaid.**

Note: Group Rates shown are for automatic renewal after your 90-day review period.

[01H] [\$X.XX] per month for me and my eligible family members.

[01G] [\$X.XX] per month for me only

I understand that in order to enroll for Group Accident Only Insurance coverage under the Group Policy issued to [Bank of America N.A.], I must be a [Bank of America N.A. Accountholder or the spouse of a Bank of America N.A. Accountholder, age 18-64], and reside in a state in which this product may legally be offered. The first [three] months of coverage will be provided at no cost to me and I may discontinue my coverage at any time. My coverage will become effective on the date stated on my Certificate. 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. Benefits reduce by one-half when a covered person attains age [70].

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.

Insured's Signature X \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo      Day      Yr

GGA160AR

Stonebridge Life Insurance Company  
Group Accident Only Insurance / Home Office: Rutland, VT  
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

[Code]

SERFF Tracking Number: AEGX-126490419 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 44770  
 Company Tracking Number: HH AR0049315F01  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Hospital Indemnity  
 Project Name/Number: Hospital Indemnity/HH AR0049315F01

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	02/10/2010
<b>Comments:</b>		
<b>Attachment:</b>		
AR - READABILITY CERTIFICATION.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	02/10/2010
<b>Bypass Reason:</b> The Enrollment Forms to be used with this product are attached to the Forms Schedule for your review and approval.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Actuarial Memorandum	Approved-Closed	02/10/2010
<b>Comments:</b>		
<b>Attachment:</b>		
Actuarial Memorandum.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Explanation_of_Variables	Approved-Closed	02/10/2010
<b>Comments:</b>		
<b>Attachment:</b>		
Explanation_of_Variables.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	02/10/2010

SERFF Tracking Number: AEGX-126490419 State: Arkansas  
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 44770  
Company Tracking Number: HH AR0049315F01  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Hospital Indemnity  
Project Name/Number: Hospital Indemnity/HH AR0049315F01

**Comments:**

**Attachment:**

AR - NAIC TRANSMITTAL DOCUMENT.PDF

	<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b> AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	<b>Date:</b> 02/10/2010

**Comments:**

**Attachment:**

AR - NAIC FORM FILING ATTACHMENT.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** Stonebridge Life Insurance Company

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

<b>Form Number</b>	<b>Score</b>
GC559AR	48.8
GM559	43.2
GGA159(99)AR	57.9
GGA160AR	55.2

Signed:   
Name: Cheryl Penner  
Title: Assistant Secretary  
Date: February 5, 2010

**STONEBRIDGE LIFE INSURANCE COMPANY  
ACTUARIAL MEMORANDUM**

**GROUP ACCIDENT POLICY  
PROVIDING EMERGENCY ROOM AND HOME RECOVERY BENEFITS  
Form GM559**

**Product Description**

- This policy provides an accident emergency treatment benefit for a covered visit to a hospital emergency room or other emergency treatment facility. Treatment must be for necessary emergency treatment of an injury and such treatment must occur within 72 hours of the accident causing the injury.
- This policy also provides a daily home recovery benefit for any covered person who is confined to a hospital as a result of bodily injury caused by an accident. The benefit will be paid for the same number of days as the covered person was hospitalized.
- This policy is non-cancellable and guaranteed issue.

There may be multiple versions available, as established in the specific group master policy. The versions may include variations in premium rates and premium paying periods, as appropriate for the group.

Premium rates were developed by extensive use of asset share studies, loss ratio calculations, and profit studies. Demographics and financial arrangements will be considered when determining appropriate premium rates for each group.

The gross rates are illustrative and will vary based on the actual combination of benefits offered.

I have carefully the rates, benefits and policy provisions and certify that:

- the issuance of this policy is not contrary to the best interest of the public;
- the issuance of this policy would be actuarially sound; and
- the benefits are reasonable in relation to the premiums charged



---

Susan L. Hunt, FSA, MAAA  
Actuary  
May 15, 2009

# Explanation of Variables

## Master Policy GM559

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

Administrative office locations may be:

2700 West Plano Parkway Plano, Texas 75075-8200  
520 Park Avenue Baltimore, Maryland 21201  
Valley Forge, Pennsylvania 19493

Policyholder: Name is specific to each policy

Effective Dates and year: Based on the policyholder information

Right to Examine: Based on the policyholder information

Policyholder Number: Number is specific to each policyholder

Participating Group: Will be used when the policy is issued to a participating group trust.

Covered Person: Birthday is based on state requirements and will never be less than what the state requires.

Eligibility: Determined by the group policyholder and the use of participating group is determined by the type of group to which the coverage is issued.

Exclusions: Exclusion number 4 will vary based on the requirements of the state

Reduction: Age ranges may be 70 to 80.

Continuation of Coverage: Birthday is based on state requirements and will never be less than what the state requires.

Payment of Premium:

The term Participating Group will be used when the coverage is issued to a group trust with participants in the trust.

Number of months and premium: Based on the policyholder information

Initial premium information: Will be included or excluded.

## Certificate GC559

Administrative office locations may be:

2700 West Plano Parkway Plano, Texas 75075-8200  
520 Park Avenue Baltimore, Maryland 21201  
Valley Forge, Pennsylvania 19493

Policy number and Policyholder name: Policy number and Policyholder name are specific to each certificate.

Right to Examine: Based on the policyholder information

Insured: To identify name and address of the Insured.

Certificate Number: Is specific to each certificate.

Schedule of Insurance: Personal data on the Schedule of Insurance is variable as it pertains to the Insured, and the amount of coverage purchased.

Covered Person: Birthday is based on state requirements and will never be less than what the state requires.

Participating Group: Will be used when the policy is issued to a participating group trust.

When insurance begins: 1 of the 2 items will be will be included.

Exclusions: Exclusion number 4 will vary based on the requirements of the state

Reduction: Age ranges may be 70 to 80.

Continuation of Coverage: Birthday is based on state requirements and will never be less than what the state requires.

Payment of Premium:

The term Participating Group will be used when the coverage is issued to a group trust with participants in the trust.

Number of months and premium: Based on the policyholder information

Initial premium information: Will be included or excluded.

**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
Margaret A. Frei, AIRC, ACS, ACP, CCP, HIA, HCSA 2700 W Plano Parkway Plano TX 75075	877-527-6444 Ext. 6289	972-881-4097	mfrei@aegonusa.com

<b>5. Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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<b>6. Company Tracking Number</b>	HH AR0049315F01
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<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b> Previous file # _____
-----------	--

<b>8. Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	<input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input 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: _____
	Group	

<b>9. Type of Insurance</b>	H02G Group Health - Accident Only
-----------------------------	-----------------------------------

<b>10. Product Coding Matrix Filing Code</b>	H02G.000 Health - Accident Only
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<b>11. Submitted Documents</b>	<input checked="" 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 checked="" type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	<b>Filing Submission Date</b>	February 5, 2010
13.	<b>Filing Fee (If required)</b>	Amount <u> \$50.00 </u> Check Date <u> N/A – via EFT </u> Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u> N/A – via EFT </u>
14.	<b>Date of Domiciliary Approval</b>	
15.	<b>Filing Description:</b>	
<p>RE: Stonebridge Life Insurance Company                  NAIC # 0468-65021 FEIN: 03-0164230                  GM559: Group Accident Emergency Room Home Recovery Policy                  GC559AR: Group Accident Emergency Room Home Recovery Certificate                  GGA159(99)AR: Enrollment Form                  GGA160AR: Enrollment Form                  Actuarial Memorandum</p> <p>Attached for your review and approval are copies of the above captioned forms. 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 bracketed and printed in red.</p> <p>GC559AR is a Group Accident Emergency Room Home Recovery Certificate. It provides emergency treatment and home recovery benefits for any insured who suffers a loss as a result bodily injury caused by an accident.</p> <p>GM559 is the master policy under which GC559 certificates will be issued.</p> <p>Enrollment Forms GGA159(99)AR and GGA160AR will be used to solicit this and other similar products.</p> <p>The Flesch scores for this Policy and Certificate are 43.2 and 48.8, respectively. Microsoft Word was used to obtain these scores.</p> <p>Illinois, our Situs State, approved the Policy and Certificate on December 29, 2009. Illinois approved the Enrollment Forms on November 4, 1999.</p> <p>The group policy is contemplated for issue to various discretionary groups that are situated in Illinois. We plan to initially issue the policy to Bank of America N. A. for their account holders.</p> <p>This product will be mass marketed by direct response and telemarketing methods and possibly on the Internet.</p> <p>We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print.</p> <p>The Company has reviewed the enclosed policy forms and certifies that each form submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.</p> <p>Completed filing forms are attached. Our filing fee is being sent via EFT.</p> <p>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 (877) 527-6444, Extension 6289 or contact me by e-mail at <a href="mailto:mfrei@aegonusa.com">mfrei@aegonusa.com</a>.</p> <p>Sincerely,</p> <p>STONEBRIDGE LIFE INSURANCE COMPANY                  Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA</p>		

<b>16. Certification (If required)</b>
<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> .
Print Name <u>Margaret A. Frei, AIRC, ACS, ACP, CCP, HIA, HCSA</u> Title <u>Senior Product Filing &amp; Compliance Analyst</u>
Signature <u></u> Date <u>February 5, 2010</u>

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		HH AR0049315F01
<b>This filing corresponds to rate filing company tracking number</b>		

	<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 Only Emergency Room and Home Recovery Certificate	GC559AR	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
02	Group Accident Only Emergency Room and Home Recovery Master Policy	GM559	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
03	Enrollment Form	GGA159(99)AR	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
04	Enrollment Form	GGA160AR	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
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> _____	