

SERFF Tracking Number: AEGX-G126717390 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 46183
Company Tracking Number: AR005691500002
TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Accidental Death
Project Name/Number: Accidental Death/AR005691500002

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Accidental Death SERFF Tr Num: AEGX-G126717390 State: Arkansas
TOI: H03G Group Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved-Closed State Tr Num: 46183
Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment Co Tr Num: AR005691500002 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: SPI ADMSLH Disposition Date: 07/20/2010
Date Submitted: 07/12/2010 Disposition Status: Approved-Closed
Implementation Date Requested: Implementation Date:

State Filing Description:

General Information

Project Name: Accidental Death Status of Filing in Domicile:
Project Number: AR005691500002 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: 07/20/2010 Explanation for Other Group Market Type:
State Status Changed: 07/20/2010
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
Group Enrollment Forms - SLAD1001GE and SLAD1002GE

Dear Commissioner:

SERFF Tracking Number: AEGX-G126717390 State: Arkansas
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 Dismemberment
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 Project Name/Number: Accidental Death/AR005691500002

The above referenced forms are submitted for your review and approval. These forms are new and do not replace any forms previously approved by your Department.

The Enrollment Forms will be used to solicit our currently approved Group Accidental Death and Dismemberment products and other similar products as your Department approves them.

This coverage will be mass-marketed via our internet website as well as by direct response methods.

Company and Contact

Filing Contact Information

Sharron Hawkins, Product Filing & Compliance sehawkins@aegonusa.com

Analyst

520 Park Avenue 410-209-5734 [Phone]

Baltimore, MD 21201 410-209-5510 [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

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 Per Form; 2 forms.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$100.00	07/12/2010	37907348

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/20/2010	07/20/2010

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Disposition

Disposition Date: 07/20/2010

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	EOV	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Group Enrollment Form	Approved-Closed	Yes
Form	Group 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 07/20/2010	SLAD1001 GE	Application/Group Enrollment Form	Application/Group Enrollment Form	Initial		0.000	SLAD1001GE Group Enrollment Form JD.PDF
Approved-Closed 07/20/2010	SLAD1002 GE	Application/Group Enrollment Form	Application/Group Enrollment Form	Initial		0.000	SLAD1002GE Group Enrollment Form JD.PDF

GROUP [ACCIDENTAL DEATH AND DISMEMBERMENT]
ENROLLMENT FORM

YES! I want to enroll for the coverage I have selected below. (Check one box only.)

[Accidental Death and Dismemberment] [with Intensive Care Unit Benefit]:

\${XX.XX} [per month] for me only \${XX.XX} [per month] for me and my eligible family members

[Sample A. Sample
1234 Address Street
Any City, State 00000-0000]

Date of Birth [01/01/1960] Male Female

Telephone Number: [(111) 111-1111]

[E-Mail: 123@123]

I understand that in order to enroll for this insurance coverage, [I must be a JCPenney Credit Cardholder or the spouse of a JCPenney Credit Cardholder, age {18 through 64}, with an account in good standing,] who resides in a state in which this insurance coverage 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. I also understand that benefits reduce by one-half when a covered person attains age {70}. [My coverage can never be cancelled as long as I pay my premiums and my renewal premiums can never be increased.] I may discontinue my coverage at any time. My coverage will become effective on the date stated on my Certificate Schedule Page. [I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

By signing below, I certify that I am currently eligible to receive Medicare benefits and have received a special notice regarding this product and Medicare benefits.

[Beneficiary designation: Any amount due for loss will be paid to you if living. Unless you specify below, any other benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any (including stepchildren and adopted children); otherwise equally to your then living parents or parent, otherwise to your estate.]

[Beneficiary SAMPLE B. SAMPLE Relationship SPOUSE]

Insured's Signature X [_____] Date [01-01-2010]

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

RESIDENTS OF:

Arkansas, 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.

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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.

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. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico

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 civil fines and criminal penalties.

Ohio

Any person who, with intent to defraud or knowing that he 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.

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.

Tennessee, and Washington

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

GROUP [ACCIDENTAL DEATH AND DISMEMBERMENT]
ENROLLMENT FORM

YES! I want to enroll for the coverage I have selected below. (Check one box only.)

[Accidental Death and Dismemberment] [with Intensive Care Unit Benefit:]

\${XX.XX} [per month] for me only \${XX.XX} [per month] for me and my eligible family members

[Sample A. Sample
1234 Address Street
Any City, State 00000-0000]

Date of Birth [01/01/1960] Male Female

Telephone Number: [(111) 111-1111]

[E-Mail: 123@123]

I understand that in order to enroll for this insurance coverage, [I must be a JCPenney Credit Cardholder or the spouse of a JCPenney Credit Cardholder, age {18 through 64}, with an account in good standing,] who resides in a state in which this insurance coverage 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. I also understand that benefits reduce by one-half when a covered person attains age {70}. [My coverage can never be cancelled as long as I pay my premiums and my renewal premiums can never be increased.] I may discontinue my coverage at any time. My coverage will become effective on the date stated on my Certificate Schedule Page. [I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

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

[Beneficiary designation: Any amount due for loss will be paid to you if living. Unless you specify below, any other benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any (including stepchildren and adopted children); otherwise equally to your then living parents or parent, otherwise to your estate.]

[Beneficiary SAMPLE B. SAMPLE Relationship SPOUSE]

Insured's Signature X [_____] Date [01-01-2010]

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

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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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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 civil fines and criminal penalties.

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	07/20/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/20/2010
Bypass Reason:	See Forms Schedule		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	EOV	Approved-Closed	07/20/2010
Comments:			
Attachment:			
EOV.PDF			

		Item Status:	Status Date:
Satisfied - Item:	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	07/20/2010
Comments:			
Attachment:			
AR - NAIC TRANSMITTAL DOCUMENT.PDF			

		Item Status:	Status Date:
Satisfied - Item:	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	07/20/2010

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Comments:

Attachment:

AR - NAIC FORM FILING ATTACHMENT.PDF

SLAD1001GE and SLAD1002 GE – Explanation of Variability

[Accidental Death and Dismemberment]	Title may vary depending on Marketing plan and if used with a different product in the future.
[Intensive Care Unit Benefit]	May vary depending on Marketing plan and if used with a different product in the future.
{XX.XX} [per month]	Benefit amount and offer is based on the marketing plan and requirements of the policyholder
Name, address, date of birth, telephone, email, male/female, required signature, date	Insured information is variable and specific to the prospective insured
[I must be a JCPenney Credit Cardholder or the spouse of a JCPenney Credit Cardholder, age {18 through 64}, with an account in good standing.]	Name of policyholder and issue ages are determined by the policyholder and who the group members are.
{70}	Age ranges may be 70 to 80
[My coverage can never be cancelled as long as I pay my premiums and my renewal premiums can never be increased.]	This sentence is used when the coverage offered is non cancelable.
[I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]	This sentence is used when the state specific fraud notices are on the back of the enrollment form.
[Beneficiary designation: Any amount due for loss will be paid to you if living. Unless you specify below, any other benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any (including stepchildren and adopted children); otherwise equally to your then living parents or parent, otherwise to your estate.] [Beneficiary _____ Relationship _____]	Beneficiary language will be included or excluded.
[2700 West Plano Parkway, Plano, Texas 75075-8200]	Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market.
State fraud statements on back of form	Used when the state specific fraud statement is not on the front page of the enrollment form.

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Stonebridge Life Insurance Company 187 West Street Rutland VT 05701	VT		468	65021	03-0164230	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Sharron E. Hawkins 520 Park Avenue Baltimore MD 21201	800-233-4624	410-209-5510	sehawkins@aegonusa.com

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	AR005691500002
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7. <input checked="" type="checkbox"/> New Submission	<input type="checkbox"/> Resubmission	Previous file # _____
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8. Market	<input type="checkbox"/> Individual	<input type="checkbox"/> Franchise		
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____		

9. Type of Insurance	H03G Group Health - Accidental Death & Dismemberment
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10. Product Coding Matrix Filing Code	H03G.000 Health - Accidental Death & Dismemberment
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11. Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input checked="" type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	7-12-2010
13.	Filing Fee (If required)	Amount <u>100.00</u> Check Date <u>EFT</u> Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number <u>EFT</u>
14.	Date of Domiciliary Approval	
15.	Filing Description:	
<p>RE: Stonebridge Life Insurance Company NAIC #0468-65021 FEIN #03-0164230 Group Enrollment Forms - SLAD1001GE and SLAD1002GE</p> <p>Dear Commissioner:</p> <p>The above referenced forms are submitted for your review and approval. These forms are new and do not replace any forms previously approved by your Department.</p> <p>The Enrollment Forms will be used to solicit our currently approved Group Accidental Death and Dismemberment products and other similar products as your Department approves them.</p> <p>This coverage will be mass-marketed via our internet website as well as by direct response methods.</p>		

16.	Certification (If required)	
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
<p>Print Name <u>Sharron E. Hawkins</u> Title <u>Product Filing & Compliance Analyst</u></p>		
<p>Signature <u><i>Sharron Hawkins</i></u> Date <u>7-12-2010</u></p>		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	AR005691500002	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Group Enrollment Form	SLAD1001GE	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Group Enrollment Form	SLAD1002GE	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	