

SERFF Tracking Number: AEGX-G127127489 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48507
Company Tracking Number: AR006121500021
TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Accidental Death
Project Name/Number: Accidental Death/AR006121500021

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Accidental Death

SERFF Tr Num: AEGX-
G127127489

State: Arkansas

TOI: H03G Group Health - Accidental Death &
Dismemberment

SERFF Status: Closed-Approved-
Closed

State Tr Num: 48507

Sub-TOI: H03G.000 Health - Accidental Death
& Dismemberment

Co Tr Num: AR006121500021

State Status: Approved-Closed

Filing Type: Form

Author: SPI ADMSLH

Reviewer(s): Rosalind Minor

Date Submitted: 04/15/2011

Disposition Date: 04/21/2011

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Accidental Death

Project Number: AR006121500021

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Other, Discretionary

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Explanation for Other Group Market Type:

Credit/Debtor Group

Overall Rate Impact:

Filing Status Changed: 04/21/2011

State Status Changed: 04/21/2011

Deemer Date:

Created By: SPI ADMSLH

Submitted By: SPI ADMSLH

Corresponding Filing Tracking Number:

Filing Description:

SLAD4100GP - Group Accident Insurance Policy

SLAD4100GC - Group Accident Insurance Certificate

SLAD4100GE - Group Accident Enrollment Form

SLAD4101GE - Group Accident Enrollment Form

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The above captioned forms are submitted for your review and approval. These forms are new and do not replace any forms previously approved by your Department. These forms have been completed in "John Doe" fashion.

This Group Accidental Death Insurance provides benefits if a Covered Person dies or suffers an Injury as a direct result of being struck by a Private Passenger Automobile or Land Motor Vehicle or as a direct result of a collision or crash of a Private Passenger Automobile or Land Motor Vehicle. Coverage ends when the Insured attains age 80.

We plan to issue the Master Policy to various discretionary groups that are situated in Missouri.

All variable information is bracketed and printed in red. We request approval of these forms with various dimensions, format, shading and colors. No dimension, format, shading or color change will produce unacceptable print.

Coverage is guaranteed issue.

The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format.

Company and Contact

Filing Contact Information

Sharron Hawkins, Product Filing & Compliance Sharron.Hawkins@transamerica.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: \$200.00
Retaliatory? No

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Fee Explanation: \$50 x 4 forms
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$200.00	04/15/2011	46612970

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/21/2011	04/21/2011

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	04/19/2011	04/19/2011	SPI ADMSLH	04/20/2011	04/20/2011

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Disposition

Disposition Date: 04/21/2011

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	Policy EOY	Approved-Closed	Yes
Supporting Document	Certificate EOY	Approved-Closed	Yes
Supporting Document	SLAD4100GE - EOY	Approved-Closed	Yes
Supporting Document	SLAD4101GE - EOY	Approved-Closed	Yes
Supporting Document	Actuarial Memo for SLAD4100GP	Approved-Closed	No
Supporting Document	SLAD4100GP - Group Accident Rate Sheet	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	MO Group Law	Approved-Closed	Yes
Form	Group Accident Insurance Policy	Approved-Closed	Yes
Form (revised)	Group Accident Insurance Certificate	Approved-Closed	Yes
Form	Group Accident Insurance Certificate	Replaced	Yes
Form	Group Accident Enrollment Form	Approved-Closed	Yes
Form	Group Accident Enrollment Form	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 04/19/2011
Submitted Date 04/19/2011
Respond By Date

Dear Sharron Hawkins,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Accident Insurance Policy, SLAD4100GP (Form)
- Group Accident Insurance Certificate, SLAD4100GC (Form)

Comment: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

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 04/20/2011
 Submitted Date 04/20/2011

Dear Rosalind Minor,

Comments:

In response to the objection letter 4-19-11 the certificate has been revised.

Response 1

Comments: We have revised the certificate by deleting the 60 day requirement for notifying the company that a child coverage should continue beyond the stated termination age. This certificate form will be issued only to Arkansas residents who enroll for coverage under the group policy.

Related Objection 1

Applies To:

- Group Accident Insurance Policy, SLAD4100GP (Form)
- Group Accident Insurance Certificate, SLAD4100GC (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

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
Group Accident Insurance Certificate	SLAD4100GC.AR		Certificate	Initial		44.200	SLAD4100GC.PDF
Previous Version							
Group Accident	SLAD410		Certificate	Initial		44.200	SLAD410

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Insurance Certificate 0GC

0GC -
Group
Accident
Insurance
Certificate.
PDF

No Rate/Rule Schedule items changed.

Sincerely,
SPI ADMSLH

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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 04/21/2011	SLAD4100 GP	Policy/Cont ract/Fratern al Certificate	Group Accident Insurance Policy	Initial		44.700	SLAD4100GP - Group Accident Insurance Policy.PDF
Approved-Closed 04/21/2011	SLAD4100 GC.AR	Certificate	Group Accident Insurance Certificate	Initial		44.200	SLAD4100GC .PDF
Approved-Closed 04/21/2011	SLAD4100 GE	Application/ Enrollment Form	Group Accident Enrollment Form	Initial		0.000	SLAD4100GE - Group Accident Enrollment Form.PDF
Approved-Closed 04/21/2011	SLAD4101 GE	Application/ Enrollment Form	Group Accident Enrollment Form	Initial		0.000	SLAD4101GE - Group Accident Enrollment Form.PDF

Stonebridge Life Insurance Company

A STOCK COMPANY

Home Office: 187 West Street, Rutland, VT 05701

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

Stonebridge Life Insurance Company

(Herein called the Company)

Having issued this Policy to

[ABC Corporation]

(Herein called Policyholder)

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

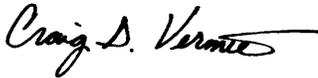
This Policy is issued in consideration of the payment of premium and statements made in the application herein provided, and shall take effect on [December 1, 2010] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR].

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

RIGHT TO EXAMINE CERTIFICATE

Any Insured may return the Certificate of Insurance within [1] [2] [3] month[s] after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded. The Certificate will be treated as if it never existed. No benefits will be paid.

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



Secretary



President

GROUP ACCIDENT INSURANCE POLICY

DEFINITIONS

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

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

- 1) the Insured's lawful spouse; and
- 2) each of the Insured's unmarried children including step-children, children born to the Insured or legally adopted by the Insured, 25 years of age or younger, (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).]

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.

HOSPITAL means an institution which is a short term acute care general hospital. Its main purpose must be to provide medical care and treatment to injured persons as Resident Patients. It must have facilities on premises for major surgery, medical diagnosis and treatment by or under the supervision of one or more licensed Physicians. It must provide 24 hour a day nursing service by or under the supervision of a registered nurse. It must have organized departments of medicine. It may not include a hospital operating primarily as a rest, convalescent, extended care, chronic or skilled nursing facility; home for the aged; a place for the care and treatment of drug addicts or alcoholics, or a mental institution; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, whether or not such a facility is part of a hospital, as defined herein, or is an entirely separate facility.

HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED means being a Resident Patient in a Hospital for Necessary 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.

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 all other causes. Injury must not be caused by or contributed to by sickness, disease or bodily or mental infirmity.

INSURED means the Insured named in the Certificate Schedule of Insurance, and whose coverage has become effective.

LAND MOTOR VEHICLE includes any gasoline, diesel, electric or similarly powered vehicle which is required to be registered with the state for use on public highways, customarily used for transportation on land and for which the operator is required to be licensed.

This category includes, but is not limited to the following:

1. vehicles defined as "Private Passenger Automobiles" in this Policy;
2. vehicles with more than four wheels, such as tractor/trailer rigs and flat bed trucks; or
3. vehicles registered to carry passengers for hire.

Farm equipment, forklifts, construction equipment, motorcycles, motor scooters, all terrain vehicles, snowmobiles, and vehicles designed primarily for off road use are specifically excluded under Land Motor Vehicle.

[PARTICIPATING GROUP means an organization 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.]

PRIVATE PASSENGER AUTOMOBILE means a four-wheeled vehicle which is required to be registered with the state for non-commercial use on public highways and includes station wagons, vans, jeeps or truck types with a factory rating load capacity of 2,000 pounds or less, or self-propelled motor home type vehicles.

Farm equipment, forklifts, construction equipment, motorcycles, motor scooters, all terrain vehicles, snowmobiles, vehicles designed primarily for off road use and vehicles registered to carry passengers for hire are specifically excluded under Private Passenger Automobile.

ELIGIBILITY

Each natural person AGE [18 THROUGH 80] WHO IS AN ABC CORPORATION ACCOUNTHOLDER (OR THE SPOUSE OF AN ABC CORPORATION ACCOUNTHOLDER AGE [18 THROUGH 80]) 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 with the Policyholder / Participating Group named in the Certificate Schedule of Insurance. 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.

RENEWAL CONDITIONS

[Continuation of an Insured's Certificate is contingent upon continuation of this Policy. This Policy may be cancelled by the Company by providing written notice to the [Participating Group/Policyholder] at least [60] days prior to cancellation of this Policy.

The Company promises to renew an Insured's Certificate as long as this Policy remains in force; the Insured continues to pay the premium when due; the Company renews all other certificates that are issued under this Policy; and the Insured has not performed an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage.]

WHEN A PERSON BECOMES INSURED

Each Insured will be issued a Certificate of Insurance following acceptance by the Company of the enrollment form, if required. The Certificate will indicate the coverage, the Effective Date of coverage, and the persons covered.

Each eligible person shall become insured on the Effective Date shown in the Certificate Schedule of Insurance provided the Company receives the initial premium [before][within 21 days of] the Certificate Effective Date and while the Insured is alive.

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

Issuance of an Insured's Certificate is not a waiver of any of the above conditions.

WHEN A PERSON'S INSURANCE ENDS

An Insured's insurance ends on the earlier of:

- 1) the last day of the period covered by the Insured's last premium contribution; or
- 2) the first monthly renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the date the Insured dies.

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

The Company will give the Insureds 31 days notice in the event the Policy terminates. Any premium paid beyond the date that coverage stops will be refunded to the Insureds.

In the event the insurance terminates, it does not affect payment for a loss which began while the coverage was in force.

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 Insured shall be the amount shown in the Certificate Schedule of Insurance issued to each individual Insured.

COVERAGE

The Company will pay the following benefits if a Covered Person dies or is Injured as a direct result of being struck by a Private Passenger Automobile or Land Motor Vehicle or as a direct result of a collision or crash of a Private Passenger Automobile or Land Motor Vehicle.

PART I ACCIDENTAL DEATH BENEFIT

If a Covered Person dies as the result of a covered Injury from an accident not otherwise excluded and death occurs within 90 days following the date of the accident which caused the Injury, the Company will pay the applicable benefit specified on the Certificate Schedule of Insurance for the loss.

PART II ACCIDENT EMERGENCY FACILITY BENEFIT

The Company will pay the Accident Emergency Facility Benefit shown on the Certificate Schedule of Insurance if a Covered Person receives emergency Necessary Treatment for a covered Injury at a Hospital Emergency Room or other Emergency Facility. Treatment must occur within 72 hours of the accident causing the Injury. Only one Accident Emergency Facility Benefit will be paid per Covered Person per accident.

PART III ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT

The Company will pay the Accident Hospital Confinement Benefit shown on the Certificate Schedule of Insurance if a Covered Person is Confined to a Hospital as a Resident Patient for the Necessary Treatment of a covered Injury. The benefit is paid beginning with the first day of Confinement and will continue for up to the maximum number of days shown on the Certificate Schedule of Insurance. The Confinement must begin 1) while this Certificate is in force and 2) within 90 days of the accident causing the Injury.

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

PART IV REHABILITATIVE THERAPY BENEFIT

The Company will pay the Rehabilitative Therapy Benefit shown on the Certificate Schedule of Insurance if a Covered Person requires physical therapy or occupational therapy because of a covered Injury. Any such therapy must be provided by a Therapist and prescribed by a Physician. Physical therapy or occupational therapy must start within [30] days of the accident causing the Injury or discharge from the hospital.

The Company will only pay for one (1) treatment per Covered Person per day for the Maximum Number of Treatments shown on the Schedule of Insurance per accident. All treatments for one accidental Injury must be treated within 12 months.

Rehabilitative Therapy Benefits will stop once the Maximum Number of Treatments per covered Accident shown on the Certificate Schedule of Insurance has been met.

[PART V PERSISTENCY BENEFIT

The Company will pay the Persistency Benefit stated on the Certificate Schedule of Insurance as long as the Policy and Certificate remain in force.]

[REDUCTION

All benefits, [except the Persistency Benefit,] in the Certificate and any riders, if attached, will reduce as shown in the Certificate Schedule of Insurance if, before the date of Injury, [the Insured] [a Covered Person] has attained the age shown in the Certificate Schedule of Insurance.]

EXCLUSIONS

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

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

BENEFICIARY

All benefits are payable to the Insured, if living. Unless otherwise specified, any other benefit due for loss of life will be paid as follows:

1. to the Insured's living lawful spouse; or if the Insured does not have 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. to the Insured's estate.

At the death of any other Covered Person, benefits will be paid to the Insured, if living; otherwise as though it were payable under items 1 through 4 above

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 and parents do not mean "step" children and parents.

CHANGE OF BENEFICIARY

An Insured may change the beneficiary at any time by writing to the Company at its Administrative Office. Once the Company records the change, it will take effect as of the day the Insured signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable. Any change of beneficiary is subject to community property laws in the Insured's state of residence.

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 monthly renewal date. If the Insured's spouse ceases to be the spouse 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 the Certificate shall terminate as of the next monthly renewal date after the covered child's marriage or the date the covered child is no longer a Covered Person as defined herein, whichever occurs first.

An unmarried covered child may continue to be covered upon reaching the limiting age specified in the Covered Person definition, if:

- 1) the covered child is incapable of self-sustaining employment by reason of mental or physical handicap; and
- 2) the covered child is dependent upon the Insured for support and maintenance; and
- 3) the Insured sends the Company a written request for continuation of coverage within 60 days; and
- 4) the Insured provides proof of incapacity as requested but no more than once annually; and
- 5) the Insured pays the premium for adult benefits, if required.

Coverage may be extended for any covered child who is a full-time student at a postsecondary educational institution and who takes a Medically Necessary Leave of Absence until the earlier of one year or the date coverage would otherwise terminate under the contract terms. The Insured must notify the Company and provide proof of the Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence is defined as a leave of absence from a postsecondary educational institution or a change in enrollment of the covered child that:

- 1) begins while the covered child is suffering from a serious illness;
- 2) is medically necessary; and
- 3) causes the covered child to lose student status for the purposes of coverage under the Certificate.

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 Insured's 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 Insured's Certificate.]

NEWBORN CHILDREN

If an Insured's spouse or any children are already covered under the 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 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 Certificate and if the Insured wishes to add child coverage, the Insured must notify the Company of the child's birth within 31 days of the birth and pay the required additional premium. The child's benefit will be the amount which would have been issued to children as of the effective date of the Certificate. After the initial 31 days, the child will not be covered unless the required additional premium is paid in accordance with the provisions of the Certificate.

PREMIUM

The premium rate for each Insured is included on the attached rate sheet.

PAYMENT OF PREMIUM

All premiums due by the terms of this Policy shall be paid 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.]

[After the first [1] [2] [3] month[s]] the Insured is required to contribute 100 percent of the premium payable for the Certificate.

[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.]

PREMIUM CHANGES

The Company has the right to change the table of rates on any date [after an Insured's Certificate has been in force one year]. The Company will provide written notice to the [Participating Group][Policyholder] at least 31 days before the date of change. The premium rates may also be changed at any time the terms of this Policy are changed [but not more than once in a twelve month period].

The premium amount due may change when a Covered Person is added to or dropped from coverage or when benefits under the Certificate change. Any additional coverage is subject to the Company's acceptance of the enrollment form, if required, and payment of any additional required premium.

There will be no change in an Insured's premium rate due to any physical impairment or claim incurred.

GRACE PERIOD

If a premium is not paid when due, the insurance shall be in default. The Company will allow a 31-day grace period to pay each premium after the first one. If a premium is not paid on or before the end of the grace period, the insurance shall terminate effective the last day of the period covered by the last premium contribution. No benefits are paid for a loss occurring after the expiration of the grace period.

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

MISSTATEMENT OF AGE

If the Insured's age 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.

WHEN THERE IS A CLAIM

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 notice should include the Insured's name and Certificate Number as shown in the Certificate Schedule of Insurance. 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 shall be deemed to have complied with the requirements of the Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proof of Loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

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. Failure to produce proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within this time period. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS

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

When a claim is paid during the Grace Period, any premium due and unpaid may be deducted from the claim payment.

PAYMENT OF CLAIMS

All benefits are payable to the Insured, if living. Loss of life benefits for the Insured is payable in accordance with the beneficiary designation in effect at the time of payment. Other benefits will be paid to the Insured. Any other benefits, other than for loss of life, unpaid at the Insured's death may be paid either to the Insured's beneficiary or estate.

[PHYSICAL EXAMINATION AND] AUTOPSY

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

GENERAL PROVISIONS

ENTIRE CONTRACT

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

INCONTESTABILITY

The Company cannot contest the Certificate except for fraud or not paying premiums.

INFORMATION TO BE FURNISHED

The **[Policyholder / Participating Group]** 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 / Participating Group]** or in possession of the **[Policyholder / Participating Group]** 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.

LEGAL ACTIONS

No action may 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 of Proof of Loss is required.

[OTHER INSURANCE

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

Stonebridge Life Insurance Company

A Stock Company

Home Office: 187 West Street, Rutland, VT 05701

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. [25XXX GCXXX] to [XYZ Corporation] (herein called Policyholder) which makes available accidental death 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

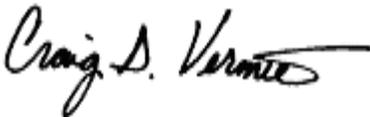
You may return the Certificate of Insurance within [1] [2] [3] month[s] after its receipt to us at our Administrative Office. Any premium you have paid will be refunded. The Certificate will be treated as if it never existed. No benefits will be paid.

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

RENEWABLE AT THE OPTION OF THE COMPANY

We promise to renew this Certificate as long as: (1) the Group Policy remains in force; (2) you continue to pay your premium when due; (3) we renew all other certificates that are issued under the Policy; and (4) you have not performed an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage.

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



Secretary



President

GROUP ACCIDENT INSURANCE
RENEWABLE AT THE OPTION OF THE COMPANY

STONEBRIDGE LIFE INSURANCE COMPANY

SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. [25517 GCXXX] to [XYZ Corporation]

[PARTICIPATING GROUP NUMBER: XXXXXX PARTICIPATING GROUP: XXXXXXXXX]
[CERTIFICATE NUMBER: 82A1000000] EFFECTIVE DATE: 11-01-2010
[INSURED]: [JOHN DOE [MONTHLY PREMIUM]: [\$12.95]
221 ANYSTREET
APARTMENT 1231
ANYTOWN, USA 12345]

[INITIAL PREMIUM: \$ 1.00]

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

[FAMILY COVERAGE]: [YES]

BENEFITS ARE LIMITED TO INJURIES OR LOSS OF LIFE DUE TO ACCIDENTS RELATED TO OR RESULTING FROM PRIVATE PASSENGER AUTOMOBILES OR LAND MOTOR VEHICLES

SCHEDULE OF INSURANCE

[BENEFIT]:	[INSURED]	[SPOUSE]	[EACH CHILD]
[PART I ACCIDENTAL DEATH BENEFIT	[\$ 50,000-500,000]	[\$ 25,000-\$500,000]	[\$ 2,500- \$ 25,000]]
[PART II ACCIDENT EMERGENCY FACILITY BENEFIT - 1 VISIT PER COVERED ACCIDENT PER COVERED PERSON:	[\$50-\$1,000 per visit	[\$50-\$1,000] per visit	[\$50-\$1,000] per visit]
[NUMBER OF COVERED ACCIDENTS PER CALENDAR YEAR: OR	[3-6]	[3-6]	[3-6]]
[MAXIMUM NUMBER OF ACCIDENTS PAID EACH CALENDAR YEAR FOR ALL COVERED PERSONS COMBINED: [1-12]]			
[PART III ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT	[\$100-\$1,000] per day	[\$100-\$1,000] per day	[\$100-\$1,000] per day]
[MAXIMUM NUMBER OF DAYS PAID PER COVERED PERSON, PER ACCIDENT	[60- 730]	[60-730]	[60-730]]
[PART IV REHABILITATIVE THERAPY BENEFIT MAXIMUM NUMBER OF VISITS PAID PER COVERED PERSON, PER ACCIDENT	[\$25-\$250] per visit [3-24]	[\$25-\$250] per visit [3-24]	[\$25-\$250] per visit [3-24]]

IF THE COVERED PERSON ATTAINS AGE 70 BEFORE THE DATE OF THE INJURY, THE BENEFITS LISTED ABOVE WILL BE REDUCED BY ONE-HALF (50%).

**[PART V
PERSISTENCY BENEFIT**

[\$10 - \$50]

**[PAYABLE 90 DAYS AFTER] THE CERTIFICATE EFFECTIVE DATE
[PAYABLE ON THE [FIRST – TENTH] CERTIFICATE ANNIVERSARY
AND THEREAFTER EVERY [ONE – TEN] YEAR[S]]**

DEFINITIONS

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

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

1. your lawful spouse; and
2. each of your unmarried children including step-children, children born to you or legally adopted by you, 25 years of age or younger. (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.)

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.

HOSPITAL means an institution which is a short term acute care general hospital. Its main purpose must be to provide medical care and treatment to injured persons as Resident Patients. It must have facilities on premises for major surgery, medical diagnosis and treatment by or under the supervision of one or more licensed Physicians. It must provide 24 hour a day nursing service by or under the supervision of a registered nurse. It must have organized departments of medicine. It may not include a hospital operating primarily as a rest, convalescent, extended care, rehabilitation, chronic or skilled nursing facility; home for the aged; a place for the care and treatment of drug addicts or alcoholics, or a mental institution; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, whether or not such a facility is part of a hospital, as defined herein, or is an entirely separate facility.

HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED means being a Resident Patient in a Hospital for Necessary 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.

IMMEDIATE FAMILY means your spouse, parent, child, brother or sister, or any person living with you.

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

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

LAND MOTOR VEHICLE includes any gasoline, diesel, electric or similarly powered vehicle which is required to be registered with the state for use on public highways, customarily used for transportation on land and for which the operator is required to be licensed.

This category includes, but is not limited to the following:

1. vehicles defined as "Private Passenger Automobiles" in this Certificate;
2. vehicles with more than four wheels, such as tractor/trailer rigs and flat bed trucks; or
3. vehicles registered to carry passengers for hire.

Farm equipment, forklifts, construction equipment, motorcycles, motor scooters, all terrain vehicles, snowmobiles, and vehicles designed primarily for off road use are specifically excluded under Land Motor Vehicle.

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 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.

Services will not be deemed necessary treatment if these criteria are not met.

[PARTICIPATING GROUP is the organization named on the Schedule of Insurance.]

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat 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.

PRIVATE PASSENGER AUTOMOBILE means a four-wheeled vehicle which is required to be registered with the state for non-commercial use on public highways and includes station wagons, vans, jeeps or truck types with a factory rating load capacity of 2,000 pounds or less, or self-propelled motor home type vehicles.

Farm equipment, forklifts, construction equipment, motorcycles, motor scooters, all terrain vehicles, snowmobiles, vehicles designed primarily for off road use and vehicles registered to carry passengers for hire are specifically excluded under Private Passenger Automobile.

RESIDENT PATIENT means a Covered Person who is confined in a Hospital as a registered bed patient and who is provided at least one day of room and board. A Covered Person is considered to be a resident patient each day of Confinement in the Hospital except for the day of discharge; unless a room and board charge is made for that day. This does not include Confinement if it is not for Necessary Treatment or if the Hospital is used primarily as a place for rest, nursing, rehabilitation, convalescence or extended care.

THERAPIST means a licensed specialist in physical therapy or occupational therapy. A Covered Person's Immediate Family or other household members will not be considered a Therapist.

WHEN YOUR INSURANCE BEGINS

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.]

Issuance of a Certificate is not a waiver of any of the above conditions.

WHEN YOUR INSURANCE ENDS

Your insurance ends on the earlier of:

1. the last day of the period covered by your last premium contribution;
2. the first monthly renewal date of the Certificate following the date the Policy is terminated or cancelled; or
3. the date you die. (See the Continuation of Coverage Provision)

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

We will give you 31 days notice in the event the Policy terminates. We will refund any premium paid beyond the date the coverage stops.

In the event the insurance terminates, it does not affect payment for a loss or Injury which began while the coverage was in force.

COVERAGE

We pay the following benefits if a Covered Person dies or suffers an Injury as a direct result of being struck by a Private Passenger Automobile or Land Motor Vehicle or as a direct result of a collision or crash of a Private Passenger Automobile or Land Motor Vehicle.

PART I ACCIDENTAL DEATH BENEFIT

We pay the Accidental Death benefit shown on the Schedule of Insurance if a Covered Person dies as the result of a covered Injury. Death must occur within 90 days after the date of the covered accident that causes the Injury.

PART II ACCIDENT EMERGENCY FACILITY BENEFIT

We pay the Accident Emergency Facility Benefit shown on the Schedule of Insurance if a Covered Person receives emergency Necessary Treatment for a covered Injury at a Hospital Emergency Room or other Emergency Facility. Treatment must occur within 72 hours of the accident causing the Injury. Only one Accident Emergency Facility Benefit will be paid per Covered Person per accident.

PART III ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT

We pay the Accident Hospital Confinement Benefit shown on the Schedule of Insurance if a Covered Person is Confined to a Hospital as a Resident Patient for the Necessary Treatment of a covered Injury. The benefit is paid beginning with the first day of Confinement and will continue for up to the maximum number of days shown on the Schedule of Insurance. The Confinement must begin 1) while this Certificate is in force and 2) within 90 days of the accident causing the Injury.

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

PART IV REHABILITATIVE THERAPY BENEFIT

We pay the Rehabilitative Therapy Benefit shown on the Schedule of Insurance if a Covered Person requires physical therapy or occupational therapy because of a covered Injury. Any such therapy must be provided by a Therapist and prescribed by a Physician. Physical therapy or occupational therapy must start within [30] days of the accident causing the Injury or discharge from the hospital.

We will only pay for one (1) treatment per Covered Person per day for the Maximum Number of Treatments shown on the Schedule of Insurance per accident. All treatments for one accidental Injury must be treated within 12 months.

Rehabilitative Therapy Benefits will stop once the Maximum Number of Treatments per covered Accident shown on the Schedule of Insurance has been met.

[PART V PERSISTENCY BENEFIT

We pay the Persistency Benefit stated in the Schedule of Insurance as long as the Policy and Certificate remain in force.]

REDUCTION

All benefits [,except the Persistency Benefit,] in this Certificate and any riders, if attached, will reduce as shown on the Schedule of Insurance if, before the date of Injury, [you have][a Covered Person has] attained the age shown on the Schedule of Insurance.

EXCLUSIONS

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

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

BENEFICIARY

All benefits are payable to you, if living. Unless you specify otherwise, any other benefit due for loss of life will be paid as follows:

1. 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. to your estate.

At the death of any other Covered Person, benefits will be paid to you, if living; otherwise as though it were payable under items 1 through 4 above.

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 and parents do not mean "step" children and parents.

CHANGE OF BENEFICIARY

You may change the beneficiary at any time by writing to us at our Administrative Office. Once we record the change, it will take effect as of the day you signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable. Any change of beneficiary is subject to community property laws in your state of residence.

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 monthly renewal date. If your spouse ceases to be your spouse for reasons other than your death, your spouse will no longer be covered as of the next monthly renewal date.

Coverage for any covered child insured under this Certificate shall terminate as of the next monthly renewal date after the covered child's marriage or the date the covered child is no longer a Covered Person as defined herein, whichever occurs first.

An unmarried covered child may continue to be covered upon reaching the limiting age as specified in the Covered Person definition, if:

1. the covered child is incapable of self-sustaining employment by reason of mental or physical handicap; and
2. dependent upon you for support and maintenance; and
3. you send us a written request for continuation of coverage; and
4. you provide proof of incapacity as requested but no more than once annually; and
5. you pay the premium for adult benefits, if required.

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 or Injury 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 and if you wish to add child coverage, you must notify us of the child's birth within 31 days of the birth and pay the required additional premium. The child's benefit will be the amount which would have been issued to children as of the effective date of this Certificate. After the initial 31 days, the child will not be covered unless the required additional premium is paid in accordance with the provisions of this Certificate.

PREMIUM

PAYMENT OF PREMIUM

All premiums due by the terms of the Policy shall be paid 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.]

[After the first [1] [2] [3] month[s] [you are required to contribute 100 percent of the premium payable for this Certificate.]

[If no initial premium is requested by us with your enrollment form, you shall have 21 days from the Effective Date shown in the 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 or Injury.]

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.

PREMIUM CHANGES

All renewal premiums will be based on our rates in effect for this Policy on the date such premiums are due.

We have the right to change the premium rates on any date. The new rates will be based on the ages of the Covered Persons on the dates they became insured. We will provide written notice at least 31 days before the date of change.

The premium rates may also be changed at any time the terms of the Group Policy are changed.

We will not increase your rates in the first Certificate year of coverage. After that, rates will not increase more than once in any 12 month period. There will be no change in the class of the Covered Persons due to any physical impairment or claim incurred.

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. No benefits are paid for a loss or Injury occurring after the expiration of the Grace Period.

REINSTATEMENT

Your Certificate will lapse if you do not pay your premium before the end of the Grace Period. If we later accept a premium and do not require an application for reinstatement, that payment will put the Certificate back in force. If we require an application for reinstatement, this Certificate will be put back in force when we approve it and the required premium is received. If we do not approve it, the Certificate will be put back in force on the 45th 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 occurs after the date of reinstatement. In all other respects, you and we have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

MISSTATEMENT OF AGE

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

WHEN THERE IS A CLAIM

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. The notice should include your name and Certificate Number as shown in the Certificate Schedule of Insurance. Notice should be mailed to us at our Administrative Office.

CLAIM FORMS

When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in this Certificate for filing Proof of Loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

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. Failure to produce proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within this time period. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS

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

When a claim is paid during the Grace Period, any premium due and unpaid may be deducted from the claim payment.

PAYMENT OF CLAIMS

All benefits are payable to you, if living. Loss of life benefits for you are payable in accordance with the beneficiary designation in effect at the time of payment. Other benefits will be paid to you. Any other benefits, other than for loss of life, unpaid at your death may be paid to your beneficiary or estate.

PHYSICAL EXAM AND AUTOPSY

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

GENERAL PROVISIONS

ENTIRE CONTRACT

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

INCONTESTABILITY

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

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.

[OTHER INSURANCE

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

[Variable Logo]
 [Plan Marketing Name]
 Enrollment Form

Underwritten by Stonebridge Life Insurance Company
 Administration Office: [2700 West Plano Parkway, Plano, Texas 75075]

[John Doe]
 [123 Main Street]
 [Apartment #X]
 [Columbia, SC XXXXX]

[Please reply by: Month XX, 2011]

[Bar Code for Scanning Purposes]

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

1. Select your insurance coverage (Check one box below)

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

[Plan Marketing Name]	[Plan 1]	[Plan 2]	[Plan 3]	[Plan 4]
Emergency Treatment	\$500 per visit	\$500 per visit	\$500 per visit	\$500 per visit
Accidental Death	\$100,000	\$200,000	\$300,000	\$500,000
Daily Hospitalization	\$200 per day	\$200 per day	\$200 per day	\$200 per day
Rehabilitative Therapy	\$50 per visit	\$50 per visit	\$50 per visit	\$50 per visit
[Monthly] Premium [Individual]	.. \$9.30	.. \$15.30	.. \$21.30	.. \$33.30
Family	.. \$14.55	.. \$20.55	.. \$26.55	.. \$38.55

2. Complete the information below [and name your beneficiary]

Customer Birth Date ____/____/____
 (required) MM / DD / YYYY

.. Male .. Female

Home Phone _____

Email: _____

[Beneficiary _____]

[Relationship to Insured _____]

Check here if you are eligible to receive Medicare Benefits]

3. Sign and date below

[By signing below, I certify that I understand coverage is limited to a total indemnity of not more than [\$1,000,000.00] for Accidental Death Insurance in effect with us or Transamerica Life Insurance Company, Stonebridge Casualty Insurance Company, Monumental Life Insurance Company or Transamerica Financial Life Insurance Company at any one time.]

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 [billed] [monthly] and [electronically] remitted to the Insurance Company [directly] from my [ABC Bank] [checking] account. [A [\$0.75] administrative fee will be added for each automatic account billing.] [If I sign and return this form without selecting a coverage amount, I understand that I will be automatically enrolled for [\$100,000] of [Customer][only] 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 also understand that coverage reduces by fifty percent (50%) at the Insured's age [70]. I acknowledge that I have received, read and understand the insurance disclosures [on the reverse side of this form][and][below].

[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank] to activate my coverage.]

X _____
 Signature of Customer (required)

Date (Required) ____/____/____
 MM DD YYYY

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.]

Payment Information:

[The first month's coverage will be provided at no cost to me.]

[The monthly costs for the first [30] days of coverage will be paid for by [J. C. Penney]

[In signing the enrollment form, I authorize the monthly premium as shown above for the coverage chosen to be billed as indicated below. [A [\$0.75] administrative fee will be added for each automatic account billing.]]

• Please charge my monthly premiums to my [J. C. Penney] 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.]

[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank] to activate my coverage.]

X _____
Signature of Customer (required)

Date (Required) ____/____/____
MM DD YYYY

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.]

SERFF Tracking Number: AEGX-G127127489 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48507
 Company Tracking Number: AR006121500021
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment
 Dismemberment
 Product Name: Accidental Death
 Project Name/Number: Accidental Death/AR006121500021

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	04/21/2011
Comments:			
Attachment:			
	AR - READABILITY CERTIFICATION.PDF		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	04/21/2011
Bypass Reason:	N/A Enrollment forms are under the Forms Schedule Tab		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Policy EOV	Approved-Closed	04/21/2011
Comments:			
Attachment:			
	Policy EOV.PDF		

		Item Status:	Status Date:
Satisfied - Item:	Certificate EOV	Approved-Closed	04/21/2011
Comments:			
Attachment:			
	Certificate EOV.PDF		

		Item Status:	Status Date:
Satisfied - Item:	SLAD4100GE - EOV	Approved-Closed	04/21/2011
Comments:			

SERFF Tracking Number: AEGX-G127127489 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48507
 Company Tracking Number: AR006121500021
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: Accidental Death
 Project Name/Number: Accidental Death/AR006121500021

Attachment:
 SLAD4100GE - EO.V.PDF

	Item Status:	Status Date:
Satisfied - Item: SLAD4101GE - EO.V Comments: Attachment: SLAD4101GE - EO.V.PDF	Approved-Closed	04/21/2011

	Item Status:	Status Date:
Satisfied - Item: SLAD4100GP - Group Accident Rate Sheet Comments: Attachment: SLAD4100GP - Group Accident Rate Sheet.PDF	Approved-Closed	04/21/2011

	Item Status:	Status Date:
Satisfied - Item: AR - NAIC TRANSMITTAL DOCUMENT Comments: Attachment: AR - NAIC TRANSMITTAL DOCUMENT.PDF	Approved-Closed	04/21/2011

	Item Status:	Status Date:
Satisfied - Item: AR - NAIC FORM FILING ATTACHMENT Comments: Attachment: AR - NAIC FORM FILING ATTACHMENT.PDF	Approved-Closed	04/21/2011

SERFF Tracking Number: AEGX-G127127489 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48507
Company Tracking Number: AR006121500021
TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Accidental Death
Project Name/Number: Accidental Death/AR006121500021

		Item Status:	Status Date:
Satisfied - Item:	MO Group Law	Approved-Closed	04/21/2011
Comments:			
Attachment:			
MO Group Law.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
SLAD4100GP	44.7
SLAD4100GC	44.2
SLAD4100GE	0
SLAD4101GE	0

Cheryl Bock

Signed: _____
Name: Cheryl Bock
Assistant Vice President of Contract
Title: Development
Date: _____

Explanation of Variability – SLAD4100GP

General Note: If the product is issued to a Participating Group Trust, we will use the Participating Group language if applicable otherwise, we will use the Policyholder language.

Page 1

- **ADMINISTRATIVE OFFICE** is bracketed as Stonebridge Life Insurance Company has several administrative office locations.
 - § 2700 West Plano Parkway
Plano, Texas 75075-8200
 - § 520 Park Avenue
Baltimore, Maryland 21201
 - § Valley Forge, Pennsylvania 19493
- **RIGHT TO EXAMINE:**
 - The Right to Examine period will be 1, 2, or 3 months, depending on what the Policyholder wants to offer.
- **SUPERSEDES PARAGRAPH:** This paragraph will be printed when we need to manage our risk of liability with a single Insured.

Page 2

- **AEGON AFFILIATE** paragraph will print if the Other Insurance Provision prints
- **COVERED PERSON** the options are:
 - means the Insured (***if covering Primary only***)
 - means, for coverage purposes only, Insured and Insured's spouse, provided coverage has become effective. (***if covering Primary and Spouse only***)
 - means, for coverage purposes only, the Insured and the following persons, provided coverage has become effective:
 1. the Insured's lawful spouse; and
 2. each of the Insured's unmarried children which would include step-children, children born to you or legally adopted by you, 25 years of age or younger, unmarried and dependent upon you for support and maintenance. (An adopted child is a child who is in your custody pursuant to an interim court order of adoption or placement of adoption. (***if Primary, Spouse and Child***))
- **PARTICIPATING GROUP** definition will only print if this coverage is issued to a Participating Group Trust.

Page 3

- **WHEN A PERSON BECOMES INSURED** will vary according to which system this form is loaded on.
 - **Newborn Children** paragraph will print if Children are covered.

Page 5

- **PERSISTENCY BENEFIT** will print if the Persistency benefit is offered.
- **REDUCTION** will print if there is any type of reduction stated on the Schedule of Insurance.

Page 6

- **CONTINUATION OF COVERAGE** will included or excluded based on the coverage in the event of the Insured's death:
 - Deleted completely (*if Primary only*)
 - Will be included (*if Primary , Spouse and Child*)
 - Will be included (*if Primary and Spouse*)
- **CONVERSION** will print if Spouse or Child are covered.

Page 7

- **PAYMENT OF PREMIUM**
 - This paragraph will print and state the time frame the premium paid by the Policyholder will cover. Either one month, two months or 3 months.
 - After the [first month / two months / three months] will print if the Policyholder is paying the first premium and match the time limit in Paragraph Two.
 - Will print if the Policyholder is NOT paying the first premium. If the premium is being paid by the Policyholder, this paragraph will not print.
 - Either Participating Group language will print if issued to a Participating Group Trust, otherwise will print Policyholder.
- **PREMIUM CHANGES**
 - If Dependent Coverage is available, the Second Paragraph will print.

Page 8

- In the **AUTOPSY** provision, if non-death benefits are issued, then **PHYSICAL EXAMINATION AND** and the variable section will print. If only Accidental Death benefits are issued, only the black text will print.

Page 9

- **OTHER INSURANCE IN THIS COMPANY** will print when we need to limit our liability for a single insured

Explanation of Variability – SLAD4100GC

General Note: If the product is issued to a Participating Group Trust, we will use the Participating Group language if applicable otherwise, we will use the Policyholder language.

Page 1

- **ADMINISTRATIVE OFFICE** is bracketed as Stonebridge Life Insurance Company has several administrative office locations.
 - § 2700 West Plano Parkway
Plano, Texas 75075-8200
 - § 520 Park Avenue
Baltimore, Maryland 21201
 - § Valley Forge, Pennsylvania 19493
- **RIGHT TO EXAMINE:**
 - The Right to Examine period will be 1, 2, or 3 months, depending on what the Policyholder wants to offer.
- **SUPERSEDES PARAGRAPH:** This paragraph will be printed when we need to manage our risk of liability with a single Insured.

Page 2

- **SCHEDULE PAGE:** Personal data on the Schedule of Insurance is variable as it pertains to the Insured, and the amount of coverage purchased.
 - **FAMILY COVERAGE/SPOUSE COVERAGE/CHILD** will be used depending on how this product is marketed and who will be covered.
 - **INITIAL PREMIUM:** States the first premium (if different than renewal premiums) and allows us to offer a 1, 2 or 3 month first premium
 - **MONTHLY PREMIUM** will show the premium
After the first month, two months or 3 months will print if Initial Premium differs from the Monthly Premium.
 - **BENEFITS** – The Policy Holder will determine the selections. Those items not selected will not appear.

Page 3

- **PERSISTENCY BENEFIT** If the benefit is offered, this will describe when and how much the benefit will be and to what extent.
- **AEGON AFFILIATE** paragraph will print if the Other Insurance Provision prints

Page 4

- **WHEN YOUR INSURANCE BEGINS** will vary according to which system this form is loaded on.
- **Newborn Children** paragraph will print if Children are covered.

Page 5

- **PERSISTENCY BENEFIT** will print if the Persistency benefit is offered.

Page 7

- **PAYMENT OF PREMIUM**

- This paragraph will print and state the time frame the premium paid by the Policyholder will cover. Either one month, two months or 3 months.
- After the [first month / two months / three months] will print if the Policyholder is paying the first premium and match the time limit in Paragraph Two.
- Will print if the Policyholder is NOT paying the first premium. If the premium is being paid by the Policyholder, this paragraph will not print.
- Either Participating Group language will print if issued to a Participating Group Trust, otherwise will print Policyholder.

Page 9

- **OTHER INSURANCE IN THIS COMPANY** will print when we need to limit our liability for a single insured

EXPLANATION OF VARIABLES FOR SLAD4100GE

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, 2011]]	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.
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]	The Marketer may offer one or more plans and give them a descriptive name such as Basic, Enhanced, Deluxe or Platinum. Benefit amounts may change based on the plan offered
[Monthly] [Individual]	Premium amounts and frequency of payment will depend on the offer and a tracking code will be associated with each. Marketer may want to say Customer only or Member only depending on the offer and group type
[Email Address: _____]	Marketer may choose to ask for email address
Beneficiary _____] Relationship to Insured _____]	Customer may provide this information
<input type="checkbox"/> Check here if you are eligible to receive Medicare Benefits:	If the coverage plan offered includes benefit provisions that may duplicate Medicare benefits, this question will be included so proper disclosures can be provided to the customer. Otherwise the question will be deleted in its entirety.
[By signing below, I certify that I understand coverage is limited to a total indemnity of not more than [\$1,000,000.00] for Accidental Death Insurance in effect with us or Stonebridge Life Insurance Company, Stonebridge Casualty Insurance Company, Monumental Life Insurance Company or Stonebridge Life Insurance Company at any one time.]	Discloses coverage limitations when the policyholder or company wants to limit total amount of coverage for a single insured who purchases Accidental Death Indemnity coverage.

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,]	Will be included as shown when the sponsor pays for the coverage for the initial term. The number of days will match the number of days the premium is paid by the sponsor. Otherwise this phrase will be deleted in its entirety.
[billed] [monthly] and [electronically]	Indicates billing method
[directly] [ABC Bank] [checking] account.	The name of the policyholder and type of account will be inserted here.
[If I sign and return this form without selecting a coverage amount, understand that I will be automatically enrolled for [\$100,000] of [Customer][only] coverage.]	Plan name determined by Marketer.
[A [\$0.75] administrative fee will be added for each automatic account billing.] [If I sign and return this form without selecting a coverage amount, I understand that I will be automatically enrolled for [\$100,000] of [Customer][only] coverage.]	Will be included or excluded
[provided the first premium is paid]. decrease at age [70].	Policyholder will determine age of reduction and may or may not include this information.
[on the reverse side of this form][and][below].	Will be included or excluded depending on if the enrollment page is more than one page and this sentence will be included when there are disclosures to be acknowledged.
[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank] to activate my coverage.]	Will be included or excluded

EXPLANATION OF VARIABLES FOR SLAD4101GE

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
Underwritten by:	The name of the Company may change.
[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, 2011]]	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.
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]	The Marketer may offer one or more plans and give them a descriptive name such as Basic, Enhanced, Deluxe or Platinum. Benefit amounts may change based on the plan offered
[Family] [Individual]	Premium amounts and frequency of payment will depend on the offer and a tracking code will be associated with each. Marketer may want to say Customer only or Member only depending on the offer and group type
[Email Address: _____]	Marketer may choose to ask for email address
Beneficiary _____] Relationship to Insured _____]	Customer may provide this information
<input type="checkbox"/> Check here if you are eligible to receive Medicare Benefits:	If the coverage plan offered includes benefit provisions that may duplicate Medicare benefits, this question will be included so proper disclosures can be provided to the customer. Otherwise the question will be deleted in its entirety.
[If I sign and return this form without selecting a coverage amount, understand that I will be automatically enrolled for [\$100,000] of [Customer][only] coverage.]	Plan name determined by Marketer.

[provided the first premium is paid]. decrease at age [70].	Policyholder will determine age of reduction and may or may not include this information.
[I have read the fraud notices on the back of this application].	Will be included or excluded depending on if the enrollment page is more than one page and this sentence will be included when there are disclosures to be acknowledged.
[By signing below, I certify that I understand coverage is limited to a total indemnity of not more than [\$1,000,000.00] for Accidental Death Insurance in effect with us or Transamerica Life Insurance Company, Stonebridge Casualty Insurance Company, Monumental Life Insurance Company or Stonebridge Life Insurance Company at any one time.]	Discloses coverage limitations when the policyholder or company wants to limit total amount of coverage for a single insured who purchases Accidental Death Indemnity coverage.
The items under the Payment Information section will be included will be included or excluded depending upon the selection made.	Will be included or excluded
[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank] to activate my coverage.]	Will be included or excluded

**Stonebridge Life Insurance Company
Rate Sheet**

SLAD4100GP- Group Motor Vehicle Accident Insurance

This policy provides the benefits for bodily injuries or loss of life due to accidents related to or resulting from private passenger automobiles or land motor vehicles.

As stated in the actuarial memorandum, there may be multiple premium pattern versions available, as established in the specific group master policy. The gross premium rates for this policy form may either be level for all months or may be \$1.00 for the initial period and monthly and level thereafter based on the rates below. The initial period may be 1, 2 or 3 months.

A monthly policy fee of \$1.00 is added to the final premium.

Rates below are per Unit, where 1 Unit = \$10,000 for the Accidental Death Benefit and 1 Unit = \$100 for the Emergency Facility, Hospital Confinement, and Rehabilitative Therapy Benefits. Benefits reduce by 50% for attained ages 70 and above.

A. \$1.00 for the first 2 months, then monthly and level.

Monthly Rates per Unit				
	Accidental Death	Emergency Facility	Hospital Confinement	Rehabilitative Therapy
Primary	\$0.62290	\$0.36330	\$0.17650	\$0.45680
Spouse	\$0.35190	\$0.11210	\$0.04980	\$0.09970
Child	\$0.35190	\$0.19930	\$0.02080	\$0.02490

Example Premium Calculation

The following is an example of premium configuration (please note that this is only an illustration of benefits; actual benefits may differ).

Member	Benefit	Benefit Amount	Number of Units	Rate per Unit	Premium
Primary	Accidental Death	\$100,000	10.0	\$0.62290	\$6.230
	Emergency Facility	\$500	5.0	\$0.36330	\$1.820
	Hospital Confinement	\$200	2.0	\$0.17650	\$0.350
	Rehabilitative Therapy	\$50	0.5	\$0.45680	\$0.230
Spouse	Accidental Death	\$100,000	10.0	\$0.35190	\$3.520
	Emergency Facility	\$500	5.0	\$0.11210	\$0.560
	Hospital Confinement	\$200	2.0	\$0.04980	\$0.100
	Rehabilitative Therapy	\$50	0.5	\$0.09970	\$0.050
Child	Accidental Death	\$5,000	0.5	\$0.35190	\$0.180
	Emergency Facility	\$500	5.0	\$0.19930	\$1.000
	Hospital Confinement	\$200	2.0	\$0.02080	\$0.040
	Rehabilitative Therapy	\$50	0.5	\$0.02490	\$0.010
	Policy Fee				\$1.00
Primary Only					\$9.60
Primary + Family					\$15.05

Note final monthly premiums are rounded to low nickel.

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	Sharron.Hawkins@transamerica.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): _____
---------------------------------	--

6. Company Tracking Number	AR006121500021
-----------------------------------	----------------

7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
-----------	--

8. Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input checked="" type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9. Type of Insurance	H03G Group Health - Accidental Death & Dismemberment
-----------------------------	--

10. Product Coding Matrix Filing Code	H03G.000 Health - Accidental Death & Dismemberment
--	--

11. Submitted Documents	<input checked="" type="checkbox"/> FORMS <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"/> 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 checked="" type="checkbox"/> Certifications <input checked="" type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____

12.	Filing Submission Date	4-15-11
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	
15.	Filing Description:	
<p>SLAD4100GP - Group Accident Insurance Policy SLAD4100GC - Group Accident Insurance Certificate SLAD4100GE - Group Accident Enrollment Form SLAD4101GE - Group Accident Enrollment Form</p> <p>The above captioned forms are submitted for your review and approval. These forms are new and do not replace any forms previously approved by your Department. These forms have been completed in "John Doe" fashion.</p> <p>This Group Accidental Death Insurance provides benefits if a Covered Person dies or suffers an Injury as a direct result of being struck by a Private Passenger Automobile or Land Motor Vehicle or as a direct result of a collision or crash of a Private Passenger Automobile or Land Motor Vehicle. Coverage ends when the Insured attains age 80.</p> <p>We plan to issue the Master Policy to various discretionary groups that are situated in Missouri.</p> <p>All variable information is bracketed and printed in red. We request approval of these forms with various dimensions, format, shading and colors. No dimension, format, shading or color change will produce unacceptable print.</p> <p>Coverage is guaranteed issue.</p> <p>The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format.</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>4-15-11</u></p>		

Form Filing Attachment

This filing transmittal is part of company tracking number AR006121500021

This filing corresponds to rate filing company tracking number

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Group Accident Insurance Policy	SLAD4100GP	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Group Accident Insurance Certificate	SLAD4100GC	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Group Accident Enrollment Form	SLAD4100GE	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	Group Accident Enrollment Form	SLAD4101GE	<input checked="" 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 _____	

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Missouri
Insurance Code

TITLE XXIV -- BUSINESS AND FINANCIAL INSTITUTIONS...Chapter 376 -- LIFE, HEALTH AND ACCIDENT
INSURANCE...General Provisions

376.421

Authorized categories for group health insurance

1. Except as provided in subsection 2 of this section, no policy of group health insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(a) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships, if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

(b) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing; and

(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten employees and in a policy insuring ten or more employees if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness subject to the following requirements:

(a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

a. Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

b. The debtors of one or more subsidiary corporations; and

c. The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control;

(b) The premium for the policy shall be paid either from the creditor's funds or from charges collected from the insured debtors, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors;

(c) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten debtors and in a policy insuring ten or more debtors if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(d) The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes

disabled as defined in the policy;

(e) The insurance may be payable to the creditor or to any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of insurance shall be payable to the insured or the estate of the insured;

(f) Notwithstanding the preceding provisions of this subdivision, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan;

(3) A policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(a) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof;

(b) The premium for the policy shall be paid either from funds of the union or organization or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing;

(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten members and in a policy insuring ten or more members if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(4) A policy issued to a trust, or to the trustee of a fund, established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustee shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(a) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(b) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance, must insure all eligible persons except those who reject such coverage in writing;

(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(5) A policy issued to an association or to a trust or to the trustees of a fund established, created and maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of fifty members; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least two years; shall have a constitution and bylaws which provide that the association or associations shall hold regular meetings not less than annually to further the purposes of the members; shall, except for credit unions, collect dues or solicit contributions from members; and shall provide the members with voting privileges and representation on the governing board and committees. The policy shall be subject to the following requirements:

(a) The policy may insure members of such association or associations, employees thereof, or employees of members, or one or more of the preceding, or all of any class or classes thereof for the benefit of persons other than the employee's employer;

(b) The premium for the policy shall be paid from funds contributed by the association or associations or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members;

(c) Except as provided in paragraph (d) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their

insurance must insure all eligible persons, except those who reject such coverage in writing;

(d) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(e) If the health benefit plan, as defined in section 376.1350, is delivered, issued for delivery, continued or renewed, is providing coverage to any resident of this state, and is providing coverage to sole proprietors, self-employed persons, small employers as defined in subsection 2 of section 379.930, RSMo, and large employers, the insurer providing the coverage to the association or trust or trustees of a fund established, created, and maintained for the benefit of members of one or more associations may be exempt from subdivision (1) of subsection 1 of section 379.936, RSMo, as it relates to the association plans established under this section. The director shall find that an exemption would be in the public interest and approved and that additional classes of business may be approved under subsection 4 of section 379.934, RSMo, if the director determines that the health benefit plan:

a. Is underwritten and rated as a single employer;

b. Has a uniform health benefit plan design option or options for all participating association members or employers;

c. Has guarantee issue to all association members and all eligible employees, as defined in subsection 2 of section 379.930, RSMo, of any participating association member company; and

d. Complies with all other federal and state insurance requirements, including but not limited to the small employer health insurance and availability act under sections 379.930 to 379.952, RSMo;

(6) A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(a) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof;

(b) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in paragraph (c) of this subdivision, must insure all eligible members;

(c) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer;

(7) A policy issued to cover persons in a group where that group is specifically described by a law of this state as one which may be covered for group life insurance. The provisions of such law relating to eligibility and evidence of insurability shall apply.

2. Group health insurance offered to a resident of this state under a group health insurance policy issued to a group other than one described in subsection 1 of this section shall be subject to the following requirements:

(1) No such group health insurance policy shall be delivered in this state unless the director finds that:

(a) The issuance of such group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged;

(2) No such group health insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in subdivision (1) of this subsection has made a determination that such requirements have been met;

(3) The premium for the policy shall be paid either from the policyholder's funds, or from funds contributed by the covered persons, or from both;

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

3. As used in this section, insurer shall have the same meaning as the definition of health carrier under section 376.1350, and "class" means a predefined group of persons eligible for coverage under a group insurance policy where members of a class represent the same or essentially the same hazard; except that, an insurer may offer a policy to an employer that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products as authorized under section 290.145, RSMo, and such insurer shall not be considered to be in violation of any unfair trade practice, as defined in section 379.936, RSMo, even if only some employers elect to purchase such a policy and other employers do not.

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***** END DOCUMENT *****

SERFF Tracking Number: AEGX-G127127489 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48507
 Company Tracking Number: AR006121500021
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: Accidental Death
 Project Name/Number: Accidental Death/AR006121500021

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)
04/15/2011	Form	Group Accident Insurance Certificate	04/20/2011	SLAD4100GC - Group Accident Insurance Certificate.PDF (Superseded)

Stonebridge Life Insurance Company

A Stock Company

Home Office: 187 West Street, Rutland, VT 05701

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. [25XXX GCXXX] to [XYZ Corporation] (herein called Policyholder) which makes available accidental death 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

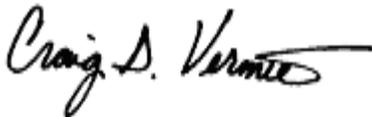
You may return the Certificate of Insurance within [1] [2] [3] month[s] after its receipt to us at our Administrative Office. Any premium you have paid will be refunded. The Certificate will be treated as if it never existed. No benefits will be paid.

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

RENEWABLE AT THE OPTION OF THE COMPANY

We promise to renew this Certificate as long as: (1) the Group Policy remains in force; (2) you continue to pay your premium when due; (3) we renew all other certificates that are issued under the Policy; and (4) you have not performed an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage.

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



Secretary



President

GROUP ACCIDENT INSURANCE
RENEWABLE AT THE OPTION OF THE COMPANY

STONEBRIDGE LIFE INSURANCE COMPANY

SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. [25517 GCXXX] to [XYZ Corporation]

[PARTICIPATING GROUP NUMBER: XXXXXX PARTICIPATING GROUP: XXXXXXXXX]
 [CERTIFICATE NUMBER: 82A1000000] EFFECTIVE DATE: 11-01-2010
 [INSURED]: [JOHN DOE [MONTHLY PREMIUM]: [\$12.95]
 221 ANYSTREET
 APARTMENT 1231
 ANYTOWN, USA 12345]

[INITIAL PREMIUM: \$ 1.00]

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

[FAMILY COVERAGE]: [YES]

BENEFITS ARE LIMITED TO INJURIES OR LOSS OF LIFE DUE TO ACCIDENTS RELATED TO OR RESULTING FROM PRIVATE PASSENGER AUTOMOBILES OR LAND MOTOR VEHICLES

SCHEDULE OF INSURANCE

[BENEFIT]:	[PRINCIPAL SUM]		
	<u>[INSURED]</u>	<u>[SPOUSE]</u>	<u>[EACH CHILD]</u>
[PART I ACCIDENTAL DEATH BENEFIT	[\$ 50,000-500,000]	[\$ 25,000-\$500,000]	[\$ 2,500- \$ 25,000]]
[PART II ACCIDENT EMERGENCY FACILITY BENEFIT - 1 VISIT PER COVERED ACCIDENT PER COVERED PERSON:	[\$50-\$1,000 per visit	[\$50-\$1,000 per visit	[\$50-\$1,000 per visit]
[NUMBER OF COVERED ACCIDENTS PER CALENDAR YEAR:	[3-6]	[3-6]	[3-6]]
OR			
[MAXIMUM NUMBER OF ACCIDENTS PAID EACH CALENDAR YEAR FOR ALL COVERED PERSONS COMBINED: [1-12]]			
[PART III ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT	[\$100-\$1,000] per day	[\$100-\$1,000] per day	[\$100-\$1,000] per day]
[MAXIMUM NUMBER OF DAYS PAID PER COVERED PERSON, PER ACCIDENT	[60- 730]	[60-730]	[60-730]]
[PART IV REHABILITATIVE THERAPY BENEFIT	[\$25-\$250] per visit	[\$25-\$250] per visit	[\$25-\$250] per visit
MAXIMUM NUMBER OF VISITS PAID PER COVERED PERSON, PER ACCIDENT	[3-24]	[3-24]	[3-24]]

IF THE COVERED PERSON ATTAINS AGE 70 BEFORE THE DATE OF THE INJURY, THE BENEFITS LISTED ABOVE WILL BE REDUCED BY ONE-HALF (50%).

**[PART V
PERSISTENCY BENEFIT**

[\$10 - \$50]

**[PAYABLE 90 DAYS AFTER] THE CERTIFICATE EFFECTIVE DATE
[PAYABLE ON THE [FIRST – TENTH] CERTIFICATE ANNIVERSARY
AND THEREAFTER EVERY [ONE – TEN] YEAR[S]]**

DEFINITIONS

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

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

1. your lawful spouse; and
2. each of your unmarried children including step-children, children born to you or legally adopted by you, 25 years of age or younger. (An adopted child is a child who is in your custody pursuant to an interim court order of adoption or placement of adoption).

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.

HOSPITAL means an institution which is a short term acute care general hospital. Its main purpose must be to provide medical care and treatment to injured persons as Resident Patients. It must have facilities on premises for major surgery, medical diagnosis and treatment by or under the supervision of one or more licensed Physicians. It must provide 24 hour a day nursing service by or under the supervision of a registered nurse. It must have organized departments of medicine. It may not include a hospital operating primarily as a rest, convalescent, extended care, rehabilitation, chronic or skilled nursing facility; home for the aged; a place for the care and treatment of drug addicts or alcoholics, or a mental institution; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, whether or not such a facility is part of a hospital, as defined herein, or is an entirely separate facility.

HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED means being a Resident Patient in a Hospital for Necessary 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.

IMMEDIATE FAMILY means your spouse, parent, child, brother or sister, or any person living with you.

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

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

LAND MOTOR VEHICLE includes any gasoline, diesel, electric or similarly powered vehicle which is required to be registered with the state for use on public highways, customarily used for transportation on land and for which the operator is required to be licensed.

This category includes, but is not limited to the following:

1. vehicles defined as "Private Passenger Automobiles" in this Certificate;
2. vehicles with more than four wheels, such as tractor/trailer rigs and flat bed trucks; or
3. vehicles registered to carry passengers for hire.

Farm equipment, forklifts, construction equipment, motorcycles, motor scooters, all terrain vehicles, snowmobiles, and vehicles designed primarily for off road use are specifically excluded under Land Motor Vehicle.

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 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.

Services will not be deemed necessary treatment if these criteria are not met.

[PARTICIPATING GROUP is the organization named on the Schedule of Insurance.]

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat 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.

PRIVATE PASSENGER AUTOMOBILE means a four-wheeled vehicle which is required to be registered with the state for non-commercial use on public highways and includes station wagons, vans, jeeps or truck types with a factory rating load capacity of 2,000 pounds or less, or self-propelled motor home type vehicles.

Farm equipment, forklifts, construction equipment, motorcycles, motor scooters, all terrain vehicles, snowmobiles, vehicles designed primarily for off road use and vehicles registered to carry passengers for hire are specifically excluded under Private Passenger Automobile.

RESIDENT PATIENT means a Covered Person who is confined in a Hospital as a registered bed patient and who is provided at least one day of room and board. A Covered Person is considered to be a resident patient each day of Confinement in the Hospital except for the day of discharge; unless a room and board charge is made for that day. This does not include Confinement if it is not for Necessary Treatment or if the Hospital is used primarily as a place for rest, nursing, rehabilitation, convalescence or extended care.

THERAPIST means a licensed specialist in physical therapy or occupational therapy. A Covered Person's Immediate Family or other household members will not be considered a Therapist.

WHEN YOUR INSURANCE BEGINS

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.]

Issuance of a Certificate is not a waiver of any of the above conditions.

WHEN YOUR INSURANCE ENDS

Your insurance ends on the earlier of:

1. the last day of the period covered by your last premium contribution;
2. the first monthly renewal date of the Certificate following the date the Policy is terminated or cancelled; or
3. the date you die. (See the Continuation of Coverage Provision)

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

We will give you 31 days notice in the event the Policy terminates. We will refund any premium paid beyond the date the coverage stops.

In the event the insurance terminates, it does not affect payment for a loss or Injury which began while the coverage was in force.

COVERAGE

We pay the following benefits if a Covered Person dies or suffers an Injury as a direct result of being struck by a Private Passenger Automobile or Land Motor Vehicle or as a direct result of a collision or crash of a Private Passenger Automobile or Land Motor Vehicle.

PART I ACCIDENTAL DEATH BENEFIT

We pay the Accidental Death benefit shown on the Schedule of Insurance if a Covered Person dies as the result of a covered Injury. Death must occur within 90 days after the date of the covered accident that causes the Injury.

PART II ACCIDENT EMERGENCY FACILITY BENEFIT

We pay the Accident Emergency Facility Benefit shown on the Schedule of Insurance if a Covered Person receives emergency Necessary Treatment for a covered Injury at a Hospital Emergency Room or other Emergency Facility. Treatment must occur within 72 hours of the accident causing the Injury. Only one Accident Emergency Facility Benefit will be paid per Covered Person per accident.

PART III ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT

We pay the Accident Hospital Confinement Benefit shown on the Schedule of Insurance if a Covered Person is Confined to a Hospital as a Resident Patient for the Necessary Treatment of a covered Injury. The benefit is paid beginning with the first day of Confinement and will continue for up to the maximum number of days shown on the Schedule of Insurance. The Confinement must begin 1) while this Certificate is in force and 2) within 90 days of the accident causing the Injury.

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

PART IV REHABILITATIVE THERAPY BENEFIT

We pay the Rehabilitative Therapy Benefit shown on the Schedule of Insurance if a Covered Person requires physical therapy or occupational therapy because of a covered Injury. Any such therapy must be provided by a Therapist and prescribed by a Physician. Physical therapy or occupational therapy must start within [30] days of the accident causing the Injury or discharge from the hospital.

We will only pay for one (1) treatment per Covered Person per day for the Maximum Number of Treatments shown on the Schedule of Insurance per accident. All treatments for one accidental Injury must be treated within 12 months.

Rehabilitative Therapy Benefits will stop once the Maximum Number of Treatments per covered Accident shown on the Schedule of Insurance has been met.

[PART V PERSISTENCY BENEFIT

We pay the Persistency Benefit stated in the Schedule of Insurance as long as the Policy and Certificate remain in force.]

REDUCTION

All benefits [except the Persistency Benefit,] in this Certificate and any riders, if attached, will reduce as shown on the Schedule of Insurance if, before the date of Injury, [you have][a Covered Person has] attained the age shown on the Schedule of Insurance.

EXCLUSIONS

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

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

BENEFICIARY

All benefits are payable to you, if living. Unless you specify otherwise, any other benefit due for loss of life will be paid as follows:

1. 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. to your estate.

At the death of any other Covered Person, benefits will be paid to you, if living; otherwise as though it were payable under items 1 through 4 above.

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 and parents do not mean "step" children and parents.

CHANGE OF BENEFICIARY

You may change the beneficiary at any time by writing to us at our Administrative Office. Once we record the change, it will take effect as of the day you signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable. Any change of beneficiary is subject to community property laws in your state of residence.

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 monthly renewal date. If your spouse ceases to be your spouse for reasons other than your death, your spouse will no longer be covered as of the next monthly renewal date.

Coverage for any covered child insured under this Certificate shall terminate as of the next monthly renewal date after the covered child's marriage or the date the covered child is no longer a Covered Person as defined herein, whichever occurs first.

An unmarried covered child may continue to be covered upon reaching the limiting age as specified in the Covered Person definition, if:

1. the covered child is incapable of self-sustaining employment by reason of mental or physical handicap; and
2. dependent upon you for support and maintenance; and
3. you send us a written request for continuation of coverage within 60 days; and
4. you provide proof of incapacity as requested but no more than once annually; and
5. you pay the premium for adult benefits, if required.

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 or Injury 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 and if you wish to add child coverage, you must notify us of the child's birth within 31 days of the birth and pay the required additional premium. The child's benefit will be the amount which would have been issued to children as of the effective date of this Certificate. After the initial 31 days, the child will not be covered unless the required additional premium is paid in accordance with the provisions of this Certificate.

PREMIUM

PAYMENT OF PREMIUM

All premiums due by the terms of the Policy shall be paid 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.]

[After the first [1] [2] [3] month[s] [you are required to contribute 100 percent of the premium payable for this Certificate.]

[If no initial premium is requested by us with your enrollment form, you shall have 21 days from the Effective Date shown in the 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 or Injury.]

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.

PREMIUM CHANGES

All renewal premiums will be based on our rates in effect for this Policy on the date such premiums are due.

We have the right to change the premium rates on any date. The new rates will be based on the ages of the Covered Persons on the dates they became insured. We will provide written notice at least 31 days before the date of change.

The premium rates may also be changed at any time the terms of the Group Policy are changed.

We will not increase your rates in the first Certificate year of coverage. After that, rates will not increase more than once in any 12 month period. There will be no change in the class of the Covered Persons due to any physical impairment or claim incurred.

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. No benefits are paid for a loss or Injury occurring after the expiration of the Grace Period.

REINSTATEMENT

Your Certificate will lapse if you do not pay your premium before the end of the Grace Period. If we later accept a premium and do not require an application for reinstatement, that payment will put the Certificate back in force. If we require an application for reinstatement, this Certificate will be put back in force when we approve it and the required premium is received. If we do not approve it, the Certificate will be put back in force on the 45th 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 occurs after the date of reinstatement. In all other respects, you and we have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

MISSTATEMENT OF AGE

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

WHEN THERE IS A CLAIM

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. The notice should include your name and Certificate Number as shown in the Certificate Schedule of Insurance. Notice should be mailed to us at our Administrative Office.

CLAIM FORMS

When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in this Certificate for filing Proof of Loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

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. Failure to produce proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within this time period. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS

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

When a claim is paid during the Grace Period, any premium due and unpaid may be deducted from the claim payment.

PAYMENT OF CLAIMS

All benefits are payable to you, if living. Loss of life benefits for you are payable in accordance with the beneficiary designation in effect at the time of payment. Other benefits will be paid to you. Any other benefits, other than for loss of life, unpaid at your death may be paid to your beneficiary or estate.

PHYSICAL EXAM AND AUTOPSY

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

GENERAL PROVISIONS

ENTIRE CONTRACT

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

INCONTESTABILITY

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

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.

[OTHER INSURANCE

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