

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48915  
 Company Tracking Number: AR006071500038  
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
 Dismemberment Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

## Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Accidental Death SERFF Tr Num: AEGX- State: Arkansas  
 G127186264  
 TOI: H03G Group Health - Accidental Death & SERFF Status: Closed-Approved- State Tr Num: 48915  
 Dismemberment Closed  
 Sub-TOI: H03G.000 Health - Accidental Death Co Tr Num: AR006071500038 State Status: Approved-Closed  
 & Dismemberment  
 Filing Type: Form Reviewer(s): Rosalind Minor  
 Author: Disposition Date: 07/07/2011  
 Date Submitted: 05/26/2011 Disposition Status: Approved-  
 Closed  
 Implementation Date Requested: Implementation Date:  
 State Filing Description:

## General Information

Project Name: Accidental Death Status of Filing in Domicile:  
 Project Number: AR006071500038 Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Group  
 Submission Type: New Submission Group Market Size: Small and Large  
 Group Market Type: Other, Discretionary, Trust Explanation for Other Group Market Type:  
 Credit Union  
 Overall Rate Impact: Filing Status Changed: 07/07/2011  
 State Status Changed: 07/07/2011  
 Deemer Date: Created By: SPI ADMSLH  
 Submitted By: SPI ADMSLH Corresponding Filing Tracking Number:  
 Filing Description:

Stonebridge Life Insurance Company  
 Form SLAD3900GP et al, Group Accidental Death and Dismemberment Insurance

RE: SLAD3900GP - Group Accidental Death and Dismemberment Insurance Policy

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
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Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR006071500038

SLAD3900GC - Group Accidental Death and Dismemberment Insurance Certificate  
SLAD4000GP - Group Accidental Death Insurance Policy  
SLAD4000GC - Group Accidental Death Insurance Certificate  
SLAD4001GE - Group Enrollment Form  
SLAD4002GE - Group Enrollment Form  
SLAD4003GE - Group Enrollment Form  
SLAD4004GE - Group Enrollment Form  
SLAD4002GR - Group Accident Only Emergency Room Benefit Rider  
SLAD4003GR - Group Accident Dependent Child Day Care Benefit Rider  
SLAD4004GR - Group Accident Higher Education Benefit Rider  
SLAD4007GR - Group Accident Paralysis Benefit Rider  
SLAD4008GR - Group Physician Office [and Wellness] Benefit Rider  
SLAD4009GR - Group Special Training Accident Benefit Rider  
SLAD4010GR - Group Accident Physician Office Visit [and Wellness] Benefit Rider

Attached for your review and approval are new forms. These forms do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion and variable information is identified within brackets. Several Explanation of Variable forms are included. An effective date coinciding with your date of approval is requested.

SLAD4000GC offers an Accidental Death benefit. Benefits may or may not terminate. Coverage may or may not reduce. Coverage can be issued for Insured, Insured and Spouse, Insured, Spouse and Child, or Insured and Family. SLAD4000GP is the Master Policy under which certificate SLAD4000GC will be issued .

SLAD3900GC offers an Accidental Death with optional Dismemberment benefit that is purchased by the Business Partner for their customers. Only single coverage is offered. SLAD3900GP is the Master Policy under which certificate SLAD3900GC will be issued .

Forms SLAD4001GE, SLAD4002GE, SLAD4003GE and SLAD4004GE are the enrollment forms that will be used to solicit this coverage.

Forms SLAD4002GR, SLAD4003GR, SLAD4004GR, SLAD4007GR, SLAD4008GR, SLAD4009GR and SLAD4010GR are riders to be used at-issue as well as an add-on with SLAD3900GP, SLAD4000GP and other similar products as your Department approves them.

This product will be mass marketed by direct response and telemarketing methods and possibly on the Internet through our website. This product will be marketed without an illustration.

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

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

The group policy is contemplated for issue to various discretionary groups that are situated in Missouri. As set forth in Section 376.693: (1) the issuance of the group policy is not contrary to the best interest of the public; (2) the issuance of the group policy would be actuarially sound; (3) the issuance of the group policy would result in economies of acquisition or administration; and (4) the benefits are reasonable in relation to the premium charged. An actuarial memorandum demonstrating the above is attached.

## Company and Contact

### Filing Contact Information

Veronique Harris, Director, Product Filing and Compliance Veronique.Harris@transamerica.com  
2839 Paces Ferry Road 678-402-2085 [Phone] 2409 [Ext]  
Suite 750 678-402-2105 [FAX]  
Atlanta, GA 30339

### 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

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? No

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
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Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR006071500038  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$100.00	05/26/2011	48100572
Stonebridge Life Insurance Company	\$700.00	06/07/2011	48414730

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
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 TOI: H03G Group Health - Accidental Death & Dismemberment Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/07/2011	07/07/2011
Approved-Closed	Rosalind Minor	06/23/2011	06/23/2011

### 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	06/08/2011	06/08/2011	SPI ADMSLH	06/17/2011	06/17/2011
Pending Industry Response	Rosalind Minor	06/01/2011	06/01/2011	SPI ADMSLH	06/03/2011	06/03/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Policy Change Endorsement	Cathy Wynn	06/30/2011	06/30/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee	Note To Filer	Rosalind Minor	06/07/2011	06/07/2011

*SERFF Tracking Number:* AEGX-G127186264      *State:* Arkansas  
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*Company Tracking Number:* AR006071500038  
*TOI:* H03G Group Health - Accidental Death &      *Sub-TOI:* H03G.000 Health - Accidental Death &  
Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
*Project Name/Number:* Accidental Death/AR006071500038

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*Company Tracking Number:* AR006071500038  
*TOI:* H03G Group Health - Accidental Death &      *Sub-TOI:* H03G.000 Health - Accidental Death &  
Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
*Project Name/Number:* Accidental Death/AR006071500038

## **Disposition**

Disposition Date: 07/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

This submission was re-opened in order for you to attach an amendment.

The approval of 6/23/11 is being replaced with this approval date.

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
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 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Actuarial Memo - SLAD3900GP, Actuarial Memo - SLAD4000GP	Approved-Closed	No
Supporting Document	Actuarial Memo - SLAD4002GR, Actuarial Memo - SLAD4003GR	Approved-Closed	No
Supporting Document	Actuarial Memo - SLAD4004GR, Actuarial Memo - SLAD4007GR	Approved-Closed	No
Supporting Document	Actuarial Memo - SLAD4008GR, Actuarial Memo - SLAD4009GR	Approved-Closed	No
Supporting Document	Actuarial Memo - SLAD4010GR	Approved-Closed	No
Supporting Document	EOV - SLAD3900GC, EOV - SLAD3900GP	Approved-Closed	Yes
Supporting Document	EOV - SLAD4000GC, EOV - SLAD4000GP	Approved-Closed	Yes
Supporting Document	EOV - Enrollment Forms, EOV - Phase 1 Riders	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Form	Group Accidental Death and Dismemberment Insurance Policy	Approved-Closed	Yes
Form	Group Accidental Death and Dismemberment Insurance Certificate	Approved-Closed	Yes
Form (revised)	Group Accidental Death Insurance Policy	Approved-Closed	Yes
Form (revised)	Group Accidental Death Insurance Certificate	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Group Accident Only Emergency Room Benefit Rider	Approved-Closed	Yes
Form	Group Accident Dependent Child Day Care Benefit Rider	Approved-Closed	Yes
Form	Group Accident Higher Education Benefit	Approved-Closed	Yes

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
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 Company Tracking Number: AR006071500038  
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
 Dismemberment Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

	Rider		
<b>Form</b>	Group Accident Paralysis Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Group Physician Office [and Wellness] Benefit	Approved-Closed	Yes
<b>Form</b>	Group Special Training Accident Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Group Accident Physician Office [and Wellness] Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Policy Change Endorsement	Approved-Closed	Yes
<b>Form</b>	Group Accidental Death Insurance Policy	Replaced	Yes
<b>Form</b>	Group Accidental Death Insurance Certificate	Replaced	Yes



SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
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 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Actuarial Memo - SLAD3900GP, Actuarial Memo - SLAD4000GP	Approved-Closed	No
Supporting Document	Actuarial Memo - SLAD4002GR, Actuarial Memo - SLAD4003GR	Approved-Closed	No
Supporting Document	Actuarial Memo - SLAD4004GR, Actuarial Memo - SLAD4007GR	Approved-Closed	No
Supporting Document	Actuarial Memo - SLAD4008GR, Actuarial Memo - SLAD4009GR	Approved-Closed	No
Supporting Document	Actuarial Memo - SLAD4010GR	Approved-Closed	No
Supporting Document	EOV - SLAD3900GC, EOV - SLAD3900GP	Approved-Closed	Yes
Supporting Document	EOV - SLAD4000GC, EOV - SLAD4000GP	Approved-Closed	Yes
Supporting Document	EOV - Enrollment Forms, EOV - Phase 1 Riders	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Form	Group Accidental Death and Dismemberment Insurance Policy	Approved-Closed	Yes
Form	Group Accidental Death and Dismemberment Insurance Certificate	Approved-Closed	Yes
Form (revised)	Group Accidental Death Insurance Policy	Approved-Closed	Yes
Form (revised)	Group Accidental Death Insurance Certificate	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Group Accident Only Emergency Room Benefit Rider	Approved-Closed	Yes
Form	Group Accident Dependent Child Day Care Benefit Rider	Approved-Closed	Yes
Form	Group Accident Higher Education Benefit	Approved-Closed	Yes



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Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR006071500038

## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 06/08/2011

Submitted Date 06/08/2011

Respond By Date

Dear Veronique Harris,

This will acknowledge receipt of the captioned filing.

Objection 1

- EOV - SLAD4000GC, EOV - SLAD4000GP (Supporting Document)
- Group Accidental Death Insurance Policy, SLAD4000GP (Form)

Comment:

With respect to handicapped dependents, ACA 23-86-108(4)(A) states that coverage for the handicapped dependent shall not terminate but coverage shall continue so long as the coverage of the employee or member remains in force and so long as the dependent remains in such condition.

Your contract language states under item 3) that the insured send the company a written request for continuation of coverage within 60 days. Please remove this provision since it is not in compliance with ACA 23-86-108(4)(A) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
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TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR006071500038

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/17/2011  
Submitted Date 06/17/2011

Dear Rosalind Minor,

### Comments:

Thank you for your letter of June 8th outlining your objection to our filing.

### Response 1

Comments: In accordance with ACA 23-86-108(4)(A) and Bulletin 14-81, the requirement of a 60 day notification when dependent coverage is to continue beyond the stated termination age has been removed from the Continuation of Coverage provision in both the policy and certificate. Please see revised forms SLAD4000GP.AR and SLAD4000GC.AR.

### Related Objection 1

Applies To:

- Group Accidental Death Insurance Policy, SLAD4000GP (Form)
- EOVS - SLAD4000GC, EOVS - SLAD4000GP (Supporting Document)

Comment:

With respect to handicapped dependents, ACA 23-86-108(4)(A) states that coverage for the handicapped dependent shall not terminate but coverage shall continue so long as the coverage of the employee or member remains in force and so long as the dependent remains in such condition.

Your contract language states under item 3) that the insured send the company a written request for continuation of coverage within 60 days. Please remove this provision since it is not in compliance with ACA 23-86-108(4)(A) and Bulletin 14-81.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48915  
 Company Tracking Number: AR006071500038  
 TOI: H03G Group Health - Accidental Death & Dismemberment Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Accidental Death Insurance Policy	SLAD400 0GP.AR		Policy/Contract/Fraternal Certificate	Initial		43.200	SLAD400 0GP_AR. PDF

**Previous Version**

Group Accidental Death Insurance Policy	SLAD400 0GP		Policy/Contract/Fraternal Certificate	Initial		43.200	SLAD400 0GP - Master Policy.PD F
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Group Accidental Death Insurance Certificate	SLAD400 0GC.AR		Certificate	Initial		48.700	SLAD400 0GC_AR - Contributo ry Certificate. PDF
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**Previous Version**

Group Accidental Death Insurance Certificate	SLAD400 0GC		Certificate	Initial		48.700	SLAD400 0GC - Contributo ry Certificate. PDF
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No Rate/Rule Schedule items changed.

I trust with this revision, you will be able to continue with your review of our filing. Please contact me with any questions you have regarding this filing.

Sincerely,

Cathy L. Wynn  
 Contract Development  
 800-521-1670, ext. 2407

*SERFF Tracking Number:* AEGX-G127186264      *State:* Arkansas  
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Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
*Project Name/Number:* Accidental Death/AR006071500038

Sincerely,

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Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR006071500038

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 06/01/2011  
Submitted Date 06/01/2011

Respond By Date

Dear Veronique Harris,

This will acknowledge receipt of the captioned filing.

### Objection 1

- EOV - SLAD3900GC, EOV - SLAD3900GP (Supporting Document)
- EOV - SLAD4000GC, EOV - SLAD4000GP (Supporting Document)
- EOV - Enrollment Forms, EOV - Phase 1 Riders (Supporting Document)
- AR - NAIC TRANSMITTAL DOCUMENT (Supporting Document)
- Group Accidental Death and Dismemberment Insurance Policy, SLAD3900GP (Form)
- Group Accidental Death and Dismemberment Insurance Certificate, SLAD3900GC (Form)
- Enrollment Form, SLAD4000GE (Form)
- Enrollment Form, SLAD4001GE (Form)
- Enrollment Form, SLAD4002GE (Form)
- Enrollment Form, SLAD4003GE (Form)
- Enrollment Form, SLAD4004GE (Form)
- Group Accident Only Emergency Room Benefit Rider, SLAD4002GR (Form)
- Group Accident Dependent Child Day Care Benefit Rider, SLAD4003GR (Form)
- Group Accident Higher Education Benefit Rider, SLAD4004GR (Form)
- Group Accident Paralysis Benefit Rider, SLAD4007GR (Form)
- Group Physician Office [and Wellness] Benefit, SLAD4008GR (Form)
- Group Special Training Accident Benefit Rider, SLAD4009GR (Form)
- Group Accident Physician Office [and Wellness] Benefit Rider, SLAD4010GR (Form)
- Group Accidental Death Insurance Policy, SLAD4000GP (Form)
- Group Accidental Death Insurance Certificate, SLAD4000GC (Form)

Comment: Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$800.00. Please submit an additional \$700.00 for this submission.

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Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
*Project Name/Number:* Accidental Death/AR006071500038

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

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Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR006071500038

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/03/2011  
Submitted Date 06/03/2011

Dear Rosalind Minor,

### Comments:

Thank you for your letter dated June 1st, 2011 stating your objection to our filing.

### Response 1

Comments: The additional filing fee of \$700.00 has been submitted. I reviewed Rule and Regulation 57 as well as the General Instructions prior to submitting this filing and read that normal fees are \$50 for each policy set, which includes riders, applications, etc. associated with that policy. Because I have 2 policies and associated forms, I calculated a fee of \$100.

### Related Objection 1

Applies To:

- Group Accidental Death and Dismemberment Insurance Policy, SLAD3900GP (Form)
- Group Accidental Death and Dismemberment Insurance Certificate, SLAD3900GC (Form)
- Group Accidental Death Insurance Policy, SLAD4000GP (Form)
- Group Accidental Death Insurance Certificate, SLAD4000GC (Form)
- Enrollment Form, SLAD4000GE (Form)
- Enrollment Form, SLAD4001GE (Form)
- Enrollment Form, SLAD4002GE (Form)
- Enrollment Form, SLAD4003GE (Form)
- Enrollment Form, SLAD4004GE (Form)
- Group Accident Only Emergency Room Benefit Rider, SLAD4002GR (Form)
- Group Accident Dependent Child Day Care Benefit Rider, SLAD4003GR (Form)
- Group Accident Higher Education Benefit Rider, SLAD4004GR (Form)
- Group Accident Paralysis Benefit Rider, SLAD4007GR (Form)
- Group Physician Office [and Wellness] Benefit, SLAD4008GR (Form)
- Group Special Training Accident Benefit Rider, SLAD4009GR (Form)
- Group Accident Physician Office [and Wellness] Benefit Rider, SLAD4010GR (Form)
- EOVS - SLAD3900GC, EOVS - SLAD3900GP (Supporting Document)
- EOVS - SLAD4000GC, EOVS - SLAD4000GP (Supporting Document)

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Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR006071500038

- EOV - Enrollment Forms, EOV - Phase 1 Riders (Supporting Document)
- AR - NAIC TRANSMITTAL DOCUMENT (Supporting Document)

**Comment:**

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$800.00. Please submit an additional \$700.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I trust you will be able to continue with the review and approval of our filing. Please contact me with any concerns you have regarding this filing.

Sincerely,

Cathy L. Wynn, FLMI, HIA  
Contract Development  
800-521-1670, ext. 2404

Sincerely,

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
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 Company Tracking Number: AR006071500038  
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment  
 Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

**Amendment Letter**

Submitted Date: 06/30/2011

**Comments:**

Due to the fact that the policy will always be issued out of the state of Missouri and not Arkansas, we should have filed this policy change endorsement - SLAD4000GC.AR PCE to be attached to the policy when Arkansas residents are covered instead of a state specific Arkansas policy. Please approve this form instead.

Please contact me with any questions concerning this filing.

Sincerely,

Cathy L. Wynn  
 800-521-1670, ext. 2404

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
SLAD4000G C.AR PCE	Policy/Contr act/Fraternal Certificate: Amendment, t Insert Page, Endorsemen t or Rider	Policy	Initial				40.000	Microsoft Word - SLAD4000GC .AR PCE.pdf

*SERFF Tracking Number:* AEGX-G127186264      *State:* Arkansas  
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Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
*Project Name/Number:* Accidental Death/AR006071500038

**Note To Filer**

**Created By:**

Rosalind Minor on 06/07/2011 09:14 AM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

06/23/2011 09:49 AM

**Subject:**

Filing Fee

**Comments:**

We appreciate your comments concerning the Filing Fee.

As you will note under the General Instructions for Arkansas, we have two instances. Please click on the instance for ArkansasLH. Under Fees, item 3 and item 5 states that the fee is \$50.00 per form. Please submit an additional fee of \$700.00 for a total of \$800.00.

We appreciate your cooperation.

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48915  
 Company Tracking Number: AR006071500038  
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment  
 Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/23/2011	SLAD3900 GP	Policy/Contract	Group Accidental Death and Dismemberment Certificate Insurance Policy	Initial		43.400	SLAD3900GP - Master Policy.PDF
Approved-Closed 06/23/2011	SLAD3900 GC	Certificate	Group Accidental Death and Dismemberment Insurance Certificate	Initial		50.300	SLAD3900GC - Non-Contributory Certificate.PDF
Approved-Closed 06/23/2011	SLAD4000 GP.AR	Policy/Contract	Group Accidental Death Insurance Policy Certificate	Initial		43.200	SLAD4000GP_AR.PDF
Approved-Closed 06/23/2011	SLAD4000 GC.AR	Certificate	Group Accidental Death Insurance Certificate	Initial		48.700	SLAD4000GC_AR - Contributory Certificate.PDF
Approved-Closed 06/23/2011	SLAD4000 GE	Application/Enrollment Form	Enrollment Form	Initial		0.000	SLAD4000GE - Enrollment Form.PDF
Approved-Closed 06/23/2011	SLAD4001 GE	Application/Enrollment Form	Enrollment Form	Initial		0.000	SLAD4001GE - Enrollment Form.PDF
Approved-Closed 06/23/2011	SLAD4002 GE	Application/Enrollment Form	Enrollment Form	Initial		0.000	SLAD4002GE - Enrollment Form.PDF
Approved-Closed 06/23/2011	SLAD4003 GE	Application/Enrollment Form	Enrollment Form	Initial		0.000	SLAD4003GE - Enrollment Form.PDF

<i>SERFF Tracking Number:</i>	<i>AEGX-G127186264</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48915</i>
<i>Company Tracking Number:</i>	<i>AR006071500038</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death &amp; Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death &amp; Dismemberment</i>
<i>Product Name:</i>	<i>Accidental Death</i>		
<i>Project Name/Number:</i>	<i>Accidental Death/AR006071500038</i>		
Approved- Closed 06/23/2011	SLAD4004 GE Application/ Enrollment Form Enrollment Form	Initial	0.000  SLAD4004GE - Enrollment Form.PDF
Approved- Closed 06/23/2011	SLAD4002 GR Certificate Group Accident Only Amendmen Emergency Room t, Insert Benefit Rider Page, Endorseme nt or Rider	Initial	40.400  SLAD4002GR - Emergency Room Rider.PDF
Approved- Closed 06/23/2011	SLAD4003 GR Certificate Group Accident Amendmen Dependent Child Day t, Insert Care Benefit Rider Page, Endorseme nt or Rider	Initial	45.900  SLAD4003GR - Child Day Care Rider.PDF
Approved- Closed 06/23/2011	SLAD4004 GR Certificate Group Accident Amendmen Higher Education t, Insert Benefit Rider Page, Endorseme nt or Rider	Initial	43.300  SLAD4004GR - Higher Education Rider.PDF
Approved- Closed 06/23/2011	SLAD4007 GR Certificate Group Accident Amendmen Paralysis Benefit t, Insert Rider Page, Endorseme nt or Rider	Initial	44.400  SLAD4007GR - Paralysis Rider.PDF
Approved- Closed 06/23/2011	SLAD4008 GR Certificate Group Physician Amendmen Office [and Wellness] t, Insert Benefit Page, Endorseme nt or Rider	Initial	40.000  SLAD4008GR - Physician Office Rider.PDF
Approved- Closed 06/23/2011	SLAD4009 GR Certificate Group Special Amendmen Training Accident t, Insert Benefit Rider Page,	Initial	46.000  SLAD4009GR - Special Training Rider.PDF



# Stonebridge Life Insurance Company

A STOCK COMPANY

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

Stonebridge Life Insurance Company  
(Herein called the Company)

Having issued this Policy to

**ABC Bank**

(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 [September 1, 2003] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR].

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

## RIGHT TO EXAMINE CERTIFICATE

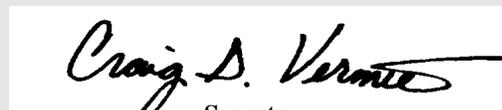
A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by will be refunded. The Certificate will be treated as if it never existed. No benefits will be paid.

**RENEWABLE AT THE OPTION OF THE COMPANY:** The Company promises to renew the Certificate as long as: (1) the Group Policy remains in force; (2) the Policyholder pays the premium when due; (3) the Company renews all other certificates that are issued under this Policy; and (4) the Insured has not performed an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage.

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.



President



Secretary

Policy No. 25451 SLAD3900GC

NON CONTRIBUTORY GROUP ACCIDENTAL DEATH [AND DISMEMBERMENT] INSURANCE POLICY

## DEFINITION

**[PRIOR PLAN]** means the Group Policy [AAAAAA] issued by the prior carrier [ABC Life Company] which terminated on [10/31/2008].]

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

**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.

**INJURED** means having suffered a bodily Injury.

**LOSS** means[:]

- 1) loss of life;
- 2) [with reference to hand or foot, complete severance at or above the wrist or ankle joint;]
- 3) [with reference to eye, the total and irrecoverable loss of the entire sight including best-corrected vision of 20/200 or more as verified by a board certified ophthalmologist].

[Loss does not mean loss of use.]

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

## ELIGIBILITY

Each natural person [AGE 18 THROUGH 84] [WHO IS A CREDIT CARDHOLDER] [(OR THE SPOUSE OF A CREDIT CARDHOLDER) [AGE 18 THROUGH 84]] [OF THE POLICYHOLDER] is eligible to become an Insured. Such persons are herein called eligible persons.

[Each natural person insured under the Prior Plan is eligible for coverage under this policy.]

[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.

## WHEN A PERSON BECOMES INSURED

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

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

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

## WHEN A PERSON'S INSURANCE ENDS

An Insured's insurance ends on:

- 1) the first monthly renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 2) the Certificate Termination Date shown on the Certificate Schedule of Insurance.

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 Insured 31 days notice in the event the Policy terminates..

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

## AMOUNT 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 the Certificate. The amounts of insurance for each Insured shall be the amount shown on the Certificate Schedule of Insurance issued to each individual Insured.

## COVERAGE

[If the Insured dies as a direct result of an Injury from an accident not otherwise excluded in the Policy and the Loss occurs within 90 days following the date of the accident which caused the Injury, the Company will pay the applicable benefit amount specified on the Certificate Schedule of Insurance for the Loss.]

### [ACCIDENTAL DEATH AND DISMEMBERMENT

If, as a result of Injury not otherwise excluded, the Insured suffer any of the following Losses within 90 days after the date of an accident which caused such Injury, the Company will pay the benefit shown below:

### SCHEDULE OF LOSSES AND BENEFIT PAYABLE

Life	Amount of Insurance
Both Hands or Both Feet or Sight of Both Eyes	Amount of Insurance
One Hand and One Foot	Amount of Insurance
One Hand and Sight of One Eye	Amount of Insurance
One Foot and Sight of One Eye	Amount of Insurance
One Hand or One Foot or Sight of One Eye	One-Half the Amount of Insurance

Amount of Insurance is as specified in the Certificate Schedule of Insurance. Only one of the above benefits, the largest, will be paid for multiple Losses that result from one accident.]

### [REDUCTION

All benefits in the Certificate and any riders, if attached, will reduce as shown on the Certificate Schedule of Insurance if, before the date of Injury, the Insured has attained the age shown on the Certificate Schedule of Insurance.]

## EXCLUSIONS

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

- 1) an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane 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.

## BENEFICIARY

[All benefits are payable to the Insured, if living. Unless the Insured specifies otherwise, any other benefit due for Loss of life will be paid as follows:][Any amount due for Loss 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, or
- 4) to the Insured's estate.

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

## CHANGE OF BENEFICIARY

The Insured may change the beneficiary at any time by writing to the Company's 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.

## PREMIUM

The premium for each Certificate shall be paid by the [Policyholder / Participating Group]. Premiums are included on the attached rate sheet.

**PREMIUM CHANGES** The Company has the right to change the premium rates on any premium due date. The Company 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 this Policy are changed.

## WHEN THERE IS A CLAIM

### NOTICE OF CLAIM

Written notice of claim must be given to the Company within 30 days after any Loss occurs or as soon as possible thereafter. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. 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 Policy as to Proof of Loss upon submitting, within the time fixed in the Policy 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. 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 the Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

## **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 will be paid to his or her Beneficiary or estate.

## **[PHYSICAL EXAMINATION AND] AUTOPSY**

The Company, at its own expense, shall have the right to **[examine the Insured when and as often as it 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 Policy is issued in consideration of the application and payment of the premium. Insureds' Certificates are furnished in accordance with and subject to the terms of the Policy. Certificate is furnished in accordance with and subject to the terms of the Policy. Certificates are not part of the Policy, but are evidence of the insurance provided under the Policy. The Policy, the Policy Application and any attachments form the entire contract of insurance. No agent may change or waive any provision of the Policy under which this coverage is provided.

Any change in this Policy must be in the form of an amendment or endorsement signed by one of the officers of the Company. Agreements made by the **[Policyholder / Participating Group]** and the Company in this manner will be binding on all persons insured. Certificate anniversaries are measured from the Certificate Effective Date.

### **INCONTESTABILITY**

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

**MISSTATEMENT OF AGE**

If the Insured's age has been misstated, all benefits shall be the amount payable given the correct age of the Insured.

**LEGAL ACTIONS**

No action may 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 of Proof of Loss is required.

**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.

**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.

# Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont

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

## CERTIFICATE OF INSURANCE

PLEASE READ YOUR CERTIFICATE CAREFULLY

---

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. [11111 SLAD3900GC] to [ABC Bank] (herein called "Policyholder") which makes available Accidental Death [and Dismemberment] insurance to you.

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

A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. 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 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.]

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



President



Secretary

NON-CONTRIBUTORY GROUP ACCIDENTAL DEATH [AND DISMEMBERMENT] INSURANCE  
NON-RENEWABLE

# Stonebridge Life Insurance Company

## SCHEDULE OF INSURANCE

[This Schedule of Insurance is part of your Certificate. This Certificate is issued under Policy No. 11111  
SLAD3900GC to ABC Bank..]

[PARTICIPATING GROUP NUMBER: 11111 SLAD3900GC] [PARTICIPATING GROUP: 123 Bank]

[CERTIFICATE NUMBER: 74A3000000] [EFFECTIVE DATE: 12/01/2001]

[INSURED: JOHN SMITH] [INSURED DATE OF BIRTH: 03/01/66]

1234 ANYSTREET

ANYTOWN, USA 12345]

[TERMINATION DATE: 4-25-2010]

**[Non-Contributory Accidental Death]**

**[Amount of Insurance]** [\$500 - \$10,000]

### **REDUCTION**

### YOUR AGE AT DATE OF INJURY BENEFIT PAYABLE

[Under [60/65/70/75/80/85]	100%]
[At age [60/65/70/75/80/85]	75%]
[At age [60/65/70/75/80/85]	50%]
[At age [60/65/70/75/80/85]	25%]
[At age 80]	12.5%]

## DEFINITIONS

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

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

**INJURED** means having suffered a bodily Injury.

**LOSS** means:

- 1) loss of life;
- 2) [with reference to hand or foot, complete severance at or above the wrist or ankle joint;]
- 3) [with reference to eye, the total and irrecoverable loss of the entire sight including best-corrected vision of 20/200 or more as verified by a board certified ophthalmologist].

[Loss does not mean loss of use.]

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

## WHEN YOUR INSURANCE BEGINS

You 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. The Effective Date of Coverage is shown on the Certificate Schedule of Insurance.

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

## WHEN YOUR INSURANCE ENDS

Your insurance ends [on the earlier of:]

- 1) the date the Policy is terminated or cancelled[; or
- 2) [the Termination Date stated on the Schedule of Insurance].

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 required otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy terminates, we will give you 31 days notice of this event.

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

## COVERAGE

[If you die as a direct result of an Injury from an accident not otherwise excluded in the Policy and the Loss occurs within 90 days following the date of the accident which caused the Injury, we will pay the applicable benefit amount specified on the Schedule Page for the Loss.]

## [ACCIDENTAL DEATH AND DISMEMBERMENT

If, as a result of Injury not otherwise excluded, you suffer any of the following Losses within 90 days after the date of an accident which caused such Injury, we will pay the benefit shown below:

## SCHEDULE OF LOSSES AND BENEFIT PAYABLE

Life	Amount of Insurance
Both Hands or Both Feet or Sight of Both Eyes	Amount of Insurance
One Hand and One Foot	Amount of Insurance
One Hand and Sight of One Eye	Amount of Insurance
One Foot and Sight of One Eye	Amount of Insurance
One Hand or One Foot or Sight of One Eye	One-Half the Amount of Insurance

Amount of Insurance is as specified in the Schedule of Insurance. Only one of the above benefits, the largest, will be paid for multiple Losses that result from one accident.]

## [REDUCTION

All benefits 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 attained the age shown on the Schedule of Insurance.]

## EXCLUSIONS

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

- 1) an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (while sane in Missouri and Colorado);
- 2) any active participation in a riot, insurrection or war, either declared or undeclared;
- 3) you taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
- 4) your blood alcohol level being .08 percent weight by volume or higher;
- 5) you operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
- 6) you 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.

## 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:][Any amount due for Loss will be paid as follows:]

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

Spouse means only the one to whom you are lawfully married on the date of your death. Except in the case of 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.

## PREMIUM

The premium will be paid by the [Policyholder / Participating Group].

## 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. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice should include your name and Certificate Number as shown in the Schedule of Insurance. Notice should be mailed to 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. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

### TIME OF PAYMENT OF CLAIMS

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

## **PAYMENT OF CLAIMS**

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 will be paid to your Beneficiary or estate.]

## **[PHYSICAL EXAMINATION AND] AUTOPSY**

At our expense, we shall have the right to [examine you when and as often as it reasonable while a claim is pending.] [We may also] have an autopsy done in case of death 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, the Policy Application and any attachments form the entire contract of insurance. No agent may change or waive any provision of the Policy under which this coverage is provided.

### **INCONTESTABILITY**

We cannot contest this Certificate except for fraud.

### **MISSTATEMENT OF AGE**

If your age has been misstated, all benefits shall be the amount payable given your correct age.

### **LEGAL ACTIONS**

No action may 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 of Proof of Loss is required.

# Stonebridge Life Insurance Company

A STOCK COMPANY

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

Stonebridge Life Insurance Company  
(Herein called the Company)

Having issued this Policy to

**[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 [September 1, 2003] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR].

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

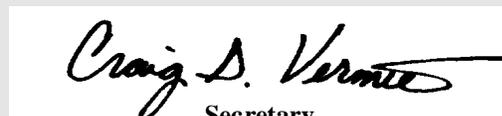
## RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded. The 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.



President



Secretary

Policy No. 11111 SLAD4000GC

**GROUP ACCIDENTAL DEATH INSURANCE POLICY**

## DEFINITION

**[PRIOR PLAN** means the Group Policy [AAAAAA] issued by the prior carrier [ABC Life Company] which terminated on [10/31/2008].]

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

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

- 1) the Insured's lawful spouse; and
- 2) each of the Insured's children including step-children, children born to the Insured or legally adopted by the Insured, 25 years of age or younger, unmarried and dependent upon the Insured for support and maintenance. (An adopted child is a child who is in the Insured's custody pursuant to an interim court order of adoption or placement of adoption). Coverage for unmarried children shall remain in force at the option of the certificate holder.]

**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.

**INJURED** means having suffered a bodily Injury.

**LOSS** means loss of life.

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

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

## ELIGIBILITY

Each natural person [AGE 18 THROUGH 84] [WHO IS AN ABC CORPORATION ACCOUNTHOLDER (OR THE SPOUSE OF AN ABC CORPORATION ACCOUNTHOLDER AGE [18 THROUGH 84]) ] is eligible to become an Insured. Such persons are herein called eligible persons.

[Each natural person insured under the Prior Plan is eligible for coverage under this policy.]

[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 which will indicate the coverage, the effective date of the coverage and the persons covered.

Each eligible person will become insured on the effective date 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 A PERSON'S INSURANCE ENDS

An Insured's insurance ends on:

- 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 monthly renewal date on or after the Insured's [65 – 100<sup>th</sup>] birthday].

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 Insured 31 days notice in the event the Policy terminates. The Company 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 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 Covered Person shall be the amount shown on the Certificate Schedule of Insurance issued to each individual Insured.

### COVERAGE

#### ACCIDENTAL DEATH BENEFIT

If a Covered Person dies as a direct result of an Injury from an accident not otherwise excluded and the Loss 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.

#### [INFLATION INCREASE BENEFIT]

[The Accidental Death Benefit [plus the benefits of any Riders attached to the Certificate] will automatically increase for each Covered Person as shown on the Certificate Schedule of Insurance.]

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

## **EXCLUSIONS**

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

- 1) an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane 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.

## **BENEFICIARY**

All benefits are payable to the Insured, if living. Unless the Insured specifies otherwise, 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, or
- 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**

The Insured may change the beneficiary at any time by writing to the Company's 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 Insured's 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 Insured's spouse for reasons other than the Insured's death, the Insured's 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 provides proof of incapacity as requested but no more than once annually; and
- 4) the Insured pays the premium for adult benefits, if applicable.

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 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 Certificate.]

### **[NEWBORN CHILDREN**

If the 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, the Insured must notify the Company of the birth of a child. There will be an increase in the premium as of the next monthly renewal date after the Company has been notified of the child's birth. The child is covered free from the time of notification until the monthly renewal date. The child will be dropped from coverage if the increased premium is not paid within 31 days after the monthly renewal date. The child's benefit will be the amount which would have been issued to children as of the Effective Date 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 [month / 2 months / 3 months] of coverage, the premium [of \$1.00] will be paid by the [Policyholder/Participating Group.]]

[After the first [month / 2 months / 3 months,]] 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. 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.

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.

### UNPAID PREMIUM

An Insured's coverage will terminate if the premium is not paid by the end of the Grace Period.

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

### 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 45<sup>th</sup> day after the date of application for reinstatement, unless the Company gives the Insured prior written notice of its disapproval.

The reinstated Certificate only covers Loss due to an Injury that occurs after the date of reinstatement. In all other respects, the Insured and the Company 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, 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 occurs or as soon as possible thereafter. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice should include the Covered Person'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 Policy as to Proof of Loss upon submitting, within the time fixed in the Policy 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. 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 the Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

### **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 will be paid to his or her 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 it 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 Policy is issued in consideration of the application and payment of the premium. Insureds' Certificates are furnished in accordance with and subject to the terms of the Policy. Certificate is furnished in accordance with and subject to the terms of the Policy. Certificates are not part of the Policy, but are evidence of the insurance provided under the Policy. The Policy, the Policy Application and any attachments form the entire contract of insurance. No agent may change or waive any provision of the Policy under which this coverage is provided.

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

## **INCONTESTABILITY**

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

## **LEGAL ACTIONS**

No action may 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 of 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 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 and Certificates. The excess will be voided and all premiums paid for such excess shall be refunded to the Insured or the Insured's beneficiary.]

## **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.

# Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont

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

## CERTIFICATE OF INSURANCE

Person(s) insured and benefits are shown in the Schedule of Insurance.

**Stonebridge Life Insurance Company** (herein called "we," "us" or "our") has issued Policy No. [11111 SLAD4000GC] to [ABC Bank] (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

A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded. The 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 our 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 for any Insured. Important provisions of the Policy are outlined herein.



President



Secretary

**GROUP ACCIDENTAL DEATH INSURANCE  
RENEWABLE AT THE OPTION OF THE COMPANY**

# Stonebridge Life Insurance Company

## SCHEDULE OF INSURANCE

This Schedule of Insurance is part of your Certificate. This Certificate is issued under Policy No. 11111  
SLAD4000GC to ABC Bank.

PARTICIPATING GROUP NUMBER: 11111 SLAD4000GC PARTICIPATING GROUP: ABC BANK

CERTIFICATE NUMBER: 74A3000000 EFFECTIVE DATE: 12/01/2001  
 INSURED: JOHN SMITH INSURED DATE OF BIRTH: 03/01/66  
 1234 ANYSTREET  
 ANYTOWN, USA 12345

[FAMILY COVERAGE: YES] [SPOUSE COVERAGE: YES]

[INITIAL PREMIUM: \$1.00 FIRST [2/3] MONTH[S]]

[MONTHLY PREMIUM [AFTER THE FIRST [2/3] MONTH[S]]: [\$0.10 - \$100.00]

[TERMINATION AGE/DATE: [65 - 100]]

### [COVERAGE:]

	[INSURED]	[COVERED SPOUSE]	[COVERED CHILD]
[ACCIDENTAL DEATH BENEFIT]	[\$1,000 - \$1,000,000] [or]	[\$500 - 1,000,000]	[\$100 - \$250,000]
[MONTHLY ACCIDENTAL DEATH BENEFIT]	[\$100 - \$16,000]	[\$50 - \$16,000]	[\$10 - \$4,000]

### FOR [1-60] MONTHS

#### REDUCTION

<u>[[YOUR][COVERED PERSON'S] AGE AT DATE OF INJURY</u>	<u>BENEFIT PAYABLE]</u>
[Under [60/65/70/75/80/85]	100%]
[At age [60/65/70/75/80/85]	75%]
[At age [60/65/70/75/80/85]	50%]
[At age [60/65/70/75/80/85]	25%]
[At age 80]	12.5%]

[INFLATION INCREASE BENEFIT] [1%-100%] OF EACH BENEFIT ISSUED]

[FOR ALL BENEFITS IN EFFECT ON THE CERTIFICATE EFFECTIVE DATE, THE INFLATION INCREASES WILL BEGIN ON THE [FIRST - FIFTH] ANIVERSARY AND EVERY [ONE - FIVE] YEARS THEREAFTER FOR A TOTAL OF [ONE - TEN] INCREASES]

[FOR BENEFITS ADDED AFTER THE CERTIFICATE EFFECTIVE DATE, THE INFLATION INCREASES WILL BEGIN ON THE [FIRST - FIFTH] ANNIVERSARY OF THE EFFECTIVE DATE OF THAT BENEFIT AND EVERY [ONE - FIVE] YEARS THEREAFTER FOR A TOTAL OF [ONE - TEN] INCREASES]

[MAXIMUM BENEFIT PAYABLE UP TO [101% - 200%] OF EACH BENEFIT ISSUED.]

[PERSISTENCY BENEFIT ] **[\$5 - \$50]**

PAYABLE 90 DAYS AFTER THE CERTIFICATE EFFECTIVE DATE

[PAYABLE ON THE [FIRST - TENTH] CERTIFICATE ANNIVERSARY AND THEREAFTER EVERY [ONE - TEN] YEAR[S]]

## DEFINITIONS

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

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

- 1) your 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). Coverage for unmarried children shall remain in force at the option of the certificate holder.]

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

**INJURED** means having suffered a bodily Injury.

**LOSS** means loss of life.

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

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

## 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 [within 21 days of] [before] 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; or
- 2) the first monthly renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the monthly renewal date on or after your [65 – 100<sup>th</sup>] birthday.

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 required 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 which began while the coverage was in force.

## COVERAGE

### ACCIDENTAL DEATH BENEFIT

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

### [INFLATION INCREASE BENEFIT]

[The Accidental Death Benefit [plus the benefits of any Riders attached to this Certificate] will automatically increase for each Covered Person as shown on the Schedule of Insurance.]

### [PERSISTENCY BENEFIT]

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

### [REDUCTION]

All benefits 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 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.

## 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, or
- 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 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 you for support and maintenance; and
- 3) the Insured provides proof of incapacity as requested but no more than once annually; and
- 4) the Insured pays the premium for adult benefits, if applicable.

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. You must notify us 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 this Certificate.]

### **[CONVERSION**

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

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

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

### **[NEWBORN CHILDREN**

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

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

## **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 [two][three] month[s] of coverage, the premium will be paid by the [Policyholder/Participating Group]].

[After the first [two][three] 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.]

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**

We have the right to change the premium rates on any date. 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.

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

There will be no change in your premium rate due to any physical impairment or claim incurred.

### **UNPAID PREMIUM**

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

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

## 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 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 45<sup>th</sup> day after the date of application for reinstatement, unless we give you prior written notice of its disapproval.

The reinstated Certificate only covers Loss due to an Injury that 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. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice should include your name and Certificate Number as shown in the Schedule of Insurance. Notice should be mailed to 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 reasonable 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.

## 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 will be paid to your Beneficiary or estate.

## [PHYSICAL EXAMINATION AND] AUTOPSY

At our expense, we shall have the right to [examine a Covered Person when and as often as it 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, the Policy Application and any attachments form the entire contract of insurance. No agent may change or waive any provision 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 may 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 of 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 your beneficiary.]

1

[Accident][al] [Death] [and Dismemberment] [Insurance] [Variable Logo] [Enrollment] Form  
[ABC Bank] Underwritten by Stonebridge Life Insurance Company, Rutland, Vermont

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

[Please respond by: [Month XX, 2001]]

2

[Bar Code for Scanning Purposes] [123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

**HOW TO ACTIVATE COVERAGE**

3

1. [Select amount of [additional insurance] coverage] [Each [\$10,000] of coverage costs [only] [\$1.06] per month.]
2. [Complete your information]
3. [Sign, date and return entire form]

4

Check here to **activate][select]** your coverage

[I currently have [\$12,000.00] of coverage.]  
[• [\$1,000] of [Accident][al] [Death] [and Dismemberment] insurance provided by [ABC Bank] at NO COST TO YOU [for [1-12 months] [30][60][90] [days]]  
[Current Coverage: √ [\$1,000] of insurance provided by [ABC Bank] at NO COST TO YOU [for one month] [for two months] [for three months]]  
[• As much as [\$1,000] of [Accident][al] [Death] [and Dismemberment] insurance paid for by [ABC Bank] at no cost to you.]

**[Check Here to] [Please] [INCREASE my ][SELECT] [CHOOSE] ADDITIONAL [INSURANCE] [Your] COVERAGE [BY]: [(Check one)]**

- [• \$25,000] [• \$100,000] [• \$200,000] [• \$500,000]
- [• \$50,000] [• \$150,000] [• \$250,000]

5

[p] [•] [ACTIVATE] [SELECT] UP TO [\$10,000] OF INSURANCE PROVIDED BY [ABC BANK] at NO COST TO YOU. (if you have a joint account, circle the name of the person to be insured.  
**Limit:** one [NO-COST-TO-YOU] [\$10,000] Certificate per joint account.)]

6

[• Check here to select Family Plan.]  
[FAMILY COVERAGE • Yes • No]  
[(Available only with additional insurance coverage.)]  
[(Maximum Coverage per person is [\$1,000,000.])]

[NOTE: AFTER [1-12] MONTHS] NO COST PERIOD, COVERAGE CONTINUES AT THE RATES SHOWN.]

7

[Primary][Additional] [Coverage]	[Monthly Premium[*]]	
	[Single Coverage] [Customer Only]	Family Plan
\$ [10,000]	• \$[ 1.18]	• \$[ 1.76]
\$ [20,000]	• \$[ 2.36]	• \$[ 3.52]
\$ [30,000]	• \$[ 3.54]	• \$[ 5.28]
\$ [40,000]	• \$[ 4.72]	• \$[ 7.04]
\$ [50,000]	• \$[ 5.90]	• \$[ 8.80]
\$[100,000]	• \$[11.80]	• \$[17.60]
\$[150,000]	• \$[17.70]	• \$[26.40]

[PLAN SELECTION (check one):  [Customer] Only  [Customer & Spouse][\*]  [Customer & Family]\*\*]

- Single Coverage (covers only you) [Monthly Premium \$X.XX]
- Joint Coverage (covers you and your spouse) [Monthly Premium \$X.XX]
- Family Coverage (covers you, your spouse and children) [Monthly Premium \$X.XX]

[\*Spouse coverage is [50%] of Applicant's selected benefit [(depending on plan selection)]

\*\*Children's benefit is [10%] of Applicant's selected benefit

8

[Premium Mode:  Monthly [(ACH only)]  Quarterly]  Semi-annual]  Annual]

**[Check [below] to select Additional Insurance Coverage:]**

- Check here to select Family Plan
- Check here to select Joint Coverage
- Check here to add [Survivor Income]

• Please add my children to the plan that I have selected for an additional [\$X.XX] per month. Covers all eligible children.]

9

**[Complete and sign][Please complete:]**

[Customer Information]

M[ale] •  F[emale] [Member's] [Insured's] [Date of Birth] [Birth Date] \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required) Mo. Day Yr.

[Home Phone ( ) \_\_\_\_-\_\_\_\_\_] [(Business) \_\_\_\_\_] [Business Phone \_\_\_\_\_-]  
[Email address \_\_\_\_\_]

[Spouse Information – if Coverage Desired]

[Name \_\_\_\_\_  
[First Middle Last]

M[ale] •  F[emale] [Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_]  
[Required Mo Day Yr.]

10

[Beneficiary Designation: All benefits will be paid to you if living. Unless you specify below, any amount due for Loss of life will be paid according to the Beneficiary Provision in the Certificate.]

[Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_]  
[Co- Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_]

[Please indicate % of Benefits for each Beneficiary listed [below] next to the Beneficiary's name.]

[Member's] [Name of] Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
[Co-Beneficiary\* \_\_\_\_\_ Relationship to Insured \_\_\_\_\_]

[• Male • Female] [Co-Insured's] Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_] [Home Phone ( ) \_\_\_\_-\_\_\_\_\_]
[(Required) Mo. Day Yr.]

[Automatic Deduction Authorization (By signing this [enrollment][activation] form I authorize you to deduct the [monthly] cost of coverage from the account indicated below.)]

[• Checking Account ] [• Savings Account]

[Name on Account: \_\_\_\_\_ Account Number: \_\_\_\_\_]

[Name of [Credit Union][Bank] \_\_\_\_\_ Routing No. \_\_\_\_\_]

[Authorization [for Payroll Deduction][to Draft [Bank] Account]:]

[YES, I would like my (and/or spouse) insurance premiums automatically withdrawn from my [bank][credit union] account each month.]

[Please complete the following information:]

- 1. [My Account is \_\_\_\_Checking \_\_\_\_Savings]
2. [Name of [Bank][Credit Union][Institution]: \_\_\_\_\_]
3. [[Bank][Credit Union][Institution] ABA Routing Number \_\_\_\_\_]
4. [Account #: \_\_\_\_\_]
5. [Please make my deduction on the \_\_\_\_\_ day of each month.]
[(1st [28th])]

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[-IMPORTANT-]

[For Checking Account Withdrawals, please include a voided blank check (write "VOID" across the blank check) with this enrollment form and sign the authorization agreement.]

[To: \_\_\_\_\_ [You are][I] hereby authorize[d] [you] to [deduct from my pay,
(Employer)]

beginning \_\_\_\_\_, and transmit] [electronically charge my account for premium debits] it to Stonebridge Life Insurance Company, Cedar Rapids, IA [in payment of the premium due]. [I understand that my account will be [charged] [debited] according to the deduction date that I have chosen.] [If I do not choose a specific date,] [[T][t]he deduction will be made on the first of each month. I agree that this electronic payment shall be regarded the same as if it were a check written by me and drawn on my account.] [This authorization is to remain in effect until revoked by me in writing. [Such decisions are to continue until:

- [1. Termination of my [employment][membership];
[2. Written notice by me to you of cancellation of this authorization; or]
[3. Termination of the payroll deduction plan by either you or Stonebridge Life Insurance Company.]]

[I understand that credit for the payment is conditioned upon the order being honored when presented. I understand that this authorization may be terminated: (1) at the option of Stonebridge Life Insurance Company if any debit is not honored when presented for payment, or (2) upon thirty (30) days written notice given by Stonebridge Life Insurance Company, the [bank][credit union] or me.]

[Employee][Member] Signature of [Account Holder]: \_\_\_\_\_ Date: \_\_\_\_\_

[I, as a full-time Member of [ABC Bank] hereby enroll in the Accident[al] [Death] [and Dismemberment] Insurance Plan as provided by Stonebridge Life Insurance Company]

[I further understand that benefits are payable only if a Total [Permanent] Disability is caused by an injury that occurs while: (1) the certificate is in force; and (2) I am Employed Full Time (working [30] hours or more per week during the [12] weeks immediately prior to the date that the injury occurs)]

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[SIGN, DATE AND MAIL] I [(and, if indicated below, my [co-insured])] hereby [enroll in][apply for] the [[Group] [Hospital] [Accident][al] [Death] [and Dismemberment] [Insurance] [Plan] underwritten by Stonebridge Life Insurance Company. [ I understand that I can have only one disability income insurance policy/certificate with the company or any AEGON Affiliate.] [By signing below, I authorize [ABC Bank] to provide the Insurance Company with my [ABC Bank] checking account number and any other information required to activate my coverage.][[If selecting additional insurance coverage,] I authorize my premium to be [deducted] [processed][billed] [quarterly] monthly] and [electronically] remitted to the Insurance Company [from] [through] my [ABC Bank][credit card] [checking] [savings] [share] [share draft] [Credit Union] account.][[If selecting additional insurance coverage,] I authorize my lending institution to collect the premium with my monthly mortgage payment [after my first [2 months] of no-cost coverage.]] [If I have selected additional insurance coverage above, I hereby consent to the release of my [ABC Bank] checking account number to third parties for the purpose of billing and processing in connection with my request for additional [Accident][al] [Death] 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]. [Note: Coverage amounts begin to decrease at age [70].] [\*A [\$0.50] administrative fee will be added for each automatic account billing.] I acknowledge that I have received, read and understand the insurance disclosures [on the reverse side of this form][and][below].

[By signing below, I certify that I am not currently eligible to receive Medicare benefits.][By signing below, I certify that I am currently eligible to receive Medicare benefits and have received a special notice regarding this product and Medicare benefits.]

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[Insured] \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature of [Insured] (Required) Mo. Day Yr.

[[Co-Insured] \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
[Signature of [Co-Insured] (Required) Mo. Day Yr.]

[ \_\_\_\_\_ ]  
[Lance Hemmer XXXXXXXX]  
Licensed Agent

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**[DO NOT SEND MONEY. COMPLETE, SIGN AND MAIL THIS FORM IN THE [POSTAGE-PAID] ENVELOPE PROVIDED.]**

**[ACCEPTANCE IS GUARANTEED**

As much as [\$1,000] of NO-COST-TO-YOU Accidental Death coverage is paid for by your [financial institution][credit union]. [IF YOU ARE 18 OR OLDER YOU CANNOT BE TURNED DOWN FOR THIS COVERAGE.]

**[SATISFACTION GUARANTEED**

You may review your Certificate of Insurance for [30] [60] [90] days and, if not completely satisfied, return it and receive a full refund of premiums you paid for additional insurance coverage.]

**Underwriter: Stonebridge Life Insurance Company [is currently rated ["A+" (Superior)] for financial strength and operating performance by the A.M. Best Company] [and] [{"AA+" (Very Strong)] for claims paying ability by Standard & Poor's Insurance Rating Services.] [The A.M. Best rating is the [second highest] out of [13] given] [and] [the Standard and Poor's rating is [second highest] out of [17] given.] [Both][The] rating[s] [were][was] given in [2000].**

**[INSURANCE DISCLOSURES]**

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**[This insurance product is not a deposit; not FDIC insured; not insured by any federal government agency; and is not guaranteed by the financial institution/affiliate.]**

**[The insurance product is: not FDIC or other government agency insured; not a deposit in, obligation of, guaranteed or underwritten by any bank or bank affiliate; not a condition of any banking service.]**

**[FDIC for all states except GA:**

**Insurance is not insured by the FDIC, any other agency of the United States, the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; and is not issued, guaranteed, or underwritten by the bank, its affiliates or the FDIC.**

**FDIC statement for GA:**

**Insurance is not insured by the FDIC, any other agency of the United States, or the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; is not guaranteed or underwritten by the bank or affiliates; and is not a condition to the provision or term of any banking service or activity.]**

**[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.]**

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[Plan Administrator]

[P. O. Box 1000]

[Any City, State Zip Code]

# APPLICATION FORM

## Accidental Death Insurance

Underwritten by Stonebridge Life Insurance Company

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

Please respond by: **[December 1, 2010]**

[John Smith  
123 Main Street  
St. Louis, MO 12345]

[0435-013B 043599999999 MZ2000104/0000F]

CHECK HERE TO SELECT YOUR COVERAGE		
ADDITIONAL COVERAGE	MONTHLY PREMIUM	
	CUSTOMER ONLY	CUSTOMER & SPOUSE
[\$ 25,000	[n \$ 2.75	n \$ 4.12
\$ 50,000	n \$ 5.50	n \$ 8.25
\$100,000	n \$11.00	n \$ 16.50
\$150,000	n \$16.50	n \$ 24.75
\$200,000	n \$22.00	n \$ 33.00
\$250,000 ]	n \$27.50	n \$ 41.25]

PLEASE

**R** RECEIVE UP TO \$1,000 OF INSURANCE PROVIDED BY ABC BANK AT NO COST TO YOU.  
(If you have a joint account with Wells Fargo Bank, circle the name of the person to be insured.  
Limit: one \$1,000 Certificate per joint account.)

COMPLETE:

Customer Information:

Date of Birth [  /  /  ]  
(Required) M M D D Y Y Y Y

Male  Female

[Beneficiary \_\_\_\_\_]

[Relationship to Insured \_\_\_\_\_]

Spouse Information - If Coverage Desired

Name [  Jane  M  Doe ]  
First Middle Last

Date of Birth [  /  /  ]  
M M D D Y Y Y Y

Male  Female

[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 and Dismemberment 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.]

I hereby apply for the Accidental Death Plan underwritten by Stonebridge Life Insurance Company. If selecting additional insurance coverage, I authorize my premium to be processed monthly and remitted to the Insurance Company from my [ABC Bank] checking account. 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 acknowledge that I have received, read and understand the insurance disclosures on the reverse side of this form.

Signature of Insured Customer (required) <input checked="" type="checkbox"/> [ _____ ]	Today's Date [ <input type="radio"/> / <input type="radio"/> / <input type="radio"/> ] M M D D Y Y Y Y
---	--

DO NOT SEND MONEY. COMPLETE, SIGN AND MAIL THIS FORM IN THE POSTAGE-PAID ENVELOPE PROVIDED.

## INSURANCE DISCLOSURES

This insurance product is not a deposit; not FDIC insured; not insured by any federal government agency; and is not guaranteed by the financial institution/affiliate.

Insurance is not insured by the FDIC, any other agency of the United States, the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; and is not issued, guaranteed, or underwritten by the bank, its affiliates or the FDIC.

**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.

# ENROLLMENT FORM

## Group Accidental Death Insurance

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

**Please respond by: [December 1, 2010]**

[John Smith  
 123 Main Street  
 St. Louis, MO 12345]

[0435-013B 0435999999999 MZ2000104/0000F]

Check here to select your voluntary coverage		
ADDITIONAL COVERAGE	MONTHLY PREMIUM	
	CUSTOMER ONLY	CUSTOMER & SPOUSE
[\$ 25,000	[n \$ 2.75	n \$ 4.12
\$ 50,000	n \$ 5.50	n \$ 8.25
\$100,000	n \$11.00	n \$ 16.50
\$150,000	n \$16.50	n \$ 24.75
\$200,000	n \$22.00	n \$ 33.00
\$250,000 ]	n \$27.50	n \$ 41.25]

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

Please complete  
 Customer Information

Date of Birth [  /  /  ]  Male  Female

[Beneficiary \_\_\_\_\_] [Relationship to Insured \_\_\_\_\_]  Male  Female

[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 and Dismemberment 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.]

I hereby enroll in the Group Accidental Death Plan underwritten by Stonebridge Life Insurance Company. After the first [30] days, I authorize my premium to be processed monthly and remitted to the Insurance Company directly from my [ABC Bank] checking account. If I sign and return this form without selecting a coverage amount, I understand that I will be automatically enrolled for [\$25,000] 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 acknowledge that I have received, read and understand the insurance disclosures on the reverse side of this form.**

Signature of Insured Customer (required) X [ _____ ]	Today's Date [ <input type="radio"/> / <input type="radio"/> / <input type="radio"/> ] M M D D Y Y Y Y
---	--

DO NOT SEND MONEY. COMPLETE, SIGN AND MAIL THIS FORM IN THE POSTAGE-PAID ENVELOPE PROVIDED.

## INSURANCE DISCLOSURES

This insurance product is not a deposit; not FDIC insured; not insured by any federal government agency; and is not guaranteed by the financial institution/affiliate.

Insurance is not insured by the FDIC, any other agency of the United States, the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; and is not issued, guaranteed, or underwritten by the bank, its affiliates or the FDIC.

**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.

Activation Form  
Accidental Death Insurance

[Variable Logo]

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, 2001]

[Bar Code for Scanning Purposes] [123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

**[R]** UP TO \$1,000 OF Accidental Death Insurance provided by [ABC BANK] AT NO COST TO YOU.  
Limit: one no cost to you \$1,000 Certificate per joint account.])

[Note to Plan Administrator: The monthly cost for the first [30] days of coverage will be paid for by [ABC Bank.]

1. Select your [additional ] insurance coverage

Primary Coverage

Monthly Premium\*

Individual

Family

\$ [10,000]  
\$ [20,000]  
\$ [30,000]  
\$ [40,000]  
\$ [50,000]  
\$ [100,000]  
\$ [150,000]

\$[ 1.18](xxx)  
 \$[ 2.36](xxx)  
 \$[ 3.54](xxx)  
 \$[ 4.72](xxx)  
 \$[ 5.90](xxx)  
 \$[11.80](xxx)

\$[ 1.76](xxx)  
 \$[ 3.52](xxx)  
 \$[ 5.28](xxx)  
 \$[ 7.04](xxx)  
 \$[ 8.80](xxx)  
 \$[17.60](xxx)  
 \$[26.40](xxx)

2. Complete Information below and name your beneficiary

Male  Female  Insured Birthdate [2\_] [2\_] [1960]  
MO DAY YEAR

[Beneficiary \_\_\_\_\_]

Print Insured Name \_\_\_\_\_

[Relationship to Insured \_\_\_\_\_]

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 and Dismemberment 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.]

I hereby enroll in the Group Accidental Death Plan underwritten by Stonebridge Life Insurance Company. [If selecting additional insurance coverage,] I authorize my premium to be [billed] monthly] and [electronically] remitted to the Insurance Company [from] my [ABC Bank] checking account. 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]. Note: Coverage amounts begin to decrease at age [70].] A [\$0.75] administrative fee will be added for each automatic account billing.] 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 Transamerica Life and Transamerica Life's Plan Administrator, neither of which are affiliated with [ABC Bank] to activate my coverage. I acknowledge that I have received, read and understand the insurance disclosures on the reverse side of this form.

Customer's  
Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Required)

(Required)

**[Residents of ARKANSAS, NEW MEXICO, and OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]**

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

**[Residents of FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]**

**[Residents of LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]**

**[Residents of MAINE, TENNESSEE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]**

**[Residents of MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]**

**[Residents of NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]**

**[Residents of NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]**

**[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.]**

Accidental Death Insurance  
Enrollment Form



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

Logo

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

Please respond by: [Month XX, 2001]

[Jane Doe (if covered)]

[Phone (Home) \_\_\_\_\_]

[e-mail address \_\_\_\_\_]

[Bar Code for Scanning Purposes]

[123-103B]

[5060002091717]

[MZ2000104/0000F & 0001F]

HOW TO ACTIVATE COVERAGE

- 1. Complete, sign and mail this form by [xx/xx/xxxx] to implement your coverage.
- 2. Select amount of insurance coverage.

**Check here to enroll in coverage**

ACTIVATE UP TO [\$150,000] OF INSURANCE PROVIDED BY [ABC BANK].

**SELECT ACCIDENTAL DEATH INSURANCE COVERAGE: [(Check one)]**

[Maximum Coverage per person is [\$150,000.]]

NOTE: [After the [two months] no cost period], your rates for your coverage are shown below.

Coverage

Monthly Premium\*

[Single Coverage]

[Family Plan]

\$ [10,000]

\$[ 1.18](xxx)

\$[ 1.76](xxx)

\$ [20,000]

\$[ 2.36](xxx)

\$[ 3.52](xxx)

\$ [30,000]

\$[ 3.54](xxx)

\$[ 5.28](xxx)

\$ [40,000]

\$[ 4.72](xxx)

\$[ 7.04](xxx)

\$ [50,000]

\$[ 5.90](xxx)

\$[ 8.80](xxx)

\$[100,000]

\$[11.80](xxx)

\$[17.60](xxx)

\$[150,000]

\$[17.70](xxx)

\$[26.40](xxx)

Check here to add [Survivor Income Rider]

[Spouse coverage is [50%] of Applicant's selected benefit [(depending on plan selection)]]

[Children's benefit is [10%] of Applicant's selected benefit]

Male  Female

Applicant's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

[Home Phone ( ) \_\_\_\_-\_\_\_\_]

(Required) Mo. Day Yr.

[Please indicate % of Benefits for each Beneficiary listed [below] next to the Beneficiary's name.]

[Applicant's] [Name of] Beneficiary \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

[Co-Beneficiary\* \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_]

Male  Female

[Co-Applicant's] Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

[Home Phone ( ) \_\_\_\_-\_\_\_\_]

(Required)

Mo. Day Yr.

Beneficiary \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

[Co- Beneficiary \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_]

SLAD4004GE

**Complete and sign 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 and Dismemberment 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.]

I hereby enroll in the Group Accidental Death [and Dismemberment] Insurance [Plan] underwritten by Stonebridge Life Insurance Company. [If selecting additional insurance coverage,] I authorize my premium to be [deducted] [monthly] and remitted to the Insurance Company [directly from] my [ABC Bank] [credit card] account. 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]. [Note: Coverage amounts begin to decrease at age [70].] [\*A [\$0.50] administrative fee will be added for each automatic account billing.] I acknowledge that I have received, read and understand the insurance disclosures [on the reverse side of this form].

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Your Signature (Required) Mo. Day Yr.

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
[Signature of [Spouse] (Required) Mo. Day Yr.]

[ \_\_\_\_\_ ]  
[James Doe XXXXXXXX]  
Licensed Resident Agent

**[Residents of ARKANSAS, NEW MEXICO, and OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]**

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

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**[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.]**

# Stonebridge Life Insurance Company

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

## GROUP ACCIDENT ONLY EMERGENCY ROOM BENEFIT RIDER

### RIDER BENEFIT SCHEDULE

INSURED: JOHN J. DOE  
345 MAIN STREET  
ANYTOWN, USA 12345

CERTIFICATE NUMBER: 12345678

EFFECTIVE DATE OF COVERAGE: 09/01/2003

TERMINATION DATE/AGE: 65

	INSURED	COVERED SPOUSE	COVERED CHILD
ACCIDENT EMERGENCY ROOM BENEFIT	[\$50] PER VISIT	[\$25] PER VISIT	[\$5] PER VISIT
MAXIMUM NUMBER OF VISITS PAID EACH CALENDAR YEAR:	6	6	6
	OR		
MAXIMUM NUMBER OF VISITS PAID EACH CALENDAR YEAR:			[1-12]
Premium:	\$2.82 per month		

The consideration for this Rider is (1) receipt of the signed enrollment form, if required, and (2) payment of the premium. The premium is [shown in the Rider Benefit Schedule][included in the Certificate Schedule of Insurance]. Premiums are to be paid in the same manner and at the same time as the Certificate.

### DEFINITIONS

For purposes of this Rider, the following Definitions apply.

**HOSPITAL EMERGENCY ROOM** means a facility that meets the following requirements:

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

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

**IMMEDIATE FAMILY** means a Covered Person's spouse, parent, child, brother or sister, or any person living with a Covered Person.

**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 the treatment constitutes Necessary Treatment. Services are not deemed Necessary Treatment if healthcare services are not found to be 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.

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

### ACCIDENT EMERGENCY ROOM BENEFIT

We will pay the Accident Emergency Room Benefit shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance] for a covered visit to a Hospital Emergency Room for Necessary Treatment of an Injury for the maximum number of visits as stated on the [Rider Benefit Schedule][Certificate Schedule of Insurance]. [The maximum number of visits is the total number of visits allowed per calendar year for all Covered Persons combined.]

Treatment must be for necessary emergency treatment of an Injury, and such treatment must occur within 72 hours of the accident causing the Injury. Only one Accident Emergency Room Benefit will be paid per Covered Person per accident.

### GENERAL PROVISIONS

#### TERMINATION

This Rider shall terminate for the following reasons:

- 1) non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
- 2) the date the Certificate terminates; or
- 3) the date the Rider terminates.

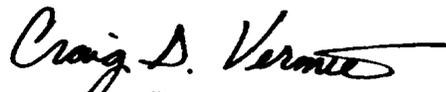
This Rider takes effect on the date entered hereon after receipt of the signed enrollment, if required.

This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Life Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

# Stonebridge Life Insurance Company

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

## GROUP ACCIDENT DEPENDENT CHILD DAY CARE BENEFIT RIDER

---

### RIDER BENEFIT SCHEDULE

INSURED: JOHN J. DOE CERTIFICATE NUMBER: 12345678  
345 MAIN STREET  
ANYTOWN, USA 12345

EFFECTIVE DATE OF COVERAGE: 09/01/2003

TERMINATION DATE/AGE: 65

#### DEPENDENT CHILD DAY CARE BENEFIT

AMOUNT OF INSURANCE PER MONTH  
FOR EACH QUALIFYING  
DEPENDENT CHILD [\$250]

OR

[1% - 10%] OF THE ACCIDENTAL DEATH BENEFIT FOR EACH QUALIFYING DEPENDENT  
CHILD

MAXIMUM NUMBER OF PAYMENTS [36] MONTHS

MAXIMUM ATTAINED CHILD AGE [14] YEARS OLD

IF NO DEPENDENT CHILDREN QUALIFY, THE ACCIDENTAL DEATH BENEFIT AMOUNT IS  
INCREASED BY [8%] OR [\$1,000 - \$25,000]

Premium: \$2.82 per month

---

The consideration for this Rider is (1) receipt of the signed enrollment form, if required, and (2) payment of the premium. The premium is [shown in the Rider Benefit Schedule][included in the Certificate Schedule of Insurance]. Premiums are to be paid in the same manner and at the same time as the Certificate.

#### DEFINITIONS

For purposes of this Rider, the following Definitions apply.

**DEPENDENT CHILD** means each of your unmarried children including step-children, children born to you or legally adopted by you and under the Maximum Attained Age stated in the [Rider Benefit Schedule][Certificate Schedule of Insurance]. (An adopted child is a child who is in your custody pursuant to an interim court order of adoption or placement of adoption).

**DAY CARE CENTER** means:

1. a facility that is legally licensed or recognized by a legal authority to provide care and supervision for children in a group setting on a regular, daily, and non-resident basis; or
2. an individual who is legally licensed or authorized by a legal authority who provides child care and supervision for such Dependent Child.

A Day Care Center does not include a hospital or other medical facility.

## ACCIDENT DEPENDENT CHILD DAY CARE BENEFIT

Upon receipt of due proof of your death due to an Injury, we will pay the benefit shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance] for each Dependent Child. The benefit payable is subject to the following conditions:

1. a death benefit is payable under the terms of the Policy; and
2. Your Dependent Child is covered under the Certificate to which this Rider is attached at the time of your death; and
3. the Dependent Child must be attending a Day Care Center on the date of the accident causing the Injury or enroll in a Day Care Center within 90 consecutive days from the accident causing the Injury; and
4. the Dependent Child must be under the Maximum Attained Age stated in the [Rider Benefit Schedule][Certificate Schedule of Insurance] on the date of the accident causing the Injury; and
5. this Rider coverage is in force.

The Accident Dependent Child Day Care Amount of Insurance stated on the [Rider Benefit Schedule][Certificate Schedule of Insurance] will be paid as long as the Dependent Child continues to be enrolled in a Day Care Center and:

1. the Dependent Child has not attained the Maximum Attained Age shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance]; and
2. payments have not been made for the Maximum Number of Payments shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance].

Benefits will not be paid for the care received while a Dependent Child is at school attending grades kindergarten through twelve.

### GENERAL PROVISIONS

#### TERMINATION

This Rider shall terminate for the following reasons:

- 1) non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
- 2) the date the Certificate terminates; or
- 3) the date the Rider terminates.

This Rider takes effect on the date entered hereon after receipt of the signed enrollment, if required.

This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Life Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

# Stonebridge Life Insurance Company

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

## GROUP ACCIDENT HIGHER EDUCATION BENEFIT RIDER

### RIDER BENEFIT SCHEDULE

---

INSURED: JOHN J. DOE  
345 MAIN STREET  
ANYTOWN, USA 12345

CERTIFICATE NUMBER: 12345678

EFFECTIVE DATE OF COVERAGE: 09/01/2003

TERMINATION DATE/AGE: 65

ACCIDENT HIGHER

EDUCATION BENEFIT: [\$100 - \$50,000] FOR EACH DEPENDENT CHILD PER YEAR

FOR A MAXIMUM OF [1-4] YEAR[S]

IF NO DEPENDENT CHILDREN QUALIFY, THE ACCIDENTAL DEATH BENEFIT IS INCREASED BY [\$100 - \$50,000]

OR

ACCIDENT HIGHER EDUCATION BENEFIT:

[1% - 10%] OF THE ACCIDENTAL DEATH BENEFIT FOR EACH QUALIFYING DEPENDENT CHILD FOR EACH UNCOMPLETED YEAR OF HIGHER EDUCATION UP TO [\$100 - \$50,000] PER YEAR FOR A MAXIMUM OF [1 - 4] YEARS.

IF NO DEPENDENT CHILDREN QUALIFY, THE ACCIDENTAL DEATH BENEFIT IS INCREASED BY [1% - 10%]

Premium: \$2.82 per month

---

The consideration for this Rider is (1) receipt of the signed enrollment form, if required, and (2) payment of the premium. The premium is [shown in the Rider Benefit Schedule][included in the Certificate Schedule of Insurance]. Premiums are to be paid in the same manner and at the same time as the Certificate.

### DEFINITIONS

For purposes of this Rider, the following Definitions apply.

**DEPENDENT CHILD** means 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).

### HIGHER EDUCATION BENEFIT

Upon receipt of due proof of your death due to an Injury, we will pay the Higher Education Benefit shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance] for each Covered Child for each uncompleted year of higher education for the Maximum Number of Years stated on the [Rider Benefit Schedule][Certificate Schedule of Insurance]. The benefit payable is subject to the following conditions:

1. a death benefit is payable under the terms of the Policy; and
2. this Rider coverage is in force; and

3. your Dependent Child is covered under the Certificate to which this Rider is attached at the time of your death; and
4. your Dependent Child must be attending or enrolled to attend in any certified and/or accredited professional or trades training program or educational degree program within the United States or Canada beyond the 12th grade level, as a full-time student, on the date of the accident causing the Injury; and
5. proof is provided, as requested, that your Dependent Child continues to be attending an institution of higher learning as a full-time student.

#### **GENERAL PROVISIONS**

#### **TERMINATION**

This Rider shall terminate for the following reasons:

- 1) non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
- 2) the date the Certificate terminates; or
- 3) the date the Rider terminates.

This Rider takes effect on the date entered hereon after receipt of the signed enrollment, if required.

This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Transamerica Life Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

# Stonebridge Life Insurance Company

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

## GROUP ACCIDENT PARALYSIS BENEFIT RIDER

### RIDER BENEFIT SCHEDULE

[INSURED: JOHN J. DOE  
345 MAIN STREET  
ANYTOWN, USA 12345

CERTIFICATE NUMBER: 12345678

EFFECTIVE DATE OF COVERAGE: 09/01/2003

TERMINATION DATE/AGE: 65

	INSURED	COVERED SPOUSE	COVERED CHILD
QUADRIPLEGIA (TOTAL PARALYSIS OF BOTH UPPER AND LOWER LIMBS)	[\$10,000]	[\$5,000]	[\$1,000]
PARAPLEGIA (TOTAL PARALYSIS OF BOTH LOWER LIMBS)	[\$5,000]	[\$2,500]	[\$500]
HEMIPLEGIA (TOTAL PARALYSIS OF UPPER AND LOWER LIMBS ON ONE SIDE OF THE BODY)	[\$5,000]	[\$2,500]	[\$500]

ELIMINATION PERIOD FOR TOTAL PARALYSIS [6 – 12] CONTINUOUS MONTHS

TOTAL MAXIMUM BENEFIT PAYABLE PER RIDER: [\$10,000 - \$1,000,000]

Premium: \$2.82 per month

The consideration for this Rider is (1) receipt of the signed enrollment form, if required, and (2) payment of the premium. The premium is [shown in the Rider Benefit Schedule][included in the Certificate Schedule of Insurance]. Premiums are to be paid in the same manner and at the same time as the Certificate.

### DEFINITIONS

For purposes of this Rider, the following Definitions apply:

**TOTAL PARALYSIS OR TOTALLY PARALYZED** means the inability to move limbs as a result of neurological damage. This loss must be determined by a Physician to be permanent.

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

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

**IMMEDIATE FAMILY** means a Covered Person's spouse, parent, child, brother or sister, or any person living with a Covered Person.

## TOTAL PARALYSIS BENEFIT

Upon receipt of due proof that a Covered Person becomes Totally Paralyzed as a result of an Injury, we will pay the benefit shown in the [Rider Benefit Schedule][Certificate Schedule of Insurance] beginning with the first day of Total Paralysis following the Elimination Period. The Total Paralysis must begin within [14 - 90] days from the date of the accident causing the Injury.

We will pay benefits in one lump sum. If the Covered Person incurs more than one type of Total Paralysis as a result of the same accident, we will only pay one benefit, the largest shown in the [Rider Benefit Schedule][Certificate Schedule of Insurance]. Once the Total Maximum Benefit Payable per Rider has been paid, no additional payments will be made and this Rider will terminate.

## GENERAL PROVISIONS

### TERMINATION

This Rider shall terminate for the following reasons:

- 1) non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
- 2) the date the Certificate terminates; or
- 3) the date the Rider terminates.

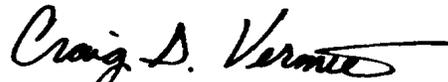
This Rider takes effect on the date entered hereon after receipt of the signed enrollment, if required.

This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Life Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

# Stonebridge Life Insurance Company

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

## GROUP PHYSICIAN OFFICE VISIT [AND WELLNESS] BENEFIT RIDER

### RIDER BENEFIT SCHEDULE

INSURED: JOHN J. DOE CERTIFICATE NUMBER: 12345678  
345 MAIN STREET  
ANYTOWN, USA 12345

EFFECTIVE DATE OF COVERAGE: 09/01/2003

TERMINATION DATE/AGE: 65

	INSURED	COVERED SPOUSE	COVERED CHILD
PHYSICIAN OFFICE VISIT BENEFIT	[\$10 - 250] PER OFFICE VISIT	[\$10 - 250] PER OFFICE VISIT	[\$10 - 250] PER OFFICE VISIT

ONLY ONE PHYSICIAN OFFICE VISIT BENEFIT IS PAYABLE PER DAY PER COVERED PERSON

MAXIMUM NUMBER OF PHYSICIAN OFFICE VISITS  
PER COVERED PERSON PAYABLE  
PER ACCIDENT OR SICKNESS [1-12]

Or [1-12]

MAXIMUM NUMBER OF PHYSICIAN OFFICE VISITS PAYABLE PER ACCIDENT OR SICKNESS: [1-12]

MAXIMUM NUMBER OF PHYSICIAN OFFICE VISITS  
PER COVERED PERSON PAYABLE  
PER CALENDAR YEAR: [1-12]

OR [1-12]

MAXIMUM NUMBER OF PHYSICIAN OFFICE VISITS PAYABLE PER CALENDAR YEAR: [2 - 12]

WELLNESS BENEFIT	[\$10 - 100] PER YEAR	[\$1 - 100] PER YEAR	[\$10 - 100] PER YEAR
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ONLY ONE WELLNESS BENEFIT IS PAYABLE PER CALENDAR YEAR PER COVERED PERSON

Premium: \$2.82 per month

The consideration for this Rider is (1) receipt of the signed enrollment form, if required, and (2) payment of the premium. The premium is [shown in the Rider Benefit Schedule][included in the Certificate Schedule of Insurance]. Premiums are to be paid in the same manner and at the same time as the Certificate.

### DEFINITIONS

For purposes of this Rider, the following Definitions apply.

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

**SICKNESS** means an illness or disease which first manifests while insurance for the Covered Person is in effect under the Policy.

**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 the treatment constitutes Necessary Treatment. Services are not deemed Necessary Treatment if healthcare services are not found to be 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.

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

**IMMEDIATE FAMILY** means a Covered Person’s spouse, parent, child, brother or sister, or any person living with a Covered Person.

**[WELLNESS means an office visit for routine examinations or other preventative testing.]**

**PHYSICIAN OFFICE VISIT [AND WELLNESS] BENEFIT**

Upon receipt of due proof that a Covered Person was treated by a Physician in a Physician’s office for the Necessary Treatment of an Injury or Sickness, we will pay the Physician Office Visit benefit shown on the **[Rider Benefit Schedule][Certificate Schedule of Insurance]**. The Maximum Number of Physician Office Visit Benefits payable for the Necessary Treatment of each accident or Sickness is shown on the **[Rider Benefit Schedule][Certificate Schedule of Insurance]**. Only one Physician Office Visit Benefit is payable per day per Covered Person.

Physician Office Visit includes visits to private practice and freestanding clinics – including urgicenters, public health clinics, family planning clinics and faculty practice plans. It does not include visits to hospital emergency or outpatient departments; freestanding ambulatory surgery centers or mental health centers.

No additional benefits will be payable in any Calendar Year when the Maximum number of Physician Office Visits Benefits payable shown on the **[Rider Benefit Schedule][Certificate Schedule of Insurance]** has been met.

**[Upon receipt of due proof that a Covered Person was treated by a Physician in a Physician’s Office for Wellness, we will pay the Wellness Benefit as shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance]. Only one Wellness Benefit is payable per Covered Person per calendar year.]**

**GENERAL PROVISIONS**

**TERMINATION**

This Rider shall terminate for the following reasons:

- 1) non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
- 2) the date the Certificate terminates; or
- 3) the date the Rider terminates.

This Rider takes effect on the date entered hereon after receipt of the signed enrollment, if required.

This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Life Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

# Stonebridge Life Insurance Company

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

## GROUP SPECIAL TRAINING ACCIDENT BENEFIT RIDER

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### RIDER BENEFIT SCHEDULE

[INSURED: JOHN J. DOE  
345 MAIN STREET  
ANYTOWN, USA 12345

CERTIFICATE NUMBER: 12345678

EFFECTIVE DATE OF COVERAGE: 09/01/2003

TERMINATION DATE/AGE: 65

COVERED  
SPOUSE

SPECIAL TRAINING ACCIDENT BENEFIT

[100 - \$5,000]

[IF THERE IS NO COVERED SPOUSE, THE ACCIDENTAL DEATH BENEFIT IS INCREASED BY [\$100 - \$5,000]].

Or

SPECIAL TRAINING ACCIDENT BENEFIT IS [1% - 10%] OF THE AMOUNT OF THE ACCIDENTAL DEATH BENEFIT

[IF THERE IS NO COVERED SPOUSE, THE ACCIDENTAL DEATH BENEFIT IS INCREASED BY [1% - 10%]].

Premium: \$2.82 per month

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The consideration for this Rider is (1) receipt of the signed enrollment form, if required, and (2) payment of the premium. The premium is [shown in the Rider Benefit Schedule][included in the Certificate Schedule of Insurance]. Premiums are to be paid in the same manner and at the same time as the Certificate.

### SPECIAL TRAINING BENEFIT

Upon receipt of due proof of your death due to an Injury, we will pay the benefit shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance] to your Covered Spouse. The benefit payable is subject to the following conditions:

1. a benefit must be payable under the terms of the Policy;
2. Dependent coverage must be in force on the date of the accident causing the Injury; and
3. the Covered Spouse must be enrolled on the date of the accident causing the Injury or enroll within [6 – 12] months in any certified and/or accredited professional or trades training program or educational degree program within the United States or Canada. The Covered Spouse must be enrolled for the purpose of obtaining an independent source of support or enriching his ability to earn a living.

We will pay benefits in one lump sum. Benefits will be payable upon proof of enrollment and payment of tuition or any appropriate fees.

## GENERAL PROVISIONS

### TERMINATION

This Rider shall terminate for the following reasons:

- 1) non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
- 2) the date the Certificate terminates; or
- 3) the date the Rider terminates.

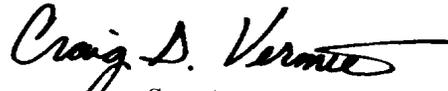
This Rider takes effect on the date entered hereon after receipt of the signed enrollment, if required.

This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Life Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

# Stonebridge Life Insurance Company

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

## GROUP ACCIDENT PHYSICIAN OFFICE VISIT [AND WELLNESS] BENEFIT RIDER

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### RIDER BENEFIT SCHEDULE

[INSURED: JOHN J. DOE CERTIFICATE NUMBER: 12345678  
345 MAIN STREET  
ANYTOWN, USA 12345

EFFECTIVE DATE OF COVERAGE: 09/01/2003

TERMINATION DATE/AGE: 65

	INSURED	COVERED SPOUSE	COVERED CHILD
ACCIDENT PHYSICIAN OFFICE VISIT BENEFIT	[\$10 - 250] PER OFFICE VISIT	[\$10 - 250] PER OFFICE VISIT	[\$10 - 250] PER OFFICE VISIT

ONLY ONE PHYSICIAN OFFICE VISIT BENEFIT IS PAYABLE PER DAY PER COVERED PERSON

MAXIMUM NUMBER OF ACCIDENT PHYSICIAN OFFICE VISITS PER COVERED PERSON PAYABLE PER ACCIDENT [1-12]

Or

MAXIMUM NUMBER OF ACCIDENT PHYSICIAN OFFICE VISITS PAYABLE PER ACCIDENT [1-12]

MAXIMUM NUMBER OF ACCIDENT PHYSICIAN OFFICE VISITS PER COVERED PERSON PAYABLE PER CALENDAR YEAR: [1-12]

OR

MAXIMUM NUMBER OF ACCIDENT PHYSICIAN OFFICE VISITS PAYABLE PER CALENDAR YEAR: [2 - 12]

WELLNESS BENEFIT	[\$10-100] PER YEAR	[\$10-100] PER YEAR	[\$10-100] PER YEAR
------------------	------------------------	------------------------	------------------------

ONLY ONE WELLNESS BENEFIT IS PAYABLE PER CALENDAR YEAR PER COVERED PERSON

Premium: \$2.82 per month

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The consideration for this Rider is (1) receipt of the signed enrollment form, if required, and (2) payment of the premium. The premium is [shown in the Rider Benefit Schedule][included in the Certificate Schedule of Insurance]. Premiums are to be paid in the same manner and at the same time as the Certificate.

### DEFINITIONS

For purposes of this Rider, the following Definitions apply.

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

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

**IMMEDIATE FAMILY** means a Covered Person's spouse, parent, child, brother or sister, or any person living with a Covered Person.

**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 the treatment constitutes Necessary Treatment. Services are not deemed Necessary Treatment if healthcare services are not found to be 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.

**[WELLNESS means an office visit for routine examinations or other preventative testing.]**

### **ACCIDENT PHYSICIAN OFFICE VISIT [AND WELLNESS] BENEFIT**

Upon receipt of due proof that a Covered Person was treated by a Physician in a Physician's office for the Necessary Treatment of an Injury, we will pay the Accident Physician Office Visit Benefit shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance]. The Maximum Number of Accident Physician Office Visit Benefits payable for the Necessary Treatment of each Injury is shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance]. Only one Physician Office Visit Benefit is payable per day per Covered Person.

The Accident Physician Office Visit must occur within [10 - 30] days of the accident causing the Injury.

Accident Physician Office Visit includes visits to private practice and freestanding clinics – including urgent centers, public health clinics, family planning clinics and faculty practice plans. It does not include visits to hospital emergency or outpatient departments; freestanding ambulatory surgery centers or mental health centers.

No additional benefits will be payable in any calendar year when the Maximum number of Accident Physician Office Visits payable shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance] has been met.

[Upon receipt of due proof that a Covered Person was treated by a Physician in a Physician's office for Wellness, we will pay the Wellness Benefit as shown on the [Rider Benefit Schedule][Certificate Schedule of Insurance]. Only one Wellness Benefit is payable per calendar year per Covered Person.]

### **GENERAL PROVISIONS**

#### **TERMINATION**

This Rider shall terminate for the following reasons:

- 1) non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
- 2) the date the Certificate terminates; or
- 3) the date the Rider terminates.

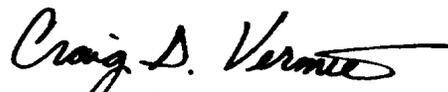
This Rider takes effect on the date entered hereon after receipt of the signed enrollment, if required.

This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Life Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

# Stonebridge Life Insurance Company

A Stock Company  
Home Office: Rutland, Vermont  
Administrative Office: 2700 W. Plano Parkway, Plano, Texas 75075-8200

## Policy Change Endorsement

Name of Policyholder [ABC Bank]	Policy Number [11111 SLAD4000GC]	Effective Date [10/01/2011]
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This Endorsement is effective on the date shown above and expires concurrently with the Policy to which it is attached. The Policy is amended as follows:

For residents of Arkansas:

Under the heading **CONTINUATION OF COVERAGE**, the third paragraph has been modified to read:

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 you for support and maintenance; and
- 3) the Insured provides proof of incapacity as requested but no more than once annually; and
- 4) the Insured pays the premium for adult benefits, if applicable.

**NOTHING HEREIN CONTAINED SHALL BE HELD TO VARY, WAIVE, ALTER OR EXTEND ANY OF THE TERMS, PROVISIONS OR LIMITATIONS OF THE POLICY OR CERTIFICATE.**



Secretary

<i>SERFF Tracking Number:</i>	<i>AEGX-G127186264</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48915</i>
<i>Company Tracking Number:</i>	<i>AR006071500038</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death &amp; Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death &amp; Dismemberment</i>
<i>Product Name:</i>	<i>Accidental Death</i>		
<i>Project Name/Number:</i>	<i>Accidental Death/AR006071500038</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	06/23/2011
<b>Comments:</b>		
<b>Attachment:</b> AR - READABILITY CERTIFICATION.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	06/23/2011
<b>Bypass Reason:</b> See Forms tab.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Actuarial Memo - SLAD3900GP, Actuarial Memo - SLAD4000GP	Approved-Closed	06/23/2011
<b>Comments:</b>		
<b>Attachments:</b> Actuarial Memo - SLAD3900GP.PDF Actuarial Memo - SLAD4000GP.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Actuarial Memo - SLAD4002GR, Actuarial Memo - SLAD4003GR	Approved-Closed	06/23/2011
<b>Comments:</b>		
<b>Attachments:</b> SLAD4002GR Actuarial Memo.PDF SLAD4003GR Actuarial Memo.PDF		

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48915  
 Company Tracking Number: AR006071500038  
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
 Dismemberment Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

**Item Status:** Approved-Closed  
**Status Date:** 06/23/2011  
**Satisfied - Item:** Actuarial Memo - SLAD4004GR,  
 Actuarial Memo - SLAD4007GR

**Comments:**

**Attachments:**

SLAD4004GR Actuarial Memo.PDF  
 SLAD4007GR Actuarial Memo.PDF

**Item Status:** Approved-Closed  
**Status Date:** 06/23/2011  
**Satisfied - Item:** Actuarial Memo - SLAD4008GR,  
 Actuarial Memo - SLAD4009GR

**Comments:**

**Attachments:**

SLAD4008GR Actuarial Memo.PDF  
 SLAD4009GR Actuarial Memo.PDF

**Item Status:** Approved-Closed  
**Status Date:** 06/23/2011  
**Satisfied - Item:** Actuarial Memo - SLAD4010GR

**Comments:**

**Attachment:**

SLAD4010GR Actuarial Memo.PDF

**Item Status:** Approved-Closed  
**Status Date:** 06/23/2011  
**Satisfied - Item:** EOV - SLAD3900GC, EOV -  
 SLAD3900GP

**Comments:**

**Attachments:**

EOV - SLAD3900GC.PDF  
 EOV - SLAD3900GP.PDF



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

**COMPANY NAME: Stonebridge Life Insurance Company**

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

<b>Form Number</b>	<b>Score</b>
SLAD3900GP	43.4
SLAD3900GC	50.3
SLAD4000GP	43.2
SLAD4000GC	48.7
SLAD4002GR	40.4
SLAD4003GR	45.9
SLAD4004GR	43.3
SLAD4007GR	44.4
SLAD4008GR	40.0
SLAD4009GR	46.0
SLAD4010GR	40.0

Signed:   
Name: Laurie A. Renko  
Title: Vice President  
Date: 05/25/2011

## Statement of Variability Certificate SLAD3900GC

**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 30, 60, or 90 days, 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.
- **TITLE**
  - If the optional Dismemberment Benefit is offered, then this language will print.

### 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.
  - **TERMINATION DATE** will print if the Policyholder selects this product with a specific Termination Date, otherwise this will not print.
  - Product information for the specific Insured will print.
  - **REDUCTION** – There are various types of reduction that can be offered; If no reduction is offered, than this section will not print. If form GC561 and form GC560 are offered in the same solicitation, then the reduction levels will match on both certificates.

### Page 3

- **LOSS** will be either:
  - Loss of Life (**if there is not Dismemberment coverage**)
  - If Dismemberment coverage is issued, then Number 2 and 3 will print and the statement that Loss does not mean loss of use.
- **PARTICIPATING GROUP** definition will only print if this coverage is issued to a Participating Group Trust.

- **WHEN YOUR INSURANCE ENDS** will state either:

Your insurance ends [on the earlier of:]

- 1) the date the Policy is terminated or cancelled[; or
- 2) [the Termination Date stated on the Schedule of Insurance].

Number 2 is optional depending if coverage terminates on a given date.

- **COVERAGE** if only Accidental Death coverage is issued then only the first paragraph will print. The section labeled “Accidental Death and Dismemberment” will not print. If Accidental Death and Dismemberment is issued, then the first paragraph will not print but the Accidental Death and Dismemberment section will print.
- **REDUCTION** will print if there is any type of reduction stated on the Schedule of Insurance.

## Page 4

- **BENEFICIARY** - If Accidental Death and Dismemberment is issued then the first sentence in this provision will print. If only Accidental Death issued, then only the second sentence will print.

## Page 5

- **PAYMENT OF CLAIMS** – If Dismemberment is offered, variable language will print.
- 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.

## Statement of Variability - Master Policy SLAD3900GP

**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 30, 60, or 90 days, depending on what the Policyholder wants to offer.
- **TITLE** – If the optional Dismemberment Benefit is offered, then this language will print.

### Page 2

- **DEFINITIONS**
  - **PRIOR PLAN** will print if we will be taking over existing business.
  - **LOSS** will either be:
    - § Loss of Life **(if there is no Dismemberment)**
    - § If Dismemberment coverage is issued, then Number 2 and 3 will print and the statement that Loss does not mean loss of use.
  - **PARTICIPATING GROUP** definition will only print if this coverage is issued to a Participating Group Trust.
- **ELIGIBILITY**, the first paragraph will describe the group.  
The second paragraph will print if we will be taking over existing business.  
The third paragraph will print if Supersedes language is printed on the Certificate.

### Page 3

- **WHEN A PERSON'S INSURANCE ENDS**, number will print if the coverage terminates on a given date.
- **COVERAGE**, if Accidental Death only is offered, only the first paragraph will print.  
If Accidental Death and Dismemberment is offered, the first paragraph will not print.
- **REDUCTION** will print if there is any type of reduction stated on the Schedule of Insurance.

## Page 4

- **BENEFICIARY –**

if only Accidental Death is being offered, the first sentence in the first paragraph will print.

If Accidental Death and Dismemberment is being offered, then the second sentence will print in the first paragraph.

## Page 5

- 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.

# Statement of Variability – Certificate SLAD4000GC

**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 30, 60, or 90 days, 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** 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.
  - **TERMINATION DATE/AGE** will print if the Policyholder selects this product with a Termination Age/Date, otherwise this will not print.
  - **COVERAGE** – The Accidental Death benefit can be paid in a Lump Sum benefit or it can be paid Monthly for X number of months. The Policy Holder will determine how they wish benefits to be paid.
  - - Instead of a flat amount, coverage for the Spouse and Child can be offered as a percentage of the Insured's Accidental Death Benefit Amount.
    - If both Spouse and Child coverage is offered, it could appear as:  
COVERED SPOUSE IS INSURED FOR [50% - 90%] OF YOUR BENEFIT[S] IF CHILDREN ARE COVERED;  
COVERED SPOUSE IS INSURED FOR [60% - 100%] OF YOUR BENEFIT[S] IF CHILDREN ARE NOT COVERED.  
  
COVERED CHILD IS INSURED FOR [10% - 20%] OF YOUR BENEFIT[S] IF SPOUSE IS COVERED;  
COVERED CHILD IS INSURED FOR [15% - 25%] OF YOUR BENEFIT[S] IF SPOUSE IS NOT COVERED.
- If Spouse Coverage only, it could appear as:  
  
COVERED SPOUSE IS INSURED FOR [50% - 100%] OF YOUR BENEFIT[S]

- **REDUCTION** – There are various types of reduction that can be offered; If no reduction is offered, then this section will not print. If form GC561 and form GC560 are offered in the same solicitation, then the reduction levels will match on both certificates.. Reduction can be based on the Insured's age or the Covered Person's age.
- **INFLATION INCREASE:** Optional benefit and if offered will be stated as a percentage of the benefit amount.
- If **INFLATION INCREASE** is offered, the first and the second paragraph can be printed depending if riders are going to be offered after the original effective date of the certificate.
- If the **PERSISTENCY BENEFIT** is offered, this will describe when and how much the Persistency Benefit will be and to what extent.
  - Option 1  
**[PERSISTENCY BENEFIT ]                    [\$5 - \$50]**  
 [PAYABLE [30-365] DAYS AFTER THE CERTIFICATE EFFECTIVE DATE]  
 [PAYABLE ON THE [FIRST – TENTH] CERTIFICATE ANNIVERSARY AND  
 THEREAFTER EVERY [ONE – TEN] YEAR[S]]
  - Option 2  
**[PERSISTENCY BENEFIT ]                    [\$5 - \$50]**  
 [PAYABLE ON THE [FIRST – TENTH] CERTIFICATE ANNIVERSARY AND  
 THEREAFTER EVERY [ONE – TEN] YEAR[S]]
  - Option 3  
**[PERSISTENCY BENEFIT ]                    [\$5 - \$50]**  
 PAYABLE [30-365] DAYS AFTER THE CERTIFICATE EFFECTIVE DATE
  - Option 4  
**[PERSISTENCY BENEFIT ]                    [\$5 - \$50]**  
 [PAYABLE [30-365] DAYS AFTER THE CERTIFICATE EFFECTIVE DATE]  
 [PAYABLE ON THE [FIRST – TENTH] CERTIFICATE ANNIVERSARY]

### Page 3

**COVERED PERSON** the options are:

- means you (*if covering Primary only*)
- means, for coverage purposes only, you and your spouse, provided coverage has become effective. (*if covering Primary and Spouse only*)
- 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. *(if Primary, Spouse and Child)*)
- **PARTICIPATING GROUP** definition will only print if this coverage is issued to a Participating Group Trust.
- **AEGON AFFILIATE** paragraph will print if the Other Insurance Provision prints
- **WHEN YOUR INSURANCE BEGINS** will vary according to which system this form is loaded on.

- **Newborn Children** paragraph will print if Children are covered.
- **WHEN YOUR INSURANCE ENDS** will state either:

***(For Primary only)***

Your insurance ends on the earlier of:

- 1) the last day of the period covered by your last premium contribution; or
- 2) the first renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the monthly renewal date on or after your [65 – 100<sup>th</sup>] birthday].

Number 3 is optional depending if coverage terminates at a given age.

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 required otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy terminates, we will give you 31 days notice of this event.

***(For Primary and Spouse)***

A Covered Person's insurance ends on the earlier of:

- 1) the last day of the period covered by your last premium contribution; or
- 2) the first renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the monthly renewal date on or after your [65 – 100<sup>th</sup>] birthday].

Your Dependent's insurance automatically ends on the first of the following dates:

- (1) The date your coverage terminates except as provided in the Continuation of Dependent Insurance Provision;
- (2) The premium due date after a Covered Person ceases to be an eligible Dependent.

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 required otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy terminates, we will give you 31 days notice of this event.

***(For Primary, Spouse and Child)***

A Covered Person's insurance ends on the earlier of:

- 1) the last day of the period covered by your last premium contribution; or
- 2) the first renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the monthly renewal date on or after your [65 – 100<sup>th</sup>] birthday].

Your Dependent's insurance automatically ends on the first of the following dates:

- (1) The date your coverage terminates except as provided in the Continuation of Dependent Insurance Provision;
- (2) The premium due date after a Covered Person ceases to be an eligible Dependent.

If an insured dependent child attains the specified age limit and proof is submitted within 31 days that the child:

- (1) is not able to become gainfully employed because of mental retardation or physical handicap;
- (2) became so incapable prior to the age limit; and
- (3) is primarily dependent on you for support and maintenance,

then the age limit will not apply as long as the child continues to meet these conditions. The child will be insured for the same benefits he previously had. Proof of continued disability and dependency may be required but not more often than once a year. Such child's insurance will not continue beyond the date it would otherwise end.

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 required otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy terminates, we will give you 31 days notice of this event.

- **INFLATION INCREASE BENEFIT** will print if Inflation coverage is offered. If Riders will inflate, we will print the language regarding Riders in the first paragraph.
- **PERSISTENCY BENEFIT** will print if the Persistency benefit is offered.
- **CHANGES IN COVERAGE** variable will print if Dependent coverage is offered.
- **REDUCTION** will print if there is any type of reduction stated on the Schedule of Insurance.

## Page 4

- **CONTINUATION OF COVERAGE** will state either:
  - Deleted completely (*if Primary only*)

### **CONTINUATION OF COVERAGE (*if Primary , Spouse and Child*)**

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

Coverage for any covered child insured under this Certificate shall terminate as of the next 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.

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

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

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

### **CONTINUATION OF COVERAGE (if Primary and Spouse)**

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

## **Page 5**

If Child is covered, then this paragraph will print.

- **CONVERSION** will print if Spouse or Child is covered.
- **NEWBORN CHILDREN** will print if Child Coverage is offered.
- **PAYMENT OF PREMIUM**
  - Second Paragraph, if the Policyholder is paying the first 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.
  - Third Paragraph, 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.
  - Fourth Paragraph 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.
  - Fifth Paragraph: Either Participating Group language will print if issued to a Participating Group Trust, otherwise will print Policyholder.

## **Page 6**

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

## **Page 7**

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

# Statement of Variability

## Master Policy SLAD4000GP

### 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 30, 60, or 90 days, depending on what the Policyholder wants to offer.
  - If this product is issued to a Participating Group Trust, we will use the Participating Group language if applicable; otherwise, we will use the Policyholder language.
- **SUPERSEDES PARAGRAPH:** This paragraph will be printed when we need to manage our risk of liability with a single Insured.

### Page 2

- **DEFINITIONS**
  - **PRIOR PLAN** will print if we will be taking over existing business.
  - **COVERED PERSON** the options are:
    - means you (*if covering Primary only*)
    - means, for coverage purposes only, you and your spouse, provided coverage has become effective. (*if covering Primary and Spouse only*)
    - means, for coverage purposes only, you and the following persons, provided coverage has become effective:
      1. your lawful spouse; and
      2. each of your 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.
- **AEGON AFFILIATE** paragraph will print if the Other Insurance Provision prints
- **WHEN YOUR INSURANCE BEGINS** will vary according to which system this form is loaded on.
  - **Newborn Children** paragraph will print if Children are covered.
- **WHEN YOUR INSURANCE ENDS** will state either:

**(For Primary only)**

Your insurance ends on the earlier of:

- 1) the last day of the period covered by your last premium contribution; or
- 2) the first renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the monthly renewal date on or after your [65 – 100<sup>th</sup>] birthday].

Number 3 is optional depending if coverage terminates at a given age.

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 required otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy terminates, we will give you 31 days notice of this event.

**(For Primary and Spouse)**

A Covered Person's insurance ends on the earlier of:

- 1) the last day of the period covered by your last premium contribution; or
- 2) the first renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the monthly renewal date on or after your [65 – 100<sup>th</sup>] birthday].

Your Dependent's insurance automatically ends on the first of the following dates:

- (1) The date your coverage terminates except as provided in the Continuation of Dependent Insurance Provision;
- (2) The premium due date after a Covered Person ceases to be an eligible Dependent.

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 required otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy terminates, we will give you 31 days notice of this event.

**(For Primary, Spouse and Child)**

A Covered Person's insurance ends on the earlier of:

- 1) the last day of the period covered by your last premium contribution; or
- 2) the first renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the monthly renewal date on or after your [65 – 100<sup>th</sup>] birthday].

Your Dependent's insurance automatically ends on the first of the following dates:

- (1) The date your coverage terminates except as provided in the Continuation of Dependent Insurance Provision;
- (2) The premium due date after a Covered Person ceases to be an eligible Dependent.

If an insured dependent child attains the specified age limit and proof is submitted within 31 days that the child:

- (1) is not able to become gainfully employed because of mental retardation or physical handicap;
- (2) became so incapable prior to the age limit; and
- (3) is primarily dependent on you for support and maintenance,

then the age limit will not apply as long as the child continues to meet these conditions. The child will be insured for the same benefits he previously had. Proof of continued disability and dependency may be required but not more often than once a year. Such child's insurance will not continue beyond the date it would otherwise end.

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 required otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy terminates, we will give you 31 days notice of this event.

- **INFLATION INCREASE BENEFIT** will print if Inflation coverage is offered. If Riders will inflate, we will print the language regarding Riders in the first paragraph.

## Page 4

- **PERSISTENCY BENEFIT** will print if the Persistency benefit is offered.
- **CHANGES IN COVERAGE** variable will print if Dependent coverage is offered.
- **REDUCTION** will print if there is any type of reduction stated on the Schedule of Insurance.
- **CONTINUATION OF COVERAGE** will state either:
  - Deleted completely (*if Primary onl*)

### **CONTINUATION OF COVERAGE (if Primary , Spouse and Child)**

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

Coverage for any covered child insured under this Certificate shall terminate as of the next renewal date after the covered child's marriage or 26<sup>th</sup> birthday, whichever occurs first.

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

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

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

## CONTINUATION OF COVERAGE *(if Primary and Spouse)*

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

### Page 5

If Child is covered, then Michelle's law will print.

- **CONVERSION** will print if Spouse or Child are covered.
- **NEWBORN CHILDREN** will print if Child Coverage is offered.
- **PAYMENT OF PREMIUM**
  - Second Paragraph, if the Policyholder is paying the first 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.
  - Third Paragraph, 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.
  - Fourth Paragraph 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.
  - Fifth Paragraph: 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 6

- In the **AUTOPSY** provision, if non-death benefits are issued, then **PHYSICAL EXAMINATION AND** the variable section will print. If only Accidental Death benefits are issued, only the black text will print.
- **OTHER INSURANCE IN THIS COMPANY** will print when we need to limit our liability for a single insured

## EXPLANATION OF VARIABLES FOR ENROLLMENT FORM

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

Variable Data	Explanation
<b>[and Dismemberment]</b>	Marketer may use with other accident only policy forms resulting in a change in the title throughout the enrollment form
<b>[2700 West Plano Parkway, Plano, Texas 75075-8200]</b>	Address will be one of the 3 administrative offices described in the explanation for the certificate and policy.
<b>[John Doe 123 Main Street Apartment #X Columbia, SC XXXXX]</b>	Customer name and address will appear here and may be preprinted on the enrollment form.
<b>[Email Address: _____]</b>	Marketer may choose to ask for email address when offering additional information
<b>[Spouse Information (if covered), Name, phone [bar code for scanning purposes]</b>	Included in the enrollment form when the policyholder offers coverage for the spouse. Holds customer information for company processing
<b>How to Activate Coverage Section</b>	Dates and amounts will vary based on the marketing plan
<b>Check here to enroll section</b>	Policyholder may choose to offer an amount of insurance at no cost to the insured. Amount of offer may vary and dismemberment may be offered. The policyholder name varies based on the entity the coverage is issued to. The offer may be for 30, 60 or 90 days. The customer may choose to purchase an additional amount of insurance.
<b>Select Additional Accidental Death Insurance Coverage Section</b>	The customer may choose additional coverage. The marketing plan may offer single or family coverage
<b>Check here to add [Survivor Income]</b>  [*Spouse coverage is [50%] of Applicant's selected benefit [(depending on plan selection)] [*Children's benefit is [10%] of applicant's selected benefit] [*Available only with additional insurance coverage]	If additional riders are offered, this section will be in the form along with the specific name of the rider. If the spouse and child coverage is a percentage of the Applicant's coverage amount, this language will be included.
Gender, date of birth, phone	Information requested for Applicant
Beneficiary Information	Beneficiary information may be requested at the time of offer
Under Complete and Sign below: <b>[ABC Bank]</b>	Policyholder name will be in form as indicated by ABC Bank
<b>[Note: coverage amounts begin to decrease at age [70]]</b>	If the benefit reduces, it may be a different age of reduction.
By signing below, I certify that I understand coverage is limited to a total indemnity of not more than <b>[\$1,000,000.00]</b> for Accidental Death <b>[and Dismemberment]</b> Insurance in effect	This statement is used when the Policyholder chooses to limit coverage for each insured.

with us or Stonebridge Life Insurance Company, Stonebridge Casualty Insurance Company, Monumental Life Insurance Company or Transamerica financial Life Insurance Company at any one time.	
[A \$0.50 administrative fee will be added for each automatic account billing.]	This disclosure is added when the policyholder has an administrative fee.
[on the reverse side of this form]	Used when disclosures appear on the reverse side of the form and not on the front.
[Signature of Spouse (required)] Date	Used when coverage is offered to the spouse
Licensed Agent information	Used when agent signature required by state

**STONEBRIDGE LIFE INSURANCE COMPANY**  
**Rider Statement of Variability**

**General Rider Information**

**ADMINISTRATIVE OFFICE** is bracketed because Stonebridge Life Insurance Company has several administrative office locations.

If coverage is issued to Primary only, then INSURED will print. If issued to Primary and/or Spouse and/or Child, then COVERED PERSON will print.

**TERMINATION DATE/AGE:** [65 – up]

If there is no Termination Date/Age, then this Section will not print.

Depending on the issue system used, the Rider Benefit Schedule information will either be printed within the Rider Benefit Schedule or within the Certificate Schedule of Insurance. We certify that all necessary information will be printed in one location or the other. If the Coverage information is printed on the Rider, then the reference to the Certificate Schedule of Insurance will be removed through out the Rider text. If the Coverage information is printed on the Certificate Schedule of Insurance then the reference to the Rider Benefit Schedule will be removed through out the Rider text and printed within the Rider Benefit Schedule will be SEE YOUR CERTIFICATE SCHEDULE OF INSURANCE.

In some Riders, the benefit(s) can be stated as a Flat dollar amount or as a percentage of the Accidental Death Benefit issued and printed on the Schedule Page of Certificate GC560.

**Rider SLAD4002GR – Group Accident Only Emergency Room Benefit Rider**

**Page 1**

- **RIDER BENEFIT SCHEDULE:** Personal data on the Benefit Schedule is variable as it pertains to the Insured, and the amount of coverage purchased. Either Maximum Number of Visits Paid Each Calendar Year will be stated by Covered Person or total number covered.
- **Schedule Numeric Ranges:**
  - **Accident Emergency Room Benefit**

§ Insured	\$50 - \$500
§ Covered Spouse	\$25 - \$500
§ Covered Child	\$5 - \$500
  - **Maximum Number of Visits**

§ Insured	1 – 6
§ Covered Spouse	1 – 6
§ Covered Child	1 – 6
OR	
§ Total Number	1 - 12

**Page 2**

Under the section Accident Emergency Room Benefit, the last sentence in the first paragraph will print if the maximum number of visits is stated as Total number.

**Rider SLAD4003GR– Group Accident Dependent Child Day Care Benefit Rider**

**Page 1**

- **RIDER BENEFIT SCHEDULE:** Personal data on the Benefit Schedule is variable as it pertains to the Insured, and the amount of coverage purchased.
- **Schedule Numeric Ranges**
  - **Child Benefit** \$100 - \$1,000
  - **Maximum Number of Payments** 12 – 60
  - **Maximum Attained Age** 12 – 14
  - **Benefit Increase Amount** \$1,000 - \$25,000
- **Schedule Percentage Ranges**

- [1% - 10%] of the Accidental Death Benefit for each qualifying dependent child
- **Maximum Number of Payments** 12 – 60
- **Maximum Attained Age** 12 – 14
- **Benefit Increase Amount** 1 - 25%

**Rider SLAD4004GR – Group Accident Higher Education Benefit Rider**

**Page 1**

- **RIDER BENEFIT SCHEDULE:** Personal data on the Benefit Schedule is variable as it pertains to the Insured, and the amount of coverage purchased.

Amount will be printed as either a flat amount or a percentage of the Accidental Death Benefit.

**Rider SLAD4007GR – Group Accident Paralysis Benefit Rider**

**Page 1**

- **RIDER BENEFIT SCHEDULE:** Personal data on the Benefit Schedule is variable as it pertains to the Insured, and the amount of coverage purchased.

- **Schedule Numeric Ranges:**

- **Quadriplegia**

**FLAT DOLLAR AMOUNTS**

§ Insured	\$10,000 - \$1,000,000
§ Covered Spouse	\$5,000 - \$1,000,000
§ Covered Child	\$1,000 - \$1,000,000

**PERCENTAGES**

§ Insured	50% - 100%
§ Covered Spouse	50% - 100%
§ Covered Child	50% 0 100%

- **Paraplegia**

**FLAT DOLLAR AMOUNTS**

§ Insured	\$5,000 - \$500,000
§ Covered Spouse	\$2,500 - \$500,000
§ Covered Child	\$500 - \$125,000

**PERCENTAGES**

§ Insured	25% - 50%
§ Covered Spouse	25% - 50%
§ Covered Child	25% - 50%

- **Hemiplegia**

**FLAT DOLLAR AMOUNTS**

§ Insured	\$5,000 - \$500,000
§ Covered Spouse	\$2,500 - \$500,000
§ Covered Child	\$500 - \$250,000

**PERCENTAGES**

§ Insured	25% - 50%
§ Covered Spouse	25% - 50%
§ Covered Child	25% - 50%

- **Total Maximum Benefit Payable per Rider will either be printed so that each Covered Person has their own Total or there will be one Total printed and this Total will be for each Covered Person**

§ Insured	\$10,000 - \$1,000,000
§ Covered Spouse	\$5,000 - \$1,000,000
§ Covered Child	\$1,000 - \$1,000,000

- **OR**

§ For Everyone	\$10,000 - \$1,000,000
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**Rider SLAD4008GR – Group Accident Physician Office [And Wellness] Benefit Rider**

This rider allows for

- 1) Accident Physician Office benefits only or
- 2) Accident Physician Office plus Wellness

**Page 1**

- **RIDER BENEFIT SCHEDULE:** Personal data on the Benefit Schedule is variable as it pertains to the Insured, and the amount of coverage purchased.
- If the Rider is scenario #1 above then all reference to Wellness through out the form will be removed (on the schedule and within the text of the form)
- If the Rider is scenario #2, all references to Wellness will be printed.

There are 3 limitations in regard to the Physician Office Visit.

- 1) Only one Physician Office Visit Benefit is payable per day per Covered Person
  - a. This limitation will always be printed
- 2) Maximum Number of Physician Office Visits Payable per Accident or Sickness
- 3) Maximum Number of Physician Office Visits Payable per Calendar Year
  - a. Either 2 or 3 will print but never both

**Rider SLAD4009GR – Group Special Training Accident Benefit Rider**

**Page 1**

- **RIDER BENEFIT SCHEDULE:** Personal data on the Benefit Schedule is variable as it pertains to the Insured, and the amount of coverage purchased.

**Rider SLAD4010GR – Accident Physician Office [And Wellness] Benefit Rider**

This rider allows for

- 1) Physician Office benefits only or
- 2) Physician Office plus Wellness

**Page 1**

- **RIDER BENEFIT SCHEDULE:** Personal data on the Benefit Schedule is variable as it pertains to the Insured, and the amount of coverage purchased.
- If the Rider is scenario #1 above then all reference to Wellness through out the form will be removed (on the schedule and within the text of the form)
- If the Rider is scenario #2, all references to Wellness will be printed.

There are 3 limitations in regard to the Accident Physician Office Visit.

- 4) Only one Physician Office Visit Benefit is payable per day per Covered Person
  - a. This limitation will always be printed
- 5) Maximum Number of Accident Physician Office Visits Payable per Accident
- 6) Maximum Number of Accident Physician Office Visits Payable per Calendar Year
  - a. Either 2 or 3 will print but never both

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

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

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

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Cathy L. Wynn 2839 Paces Ferry Road, Suite 750 Atlanta GA 30339	800-521-1670 Ext. 2404	678-402-2105	cathy.wynn@transamerica.co

<b>5. Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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<b>6. Company Tracking Number</b>	AR006071500038
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<b>7. <input checked="" type="checkbox"/> New Submission</b>	<input type="checkbox"/> Resubmission	Previous file # _____
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<b>8. Market</b>	<input type="checkbox"/> Individual	<input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input checked="" type="checkbox"/> Discretionary <input checked="" type="checkbox"/> Trust <input type="checkbox"/> Other: _____	

<b>9. Type of Insurance</b>	H03G Group Health - Accidental Death & Dismemberment
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<b>10. Product Coding Matrix Filing Code</b>	H03G.000 Health - Accidental Death & Dismemberment
--	--

<b>11. Submitted Documents</b>	<input checked="" type="checkbox"/> <b>FORMS</b> <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input checked="" type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____  <input type="checkbox"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input checked="" type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input checked="" type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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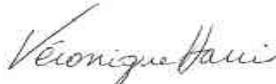
12.	<b>Filing Submission Date</b>	05/26/2011
13.	<b>Filing Fee (If required)</b>	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	<b>Date of Domiciliary Approval</b>	04/12/2011
15.	<b>Filing Description:</b>	
<p>Stonebridge Life Insurance Company                  Form SLAD3900GP et al, Group Accidental Death and Dismemberment Insurance</p> <p>RE: SLAD3900GP - Group Accidental Death and Dismemberment Insurance Policy                  SLAD3900GC - Group Accidental Death and Dismemberment Insurance Certificate                  SLAD4000GP - Group Accidental Death Insurance Policy                  SLAD4000GC - Group Accidental Death Insurance Certificate                  SLAD4001GE - Group Enrollment Form                  SLAD4002GE - Group Enrollment Form                  SLAD4003GE - Group Enrollment Form                  SLAD4004GE - Group Enrollment Form                  SLAD4002GR - Group Accident Only Emergency Room Benefit Rider                  SLAD4003GR - Group Accident Dependent Child Day Care Benefit Rider                  SLAD4004GR - Group Accident Higher Education Benefit Rider                  SLAD4007GR - Group Accident Paralysis Benefit Rider                  SLAD4008GR - Group Physician Office [and Wellness] Benefit Rider                  SLAD4009GR - Group Special Training Accident Benefit Rider                  SLAD4010GR - Group Accident Physician Office Visit [and Wellness] Benefit Rider</p> <p>Attached for your review and approval are new forms. These forms do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion and variable information is identified within brackets. Several Explanation of Variable forms are included. An effective date coinciding with your date of approval is requested.</p> <p>SLAD4000GC offers an Accidental Death benefit. Benefits may or may not terminate. Coverage may or may not reduce. Coverage can be issued for Insured, Insured and Spouse, Insured, Spouse and Child, or Insured and Family. SLAD4000GP is the Master Policy under which certificate SLAD4000GC will be issued .</p> <p>SLAD3900GC offers an Accidental Death with optional Dismemberment benefit that is purchased by the Business Partner for their customers. Only single coverage is offered. SLAD3900GP is the Master Policy under which certificate SLAD3900GC will be issued .</p> <p>Forms SLAD4001GE, SLAD4002GE, SLAD4003GE and SLAD4004GE are the enrollment forms that will be used to solicit this coverage.</p> <p>Forms SLAD4002GR, SLAD4003GR, SLAD4004GR, SLAD4007GR, SLAD4008GR, SLAD4009GR and SLAD4010GR are riders to be used at-issue as well as an add-on with SLAD3900GP, SLAD4000GP and other similar products as your Department approves them.</p> <p>This product will be mass marketed by direct response and telemarketing methods and possibly on the Internet through our website. This product will be marketed without an illustration.</p> <p>We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print.</p> <p>The referenced forms may be used in other media formats including translations into (Spanish, Chinese, Korean, Vietnamese, Polish, etc) and in such case, we certify the content will not change.</p>		

The group policy is contemplated for issue to various discretionary groups that are situated in Missouri. As set forth in Section 376.693: (1) the issuance of the group policy is not contrary to the best interest of the public; (2) the issuance of the group policy would be actuarially sound; (3) the issuance of the group policy would result in economies of acquisition or administration; and (4) the benefits are reasonable in relation to the premium charged. Actuarial memorandums demonstrating the above are attached.

**16. Certification (If required)**

**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 Arkansas.

Print Name Veronique I. Harris, FLMI, AFSI, AIRC, ACS, ARA Title Director, Product Filing and Compliance

Signature  Date 05/26/2011

SERFF Tracking Number: AEGX-G127186264 State: Arkansas  
 Filing Company: Stonebridge Life Insurance Company State Tracking Number: 48915  
 Company Tracking Number: AR006071500038  
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
 Dismemberment Dismemberment  
 Product Name: Accidental Death  
 Project Name/Number: Accidental Death/AR006071500038

## 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)
05/26/2011	Form	Group Accidental Death Insurance Policy	06/17/2011	SLAD4000GP - Master Policy.PDF (Superseded)
05/26/2011	Form	Group Accidental Death Insurance Certificate	06/17/2011	SLAD4000GC - Contributory Certificate.PDF (Superseded)

# Stonebridge Life Insurance Company

A STOCK COMPANY

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

Stonebridge Life Insurance Company  
(Herein called the Company)

Having issued this Policy to

**[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 [September 1, 2003] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR].

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

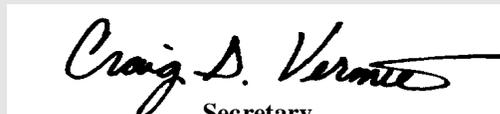
## RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded. The 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.



President



Secretary

Policy No. 11111 SLAD4000GC

**GROUP ACCIDENTAL DEATH INSURANCE POLICY**

## DEFINITION

**[PRIOR PLAN** means the Group Policy [AAAAAA] issued by the prior carrier [ABC Life Company] which terminated on [10/31/2008].]

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

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

- 1) the Insured's lawful spouse; and
- 2) each of the Insured's children including step-children, children born to the Insured or legally adopted by the Insured, 25 years of age or younger, unmarried and dependent upon the Insured for support and maintenance. (An adopted child is a child who is in the Insured's custody pursuant to an interim court order of adoption or placement of adoption). Coverage for unmarried children shall remain in force at the option of the certificate holder.]

**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.

**INJURED** means having suffered a bodily Injury.

**LOSS** means loss of life.

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

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

## ELIGIBILITY

Each natural person [AGE 18 THROUGH 84] [WHO IS AN ABC CORPORATION ACCOUNTHOLDER (OR THE SPOUSE OF AN ABC CORPORATION ACCOUNTHOLDER AGE [18 THROUGH 84])] is eligible to become an Insured. Such persons are herein called eligible persons.

[Each natural person insured under the Prior Plan is eligible for coverage under this policy.]

[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 which will indicate the coverage, the effective date of the coverage and the persons covered.

Each eligible person will become insured on the effective date 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 A PERSON'S INSURANCE ENDS

An Insured's insurance ends on:

- 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 monthly renewal date on or after the Insured's [65 – 100<sup>th</sup>] birthday].

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 Insured 31 days notice in the event the Policy terminates. The Company 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 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 Covered Person shall be the amount shown on the Certificate Schedule of Insurance issued to each individual Insured.

### COVERAGE

#### ACCIDENTAL DEATH BENEFIT

If a Covered Person dies as a direct result of an Injury from an accident not otherwise excluded and the Loss 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.

#### [INFLATION INCREASE BENEFIT]

[The Accidental Death Benefit [plus the benefits of any Riders attached to the Certificate] will automatically increase for each Covered Person as shown on the Certificate Schedule of Insurance.]

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

## **EXCLUSIONS**

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

- 1) an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane 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.

## **BENEFICIARY**

All benefits are payable to the Insured, if living. Unless the Insured specifies otherwise, 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, or
- 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**

The Insured may change the beneficiary at any time by writing to the Company's 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 Insured's 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 Insured's spouse for reasons other than the Insured's death, the Insured's 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 applicable.

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 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 Certificate.]

### **[NEWBORN CHILDREN**

If the 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, the Insured must notify the Company of the birth of a child. There will be an increase in the premium as of the next monthly renewal date after the Company has been notified of the child's birth. The child is covered free from the time of notification until the monthly renewal date. The child will be dropped from coverage if the increased premium is not paid within 31 days after the monthly renewal date. The child's benefit will be the amount which would have been issued to children as of the Effective Date 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 [month / 2 months / 3 months] of coverage, the premium [of \$1.00] will be paid by the [Policyholder/Participating Group.]]

[After the first [month / 2 months / 3 months,]] 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. 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.

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.

### UNPAID PREMIUM

An Insured's coverage will terminate if the premium is not paid by the end of the Grace Period.

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

### 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 45<sup>th</sup> day after the date of application for reinstatement, unless the Company gives the Insured prior written notice of its disapproval.

The reinstated Certificate only covers Loss due to an Injury that occurs after the date of reinstatement. In all other respects, the Insured and the Company 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, 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 occurs or as soon as possible thereafter. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice should include the Covered Person'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 Policy as to Proof of Loss upon submitting, within the time fixed in the Policy 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. 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 the Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

### **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 will be paid to his or her 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 it 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 Policy is issued in consideration of the application and payment of the premium. Insureds' Certificates are furnished in accordance with and subject to the terms of the Policy. Certificate is furnished in accordance with and subject to the terms of the Policy. Certificates are not part of the Policy, but are evidence of the insurance provided under the Policy. The Policy, the Policy Application and any attachments form the entire contract of insurance. No agent may change or waive any provision of the Policy under which this coverage is provided.

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

## **INCONTESTABILITY**

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

## **LEGAL ACTIONS**

No action may 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 of 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 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 and Certificates. The excess will be voided and all premiums paid for such excess shall be refunded to the Insured or the Insured's beneficiary.]

## **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.

# Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont

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

## CERTIFICATE OF INSURANCE

Person(s) insured and benefits are shown in the Schedule of Insurance.

**Stonebridge Life Insurance Company** (herein called "we," "us" or "our") has issued Policy No. [11111 SLAD4000GC] to [ABC Bank] (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

A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded. The 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 our 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 for any Insured. Important provisions of the Policy are outlined herein.



President



Secretary

**GROUP ACCIDENTAL DEATH INSURANCE  
RENEWABLE AT THE OPTION OF THE COMPANY**

# Stonebridge Life Insurance Company

## SCHEDULE OF INSURANCE

This Schedule of Insurance is part of your Certificate. This Certificate is issued under Policy No. 11111  
SLAD4000GC to ABC Bank.

PARTICIPATING GROUP NUMBER: 11111 SLAD4000GC PARTICIPATING GROUP: ABC BANK

CERTIFICATE NUMBER: 74A3000000 EFFECTIVE DATE: 12/01/2001  
 INSURED: JOHN SMITH INSURED DATE OF BIRTH: 03/01/66  
 1234 ANYSTREET  
 ANYTOWN, USA 12345

[FAMILY COVERAGE: YES] [SPOUSE COVERAGE: YES]

[INITIAL PREMIUM: \$1.00 FIRST [2/3] MONTH[S]]

[MONTHLY PREMIUM [AFTER THE FIRST [2/3] MONTH[S]]: [\$0.10 - \$100.00]

[TERMINATION AGE/DATE: [65 - 100]]

### [COVERAGE:]

	[INSURED]	[COVERED SPOUSE]	[COVERED CHILD]
[ACCIDENTAL DEATH BENEFIT]	[\$1,000 - \$1,000,000] [or]	[\$500 - 1,000,000]	[\$100 - \$250,000]
[MONTHLY ACCIDENTAL DEATH BENEFIT]	[\$100 - \$16,000]	[\$50 - \$16,000]	[\$10 - \$4,000]

### FOR [1-60] MONTHS

#### REDUCTION

<u>AGE AT DATE OF INJURY</u>	<u>BENEFIT PAYABLE</u>
[Under [60/65/70/75/80/85]	100%
[At age [60/65/70/75/80/85]	75%
[At age [60/65/70/75/80/85]	50%
[At age [60/65/70/75/80/85]	25%
[At age 80]	12.5%]]

[INFLATION INCREASE BENEFIT] [1%-100%] OF EACH BENEFIT ISSUED]

[FOR ALL BENEFITS IN EFFECT ON THE CERTIFICATE EFFECTIVE DATE, THE INFLATION INCREASES WILL BEGIN ON THE [FIRST - FIFTH] ANIVERSARY AND EVERY [ONE - FIVE] YEARS THEREAFTER FOR A TOTAL OF [ONE - TEN] INCREASES]

[FOR BENEFITS ADDED AFTER THE CERTIFICATE EFFECTIVE DATE, THE INFLATION INCREASES WILL BEGIN ON THE [FIRST - FIFTH] ANNIVERSARY OF THE EFFECTIVE DATE OF THAT BENEFIT AND EVERY [ONE - FIVE] YEARS THEREAFTER FOR A TOTAL OF [ONE - TEN] INCREASES]

[MAXIMUM BENEFIT PAYABLE UP TO [101% - 200%] OF EACH BENEFIT ISSUED.]

[PERSISTENCY BENEFIT] [\$5 - \$50]

PAYABLE 90 DAYS AFTER THE CERTIFICATE EFFECTIVE DATE

[PAYABLE ON THE [FIRST - TENTH] CERTIFICATE ANNIVERSARY AND THEREAFTER EVERY [ONE - TEN] YEAR[S]]

## DEFINITIONS

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

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

- 1) your 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). Coverage for unmarried children shall remain in force at the option of the certificate holder.]

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

**INJURED** means having suffered a bodily Injury.

**LOSS** means loss of life.

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

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

## 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 [within 21 days of] [before] 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; or
- 2) the first monthly renewal date of the Certificate following the date the Policy is terminated or cancelled; or
- 3) the monthly renewal date on or after your [65 – 100<sup>th</sup>] birthday.

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 required 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 which began while the coverage was in force.

## COVERAGE

### ACCIDENTAL DEATH BENEFIT

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

### [INFLATION INCREASE BENEFIT]

[The Accidental Death Benefit [plus the benefits of any Riders attached to this Certificate] will automatically increase for each Covered Person as shown on the Schedule of Insurance.]

### [PERSISTENCY BENEFIT]

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

### [REDUCTION]

All benefits 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 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.

## 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, or
- 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 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 you 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 applicable.

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. You must notify us 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 this Certificate.]

### **[CONVERSION**

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

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

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

### **[NEWBORN CHILDREN**

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

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

## **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 [two][three] month[s] of coverage, the premium will be paid by the [Policyholder/Participating Group]].

[After the first [two][three] 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.]

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**

We have the right to change the premium rates on any date. 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.

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

There will be no change in your premium rate due to any physical impairment or claim incurred.

### **UNPAID PREMIUM**

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

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

## 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 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 45<sup>th</sup> day after the date of application for reinstatement, unless we give you prior written notice of its disapproval.

The reinstated Certificate only covers Loss due to an Injury that 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. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice should include your name and Certificate Number as shown in the Schedule of Insurance. Notice should be mailed to 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 reasonable 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.

## 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 will be paid to your Beneficiary or estate.

## [PHYSICAL EXAMINATION AND] AUTOPSY

At our expense, we shall have the right to [examine a Covered Person when and as often as it 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, the Policy Application and any attachments form the entire contract of insurance. No agent may change or waive any provision 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 may 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 of 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 your beneficiary.]