

SERFF Tracking Number: ANTX-127351709 State: Arkansas  
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 49467  
 Company Tracking Number:  
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only  
 Product Name: SLAICO Accident  
 Project Name/Number: /

## Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: SLAICO Accident

SERFF Tr Num: ANTX-127351709 State: Arkansas

TOI: H02I Individual Health - Accident Only

SERFF Status: Closed-Approved-Closed  
 State Tr Num: 49467

Sub-TOI: H02I.000 Health - Accident Only

Co Tr Num: State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Deborah Biediger, Patty Clavette

Disposition Date: 08/08/2011

Date Submitted: 08/04/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 07/12/2011

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 08/08/2011

State Status Changed: 08/08/2011

Deemer Date:

Created By: Deborah Biediger

Submitted By: Deborah Biediger

Corresponding Filing Tracking Number:

Filing Description:

Attached for review and approval is Standard Life and Accident Insurance Company's (NAIC # 86355) new Individual Policy of Accident Insurance and form SL-BBIP-10-AR, Accident Insurance Application, form SL-BBINDAR. Also included in the submission is the rates, actuarial memorandum and supporting actuarial documentation. This is a new submission that does not replace any previously approved forms. This product provides coverage for death, dismemberment and specified disabilities resulting from a covered accident only. Subject to timely payment of premiums, the policy is renewable at the Covered Person's option. Coverage will terminate on the next premium due date following the Covered Person's 85th birthday.

This product will be sold to individual applicants from ages 18 –75 through licensed producers. There is a benefit

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reduction to 50% at age 75. The variable material shown in the policy reflects the benefit levels selected and insured specific information. The variable language or amounts on final printed forms will be no more restrictive than that which is reflected in the attached forms.

For Medicare eligible applicants, I have attached for informational purposes under the Supporting Documentation tab, the statutorily required Duplication Notice, form ADDND06 and the Replacement Notice, form SL-REPLNOT. Also, attached for informational purposes under Supporting Documentation is form CCN-AR3 which was most recently approved for use by the Department on on 10252011 under SERFF tracking number ANTX-126828895. This form will be completed and mailed out with each newly issued policy.

## Company and Contact

### Filing Contact Information

Deborah Biediger, Compliance Analyst deborah.biediger@anico.com  
 One Moody Plaza SSH MP, Ste. 200 281-538-4838 [Phone]  
 Galveston, TX 77550 409-766-2024 [FAX]

### Filing Company Information

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Texas  
 One Moody Plaza, SSH MP, Ste. 200 Group Code: 408 Company Type: Health Insurance  
 Galveston, TX 77550 Group Name: State ID Number:  
 (281) 538-4842 ext. [Phone] FEIN Number: 73-0994234

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? No  
 Fee Explanation: \$50.00 for Rates  
 \$150.00 (3 forms X \$50.00 = \$150.00)

Retaliatory fee is \$50.00 so AR state fees are higher and higher amount is being submitted.i

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$200.00	08/04/2011	50357348

SERFF Tracking Number: ANTX-127351709 State: Arkansas  
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TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
Product Name: SLAICO Accident  
Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/08/2011	08/08/2011

SERFF Tracking Number: ANTX-127351709 State: Arkansas  
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 Product Name: SLAICO Accident  
 Project Name/Number: /

## Disposition

Disposition Date: 08/08/2011

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Standard Life and Accident Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: ANTX-127351709 State: Arkansas  
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 Product Name: SLAICO Accident  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Previously approved notice	Approved-Closed	Yes
Supporting Document	Statutorily required notices	Approved-Closed	Yes
Form	INDIVIDUAL POLICY OF ACCIDENT INSURANCE	Approved-Closed	Yes
Form	ACCIDENT INSURANCE APPLICATION	Approved-Closed	Yes
Form	OUTLINE OF COVERAGE	Approved-Closed	Yes
Rate	Monthly Gross Premiums and Rate Exhibit	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: SL-BBIP-10-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/08/2011	SL-BBIP-10-AR	Policy/Contract	INDIVIDUAL POLICY OF ACCIDENT INSURANCE Certificate	Initial			Policy.pdf
Approved-Closed 08/08/2011	SL-BBIP-10-AR	Application/Enrollment Form	ACCIDENT INSURANCE APPLICATION	Initial			ST-2625 AR_App.pdf
Approved-Closed 08/08/2011	SL-BBIP-10-AR	Outline of Coverage	OUTLINE OF COVERAGE	Initial			Generic Outline of Coverage.pdf

## Standard Life and Accident Insurance Company

A Member of the American National Family of Companies

Home Office: One Moody Plaza, Galveston, Texas, 77550

Toll-Free Telephone Number: 1-888-350-1488

(A Stock Insurance Company hereafter referred to as "Standard Life", "We", "Us", "Our" or "the Company")

### INDIVIDUAL POLICY OF ACCIDENT INSURANCE

This is Your Policy of insurance and is a legal contract between You and the Company. It explains the rights and benefits that are determined by the Policy. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy is non-participating. **READ THIS POLICY CAREFULLY!**

**CONSIDERATION.** This Policy is issued in consideration of the statements made in the Application and payment of the initial premium. Coverage is not provided until the first full premium is paid. The first premium pays for the Initial term of coverage. The initial term of coverage begins at 12:01 a.m. on the Date of Issue shown on the Policy Schedule of Benefits.

**PREMIUMS.** The Company may change premiums for coverage. Premiums may be changed and are due as stated in Section Nine. Premiums.

**GUARANTEED RENEWABLE.** Subject to timely payment of premiums, this Policy is renewable at your option. A Covered Person's coverage will terminate on the next premium due date following their 85th birthday. The Company will not refuse renewal of coverage under the Policy except for reasons stated in the Policy. The Company will not non-renew coverage just because of the claims You file or because of a change in the health or type of work of any Covered Person.

**YOUR 30 DAY RIGHT TO EXAMINE POLICY.** Within 30 days after You get this Policy, You may return it in person or by regular mail to the Company, its agency office or the agent who sold it to You, if for any reason You decide You do not want it. The Company will return Your premium to You. Then You and the Company will be in the same position as if a Policy had never been issued.

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, You should review the *Guide To Health Insurance For People With Medicare* available from the Company.

This Policy is signed below on behalf of Standard Life by its duly authorized officers.



Secretary



President

**THIS IS AN ACCIDENT ONLY POLICY AND DOES NOT PAY BENEFITS FOR SICKNESS. PLEASE READ CAREFULLY!**

No benefits are payable for Fractures or Dislocations when a Bone Degeneration Disease is diagnosed before the effective date. Benefits are reduced if a Bone Degeneration Disease is diagnosed after the effective date.

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Loss of Hearing (in both ears)	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Loss of Thumb and Index Finger of the Same Hand	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Loss of all Four Fingers of the Same Hand	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Loss of all the Toes of the Same Foot	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Loss of Upper Arm above the elbow, including hand and all fingers	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Loss of Upper Leg above the knee, including foot and all toes	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Loss of Lower Arm below the elbow, including hand and all fingers	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Loss of Lower Leg below the knee, including foot and all toes	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]

**FRACTURE BENEFIT:**

[A Dependent Child's Benefit Amount and Lifetime Maximum is 50% of the amounts listed below.]

Lifetime Maximum payable for all Fractures: (Per Person)	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
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**Bone Category  
(See Medical Terms for Definitions)**

**[Benefit Amount] [Principal Sum Percentage]**

Spine/Vertebral Column	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Cheekbone	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Collarbone	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Foot (other than toes)	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Hand (other than fingers)	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Hip	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Kneecap	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Lower Arm	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]

Lower Jaw	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Lower Leg	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Neck	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Pelvis	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Shoulder Blade	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Skull	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Sternum	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Tailbone	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Upper Arm	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Upper Jaw	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Upper Leg/Femur	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Wrist	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]

**DISLOCATION BENEFIT:**

[A Dependent Child's Benefit Amount and Lifetime Maximum is 50% of the amounts listed below.]

Lifetime Maximum payable for all Dislocations: (Per Person)	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
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**Bone Category  
(See Medical Terms for Definitions)**

**[Benefit Amount] [Principal Sum Percentage]**

Ankle	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Collarbone	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Elbow	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Hip	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]
Jaw	[\$0 - \$1,000,000 ] [0% - 100% of the Death Benefit Principal Sum]



## SECTION ONE – GENERAL DEFINITIONS

**“Accident” or “Accidental”** means an act or event which is unforeseen, unexpected and unanticipated, definite as to time and place, which:

1. causes Injury to one or more Covered Persons; and
2. occurs while coverage is in effect for the Covered Person.

**“Age”** means a Covered Person’s Age as of his/her last birthday.

**“Beneficiary”** means the person or persons listed in the application that You name or change on a form executed by You and satisfactory to Us. Consent of the Beneficiary is not required to affect any changes, unless the Beneficiary has been designated as an irrevocable Beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

A Beneficiary designation or change will become effective on the date You execute it. However, We will not be liable for any action taken or payment made before We record notice of the change at Our Home Office.

If more than one person is named as Beneficiary, the interests of each will be equal unless You specified otherwise. The share of any Beneficiary who does not survive You will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named Beneficiary or surviving Beneficiary We may make direct payment to the first surviving class of the following classes of persons:

1. Your spouse or
2. Your child or Children;
3. Your mother or father;
4. Your sisters or brothers;
5. Your estate

**“Common Carrier”** means a vehicle that is duly licensed by a proper authority to transport passengers for a fee. Common Carrier vehicles are limited to airplanes, trains, buses, trolleys and boats that operate on a regularly scheduled basis between predetermined points or cities. A taxi is not a common-carrier vehicle.

**“Covered Person”** means the Insured or eligible Dependent(s) listed as a Covered Person in the Policy Schedule of Benefits for whom an Application has been received by us and proper premium payment has been made.

**“Date of Issue”** means the date coverage begins for Covered Persons listed in the Policy Schedule of Benefits. It is used to determine Policy anniversary dates for each Covered Person.

**“Dependent”** means an Insured’s family as follows:

1. The lawful Spouse[\*]; or
2. Unmarried children (whether natural, adopted or stepchildren) under Age 26; or
3. Unmarried children for whom the Insured is required to provide insurance under a medical support order or an order enforceable by a court.

[\*The term Spouse as used throughout this Policy will also mean the Insured’s Domestic Partner.]

**“Domestic Partner”** means an opposite or same sex partner who maintains a committed relationship for at least 12 consecutive months immediately preceding the effective date of coverage that meets each of the following criteria: 1) be at least 18 years old and competent to contract; 2) be the sole Domestic Partner of the other person and maintain a common residence; 3) not related by blood in a way that would prevent them from being legally married to each other in the state of residence; and 4) not be married or an insured of another domestic partnership. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed affidavit of domestic partnership.]

**“Effective Date”** is the date coverage begins for each Covered Person under the Policy. It may be different for a Covered Person added to the Policy after the original Date of Issue or when a change in coverage for any Covered Person occurs.

**“Injury” or “Injuries”** means Accidental bodily Injury sustained by a Covered Person that:

1. is the direct cause of the condition for which benefits are provided,
2. is independent of disease or bodily infirmity or any other cause, and
3. occurs while the insurance is in force.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

**“Insured”** means the person named in the Application and listed on the Schedule of Benefits for whom an Application has been received and accepted by Us and proper premium payment has been made.

**“Organized”** means affiliated in an organization and functioning within a formal structure, as in the coordination and direction of activities.

**“Physician”** means a practitioner of the healing arts who is licensed by the state to treat the type of Injury for which claim is made. It does not include You or any relative or family member of Yours by blood, marriage or adoption.

**“You” or “Your” or “Yours”** means the Insured listed in the Application for this Policy.

## SECTION TWO - MEDICAL TERMS

**“Ankle”** means the distal fibula, tibia, navicular, and calcaneous bones.

**“Bone Degeneration Disease”** means any disease causing bone loss or deterioration of bone structure including but not limited to the following diagnosis: osteoporosis, Paget’s disease, osteogenesis imperfecta, bone malignancies, osteonecrosis and metabolic bone disease.

**“Cheekbone”** means zygomatic or malar bone.

**“Collarbone”** means the clavicle bones.

**“Dislocation”** means displacement or disarrangement of the normal anatomical relation of the bones in a joint in which there is loss of contact between articular surfaces.

**“Finger”** means the digits of the hand consisting of the proximal, middle and distal phalangeal bones that comprise the four fingers and the thumb.

**“Feet” or “Foot”** means the part of the lower extremity consisting of the calcaneous bone, cuboid bone, cuneiform bones, metatarsal bones, navicular bones, phalanges, and the bones which form the ankle. For Fracture of Dislocation purposes, the Toes and Fingers are not covered.

**“Fracture”** means a break or interruption in the continuity of a bone.

**“Green Stick Fracture”** means a fracture in a soft bone in which the bone bends and partially breaks.

**“Hairline Fracture”** means a break that appears as a narrow crack along the surface of the bone.

**“Hand”** means a portion of the upper limb consisting of the wrist, palm, four fingers and thumb. For Fracture of Dislocation purposes, the Toes and Fingers are not covered.

**“Hip”** means the femoral neck.

**“Kneecap”** means the patella.

**“Loss of finger or toe”** means complete severance through or above the metacarpophalangeal joint of a finger or metatarsophalangeal joint of a toe.

**“Loss of hand or foot”** means permanent severance of an arm distal to the ulna and radius; or distal to the tibia and fibula of the leg respectively.

**“Loss of hearing”** means total and irrecoverable loss of the ability to perceive sound.

**“Loss of sight”** means a total, permanent and irrecoverable loss of perception to light.

**“Loss of speech”** means total and irrecoverable loss of the ability to speak.

**“Lower Arm”** means the radius and ulna.

**“Lower Jaw”** means the mandible.

**“Lower Leg”** means the tibia and fibula.

**“Neck”** means the seven cervical vertebrae.

**“Pelvis”** means the area formed by the pubic bone, ilium, and ischium.

**“Reduction”** means manipulative or surgical restoration procedures of a fractured or dislocated body part to its normal anatomical relation.

**“Second Degree Burn”** means a burn marked by pain, blistering and superficial destruction of the dermis.

**“Shoulder Blade”** means scapula.

**“Skull”** means the bones of the head collectively.

**“Spine/Vertebral Column”** means 7 cervical, 12 thoracic, 5 sacral, and 4 coccygeal bones.

**“Sternum”** means the breastbone located in the center of the chest. This does not include ribs.

**“Tailbone”** means the four coccygeal vertebrae.

**“Third Degree Burn”** means a burn that causes damage to subcutaneous tissue.

**“Upper Arm”** means the humerus.

**“Upper Jaw Bone”** means maxilla.

**“Upper Leg”** means the femur/thigh.

**“Wrist”** means the proximal segment of the hand consisting of the carpal bones.

### **SECTION THREE – ELIGIBILITY AND EFFECTIVE DATE**

**FAMILY MEMBERS.** The only members of Your family eligible for coverage under the Policy are You and Your eligible Dependents for which an Application and premium has been accepted by the Company. Each person must be acceptable to the Company based on its rules in effect at the time of the Application for each person's coverage. Covered Persons as of the Date of Issue are shown on the Policy Schedule of Benefits.

**ADDITIONAL FAMILY MEMBERS.** You may add eligible members of Your family to the Policy after the Date of Issue with the consent of the Company. Evidence of eligibility and insurability satisfactory to the Company must be furnished. Each person must be acceptable to the Company based on its rules in effect at the time of the application for each person's coverage. The renewal premium for this Policy may be increased by the premium required for the new family member. The addition of the new family member will be shown by an endorsement to this Policy. The Effective Date with respect to the new family member will be the Effective Date shown on the endorsement.

**NEWBORN CHILDREN.** Your newborn child is automatically covered from the moment of birth until such child is 90 days old. Coverage for newborns shall be the same as for all other covered Dependent children. If You do not have other covered Dependents and desire uninterrupted coverage, at the end of the 90 day period, You will have the option to add Dependent child coverage to Your Policy. You must notify the Company in writing within 90 days of such birth and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 90 day period.

**ADOPTED CHILDREN.** An adopted child is automatically covered for the first 60 days from the date of the filing of a petition for adoption. Coverage is provided from the moment of birth if the petition for adoption and application for coverage is submitted to Us within 60 days after the birth. Coverage for such child will be the same as for all other covered Dependent children. If You do not have other covered Dependents and desire uninterrupted coverage, at the end of the 60 day period, You will have the option to add Dependent child coverage to Your Policy. You must notify the Company in writing within 60 days of the date of filing or from the date of birth and pay the required additional premium (if any), in order to have coverage for the adopted child continue beyond such 60 day period.

Coverage for a child that is placed with You for adoption will continue in accordance with the provisions of the Policy, unless the petition is denied prior to legal adoption and the child is removed from placement.

**COURT ORDERED CUSTODY.** We will not restrict or deny coverage due to the fact that: 1) a Dependent child does not reside with the noncustodial parent; or 2) the parent-child relationship was established through a paternity action; or 3) the minor child is covered through the state-administered Medicaid program; or 4) the minor child is not claimed as a dependent on the noncustodial parent's federal or state income tax return.

## **SECTION FOUR – TERMINATION**

Coverage under the Policy will cease at 12:01 a.m. for all Covered Persons, based on the time zone in the place where You reside, on the earliest of the following:

1. The date You fail to pay premiums in accordance with the terms of the Policy, including any timeliness requirements;
2. On the next premium due date after the Company receives a written request from You to terminate the Policy, or any later date stated in Your request;
3. The date You perform an act or practice that constitutes fraud, or are found to have made an intentional misrepresentation of material fact, relating in any way to the Policy, including claims for benefits under the Policy;
4. The date the Company declines to renew all policies of this form in the state in which You reside; or
5. The date of Your death or the termination date of Your coverage, if Your spouse is not covered under the Policy.

If the Company terminates or non-renews coverage under number 4 above, the Company will provide 90 days written notice before the date coverage will be discontinued.

**TERMINATION OF COVERAGE** You will cease to be a Covered Person on the date of Your death. Your spouse, if a Covered Person who is under age 85 when Your coverage ends, will become the Insured.

A Covered Person's coverage will terminate on the next premium due date after such person attains the age of 85.

**TERMINATION OF SPOUSE'S COVERAGE** Your spouse will cease to be a Covered Person at the earlier of Your spouse's death or the next premium due date after You and Your spouse become legally divorced.

**TERMINATION OF A CHILD'S COVERAGE** A child's coverage will terminate at the earlier of: 1) Your death (if there is no surviving spouse covered under the Policy); 2) the child's death; 3) the next premium due date after the child's marriage; or 4) the next premium due date after the child's 26th birthday. Coverage for a mentally incapacitated or physically handicapped child will not end when scheduled if the child depends on You for primary support and maintenance. Proof of the incapacity or dependency must be furnished to Us upon our request and at Our expense. The premium for such child's continued coverage will remain at the child rate until the child is no longer dependent or incapacitated. You must notify Us if the incapacity or dependency is removed or terminated. The premium for such child's continued coverage will be the same as for an adult of like Age and sex.

**PREMIUM CHANGE DUE TO TERMINATION OF COVERAGE.** Future premiums for coverage will be adjusted, if necessary, when coverage for a Covered Person ends. If the Company accepts a premium for a Covered Person whose coverage should have ended, such premium will be refunded.

## **SECTION FIVE – CONVERSION**

In certain cases, if coverage ends under this Policy a Covered Person may be able to buy a new Policy with the Company. We will issue it without regard to health status, but subject to the rules below:

**WHO MAY CONVERT** The following persons whose coverage has ended under this Policy, may buy a new Policy: (1) a child who is no longer considered an eligible Dependent; (2) a former spouse, if there is a legal divorce; or (3) in the event of Your death, a Covered Person listed in the Schedule of Benefits if Your spouse is a Covered Person.

**WHAT MUST BE DONE** The Covered Person must apply to the Company in writing not more than 31 days after coverage ends. The first full premium for the new Policy also must be paid with the application. The premium for the conversion Policy shall be determined in accordance with Our table of premium rates applicable to the age and class of risk of each person to be covered under that Policy and to the type and amount of insurance provided.

**THE NEW POLICY** The new Policy will be similar to this Policy at the option of the Company. Loss for which benefits may be paid under this Policy will not be covered under the new Policy. The new Policy that We normally issue in accordance with this part may not yet be approved for use in the place where the person lives. In that case, the Company will not be obliged to issue a new Policy.

**WHEN NOT AVAILABLE** Conversion will not be available for any Covered Person if coverage ends because: (1) You fail to pay a premium in the time allowed; (2) the date the Covered Person performs an act or practice that constitutes fraud, or are found to have made an intentional misrepresentation of material fact, relating in any way to the Policy, including claims for benefits under the Policy; or (3) such person has attained the age of 85.

## **SECTION SIX – ACCIDENT BENEFITS**

If a covered Accident occurs while the coverage is in force and the Covered Person experiences death or an Injury treated by a Physician while coverage is in force, We will pay the benefit amount stated in the Policy Schedule of Benefits for loss described below. Coverage is subject to all maximums, terms and conditions stated in the Policy and Policy Schedule of Benefits.

### **ACCIDENTAL DEATH BENEFIT**

If a Covered Person suffers a covered Injury that results in the Covered Person's Death within 90 days of the date of the Accident that caused the Injury, the Company will pay the Death Benefit listed in the Policy Schedule of Benefits. The Company must receive proof that the Covered Person's death:

1. resulted directly and independently of all other causes from the covered Accident; and
2. occurs while this Policy is in force.

### **ACCIDENTAL DISMEMBERMENT BENEFIT**

If a Covered Person suffers a covered Injury that results in a Dismemberment specified in the Policy Schedule of Benefits within 90 days of the date of the Accident that caused the Injury, the Company will pay the Dismemberment Benefit listed in the Policy Schedule of Benefits.

In the event of multiple dismemberments during the same Accident, only one Dismemberment Category, the largest to which the Covered Person would be eligible to receive, will be payable.

### **COMMON CARRIER BENEFIT**

If a Covered Person suffers a covered Injury that results in death and an Accidental Death Benefit is payable under the Policy and the Accident causing death occurs while riding in or on a Common Carrier, the Company will pay the Common Carrier Benefit listed in the Policy Schedule of Benefits. This benefit is in addition to the Accidental Death Benefit stated in the Schedule of Benefits. A taxi is not a Common Carrier.

This benefit will also apply if the Accident occurs while entering or exiting, getting in or out of, or on or off of, the Common Carrier.

## **FRACTURE BENEFIT**

If a Covered Person suffers a covered Injury that results in diagnosis and treatment by a Physician for a Fracture specified in the Policy Schedule of Benefits within 90 days of the date of the Accident that caused the Injury, the Company will pay the Fracture Benefit listed in the Policy Schedule of Benefits.

In the event of multiple Fractures during the same Accident, only one covered Fracture Benefit, the largest to which the Covered Person would be eligible to receive, will be payable.

The Fracture must require Reduction of the bone under anesthesia to be covered under this provision.

No benefits are payable for:

1. Pathological Fracture;
2. Hairline Fracture or Green Stick Fracture;
3. Fractures to the Toes or Fingers; or
4. Fractures when Bone Degeneration Disease was diagnosed prior to the Covered Person's Effective Date of coverage, regardless if the Bone Degeneration Disease contributed to the Injury or not.

If a Covered Person is diagnosed as having Bone Degeneration Disease after their Policy Effective Date and suffers a Fracture, the first Fracture will be covered under the regular terms of the Policy. However, after the first, all further Fractures of any area payable under the Policy will be reduced by 50%. This limitation applies regardless if the Bone Degeneration Disease contributed to the Injury or not.

All Fractures and Dislocations are subject to the Fractures and Dislocations Lifetime Maximum Benefit stated in the Schedule of Benefits.

## **DISLOCATION BENEFIT**

If a Covered Person suffers a covered Injury that results in diagnosis and treatment by a Physician for a Dislocation specified in the Policy Schedule of Benefits within [30][60][90] days of the date of the Accident that caused the Injury, the Company will pay the Dislocation Benefit listed in the Policy Schedule of Benefits.

The Dislocation must require Reduction of the joint or bone to a normal position under anesthesia to be covered under this provision.

In the event of multiple Dislocations during the same Accident, only one covered Dislocation Benefit, the largest to which the Covered Person would be eligible to receive, will be payable.

No benefits are payable for:

1. Dislocations of the Toes or Fingers;
2. Subsequent Dislocations of the hip, shoulder or knees after the first Dislocation; or
3. Dislocations when Bone Degeneration Disease was diagnosed prior to the Covered Person's Effective Date of coverage, regardless if the Bone Degeneration Disease contributed to the Injury or not.

If a Covered Person is diagnosed as having Bone Degeneration Disease after their Policy Effective Date and suffers a Dislocation, the first Dislocation will be covered under the regular terms of the Policy. However, after the first, all further Dislocations of any area covered under the Policy will be reduced by [50%][25%][10%]. This limitation applies regardless if the Bone Degeneration Disease contributed to the Injury or not.

All Fractures and Dislocations are subject to the Fractures and Dislocations Lifetime Maximum Benefit stated in the Schedule of Benefits.

## BURN BENEFIT

If a Covered Person suffers a covered Injury that results in diagnosis and treatment by a Physician for a Second Degree Burn or Third Degree Burn specified in the Policy Schedule of Benefits within 90 days of the date of the Accident that caused the Injury, the Company will pay the Burn Benefit listed in the Policy Schedule of Benefits.

The Company has a right, at Our own expense, to have the Physician's determination verified by a Physician of the Company's choice.

In the event of multiple Burns during the same Accident, only one covered Burn Benefit, the largest to which the Covered Person would be eligible to receive, will be payable.

## SECTION SEVEN - EXCLUSIONS AND LIMITATIONS

Benefits otherwise payable under the Policy are reduced 50% on the later of a Covered Person's Age 75 or his/her 5<sup>th</sup> Policy anniversary.

No benefits will be paid due to any loss caused by, contributed by or related to the following and/or their treatments and/or complications thereof:

1. An Accident or Injury that occurs prior to the effective date of this Policy;
2. Suicide, or any attempt at suicide, or any intentionally self-inflicted Injury, while sane or insane;
3. The commission of or attempt to commit an assault, or a felony, or being engaged in an illegal occupation;
4. Participation in a riot, war, or any act attributable to war, whether or not the Covered Person is in the military. The term "war" includes both declared and undeclared war;
5. Loss as a result of any sickness, illness, disease or mental condition, even though a proximate or precipitating cause of loss was an Accidental Injury. This includes a group of diseases that cause bone and marrow cell death and inherited diseases that weaken connective tissue;
6. Bacterial infection not occurring along with or as a result of an Injury;
7. Alcohol abuse or addiction, or the Covered Person being intoxicated (defined as blood alcohol concentration equal to or in excess of .08 gms/dl blood alcohol). This applies whether or not the Covered Person is charged with any violation in connection with a loss and there is no need to prove a loss was caused, contributed to, or resulted from the excessive blood alcohol concentration;
8. Voluntary ingestion of alcohol, inhalation or injection of any narcotic, drug, toxins, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage. This applies even if the Covered Person did not intend to cause the harm which resulted from the action;
9. Mental or nervous disorders, that includes all disorders listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association;
10. Flight in any vehicle or device for aerial navigation, except as a fare-paying passenger on a regularly scheduled flight by a commercial airline;
11. Injury received while engaging in hazardous occupation or other activity including participating, instructing, demonstrating, guiding or accompany others in the following: professional or semi-professional sports, extreme sports, Organized body contact sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, mountain climbing, bungee jumping, scuba diving, sail gliding, parasailing, parakiting, rock or mountain climbing, cave exploration, parkour, racing including stunt show or speed test of any motorized or non-motorized vehicle, rodeo activities, or similar hazardous activities. Also excluded is Injury received while practicing, exercising, undergoing conditional or physical preparation for such activity;
12. Injuries intentionally inflicted by another person where the Covered Person voluntarily incurs obvious hazard or where the Covered Person places himself in a position that may be reasonably expected to bring about Injury;
13. Repetitive stress injuries or syndromes precipitated by repeated or over use of a body part. Examples of this include but not limited to rotary cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis.
14. Hairline Fractures or Green Stick Fractures;
15. Loss of hearing, speech, or sight when proximate cause is comatose state.

## SECTION EIGHT – CLAIMS

**NOTICE OF CLAIM** You must give the Company written notice of a claim. It should be given within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by You or on behalf of You to Us at our Home Office, or to any authorized agent of the Company, with information sufficient to identify You, will be deemed notice to the Company.

**CLAIM FORMS** The Company will send You a claim form when Your notice of claim is received. If the form is not furnished within 15 days from the time You give notice. You may fulfill the proof of loss requirements by sending written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time set in Proof of Loss.

**PROOF OF LOSS** You must give the Company written proof of loss within 90 days after such loss. If it is not reasonably possible to do so, the Company will not reduce or deny Your claim for being late if proof is given as soon as reasonably possible. It must, however, be given within 15 months from the date of loss, unless You are not legally capable.

**TIME OF PAYMENT OF CLAIMS** All benefits due under the Policy will be paid as soon as due proof of loss is received.

**PAYMENT OF CLAIMS** All benefits due under the Policy will be paid to You, Your beneficiary or Your estate. If they are payable to Your estate, the Company may pay such benefits, up to an amount not to exceed \$1,000, to any of Your relatives by blood or marriage who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company to the extent of such payment.

**ASSIGNMENT** An Insured may assign all of his or her rights, privileges and benefits under the Policy without the consent of his or her designated beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

**CHANGE OF BENEFICIARY** The right to change a Beneficiary is reserved for the Insured, and the consent of the Beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of Beneficiary or beneficiaries, or for any other changes in this Policy.

**PHYSICAL EXAMINATIONS AND AUTOPSY** The Company may have a Covered Person examined at its own expense as often as it may reasonably require while their claim is pending under this Policy and to make an autopsy in case of death where it is not forbidden by law.

**LEGAL ACTIONS** No action at law or in equity shall be brought to recover under the Policy for at least 60 days after You have given the Company written proof of loss in accordance with the requirements of the Policy. You cannot start such action more than 2 years after the date proof of loss is required to be furnished.

## SECTION NINE – PREMIUMS

**PREMIUM DUE DATE** The initial premium is for the term shown on the Schedule of Benefits. The renewal premium for later periods of coverage is due on the first day of the next term. This Policy will end (lapse) if the renewal premium in effect is not paid before the end of the Grace Period.

**RENEWAL PREMIUMS** The Company may change premiums for coverage. No change in premium will take effect before the first Policy anniversary unless the terms of the coverage change. Any change will apply to future premiums only. After Your first Policy anniversary, We may change premiums anytime, and from time to time, that We decide to change rates for persons in Your class. The Company will give You at least 60 days written notice before any premium change. Premiums may change if You increase or decrease benefits or add or delete dependents.

**GRACE PERIOD** There will be a grace period for payment of each renewal premium. It will be 31 days from the date the premium is due. This Policy will stay in force during the 31 days. If the premium is not paid before the grace period ends, coverage will lapse.

**UNPAID PREMIUM** Any due and unpaid premium for the Policy may be deducted from any benefits then payable.

**PREMIUM REFUND AT DEATH** -- If a Covered Person's coverage terminates due to death, the Company will refund the pro rata unearned portion of any premium paid beyond the end of the Policy month in which the death occurred. Unearned premiums will be paid in lump sum no later than thirty (30) days after We receive proof of such death.

**REINSTATEMENT** Coverage lapses if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agents acceptance of premium) without requiring an application for reinstatement, reinstates coverage under the Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of the Policy, including Time Limit on Certain Defenses. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the forty-fifth 45th day following the date of the reinstatement Application .

The reinstated plan only covers an eligible loss that results from an Injury that a Covered Person sustains after reinstatement. In all other respects, Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date. **We will not consider a request for reinstatement that you make more than 180 days after your Policy has lapsed.**

**ELECTRONIC ACCOUNT DEBIT AUTHORIZATION** If You have chosen Electronic Account Debit as Your method of premium payment, You agree that:

1. We are authorized to debit Your named account for premium payments;
2. The account debit will be made electronically without the signature of any officer or employee of the Company; We will not provide a receipt for any account debit;
3. The Company will not incur any liability because of dishonor of the account debit;
4. Upon refusal of the financial institution to honor any attempted debit of the named account, We will cease to debit Your account. We will send You written notice, requesting payment in full of the required premium. Upon Your payment of the required premium, We will again begin to debit Your account. However, if You do not pay the required premium, Your coverage will lapse in accordance with the Grace Period provision; and
5. Except as provided in (4) above, the authorization remains effective unless either party ends the authorization. Before ending the authorization, a party must provide the other party at least 30 days advance written notice. We are not liable for amounts debited from Your account prior to Our receipt of written notification to end coverage.

## SECTION TEN - ABOUT YOUR POLICY

**ENTIRE CONTRACT, CHANGES** The Policy with the application and attached papers, is the entire contract of insurance. It may not be changed in any way by any agent. Only an executive officer of the Company can approve a change. Any such change must be attached to this Policy.

If the Policy is reinstated or renewed and the Policyholder or the beneficiary or assignee of the Policy makes a written request to Us for a copy of the application, We will within 30 days after receipt of the request at Our Home Office or any of Our branch offices deliver or mail to the person making the request a copy of the application. If the copy is not delivered or mailed after being requested, We will be precluded from introducing the application in evidence in any action or proceeding based upon or involving the Policy or its reinstatement or renewal. In the case of a request from a beneficiary, the time within which We are required to furnish a copy of the application will not begin to run until after receipt of evidence satisfactory to Us of the beneficiary's vested interest in the Policy.

**TIME LIMIT ON CERTAIN DEFENSES** After 3 years from the Covered Person's Policy Date, We may only use fraudulent misstatements in such Covered Person's Application to void coverage under this Policy or to deny any claim under this Policy incurred after such 3 year period.

**MISSTATEMENT OF AGE** If a Covered Person's Age as shown in the application is incorrect, all amounts payable under the Policy will be the amounts the premium actually paid would have purchased at the correct Age. The Company's liability will be limited to a refund of the premium paid for such Covered Person if, according to the correct Age of the Covered Person, coverage under the Policy would not have been issued.

**CONFORMITY WITH STATE STATUTES** Any provision which, on the Effective Date, is in conflict with the laws of the state where You then live is automatically amended to conform to the minimum requirements of those laws.

**TIME PERIODS** Each Policy term will begin and end at 12:01 A.M. in the state where You live.

**Standard**  **Life**  
AND ACCIDENT  
INSURANCE COMPANY  
A MEMBER OF THE AMERICAN NATIONAL FAMILY OF COMPANIES

**ACCIDENT INSURANCE APPLICATION** Please Print — Use Black Ink  New Policy  Reinstatement

**SECTION A**

1. Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_ Best time to call \_\_\_\_\_  a.m.  p.m. Email \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Occupation \_\_\_\_\_  
 Billing Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Please print the full name of all other Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)	Occupation
	Spouse						

**3. BENEFIT AND PREMIUM DATA**

Plan:  Bronze  Silver  Gold  Platinum

**Billable Premium**  
\$ \_\_\_\_\_

**Billing Mode**  
 Annual  Semi-Annual  
 Quarterly  Monthly PAC  
 List Bill

4. First Beneficiary (Name: last, first, middle initial) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Second Beneficiary (Name: last, first, middle initial) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_

**SECTION B** (Applicant or any Proposed Insured is not eligible for Accident insurance if any question in SECTION B is answered Yes.)

5. Within the last 12 months has the Applicant or any Proposed Insured been paralyzed, confined to a nursing home or assisted living facility, received the services of a home health agency, lost a hand, foot, leg, or arm, had impaired mobility of any kind or been hospitalized for alcohol treatment, drug abuse, or mental and/or nervous disorder? .....  Yes  No  
 If Yes, list name of Applicant or Proposed Insured. \_\_\_\_\_
6. Does the Applicant or any Proposed Insured use a cane, walker, motorized vehicle, wheelchair or require mobility assistance by another person? .....  Yes  No  
 If Yes, list name of Applicant or Proposed Insured. \_\_\_\_\_
7. Has the Applicant or any Proposed Insured ever been diagnosed with any bone disease or disorder including but not limited to Osteoporosis, Osteonecrosis, Paget Disease or Bone Cancer? .....  Yes  No  
 If Yes, list name of Applicant or Proposed Insured. \_\_\_\_\_

**SECTION C**

**ATTENTION** — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

**ACKNOWLEDGMENT** — If eligible for Medicare, I/we have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare. I/We have also received an outline of coverage if required in my/our state.

**SECTION C** *(Continued)*

**FRAUD WARNING** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

**APPLICATION DECLARATION AND AGREEMENT** — Each of the undersigned has completed this application and represents that the answers and statements in Sections A and B on this application are true, complete, and correctly recorded to the best of my/our knowledge and belief; and agree they will be used to determine each Proposed Insured's eligibility for coverage applied for hereby. I/We understand and agree that: **1.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **2.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **3.** no insurance shall take effect unless a policy is issued (or if this application is made to change or reinstate an existing policy, unless the request is approved by the Company) and actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Proposed Insureds. I/We will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the policy issued. If this application is taken over the phone, I/we agree that my/our electronic signature(s) serve(s) as my/our original signature(s).

**I/We understand and agree that:** **1.** eligibility for the Plan does not constitute initial coverage under the Plan; and **2.** initial coverage under the Plan is subject to the Company's criteria.

**This is an Accident Only Policy. Please review the Policy carefully.**

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Date

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Dated at City, State

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Applicant's Signature

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Spouse's Signature (if coverage is requested)

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

I/We hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant or any Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I/We understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I/We understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I/We may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I/We, or my/our authorized representative, am/are entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I/We understand I/we may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I/We may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I/we agree that my/our electronic signature serves as my/our original signature.

\_\_\_\_\_ Date

\_\_\_\_\_ Dated at City, State

\_\_\_\_\_ Applicant's Signature

\_\_\_\_\_ Spouse's Signature (if coverage is requested)

\_\_\_\_\_ Witness

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other \_\_\_\_\_ .

AUTHORIZATION TO MY BANK	
<p><b>PREAUTHORIZED CHECK AUTHORIZATION</b></p> <p><b>Attach Voided Check or Deposit Ticket Here and Sign Authorization</b></p> <p><input type="checkbox"/> Checking</p> <p><input type="checkbox"/> Savings</p>	<p align="center"><b>Bank Information</b></p> <p>_____ Name</p> <p>_____ City _____ State _____ Zip</p> <p>We will not draft from your account until underwriting approves your application.</p> <p>As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.</p> <p>_____  _____ Date Signed Signature (as it appears on bank records)</p> <p>Complete if no personalized deposit ticket is available.</p> <p>Account Number _____</p> <p>Routing Number _____</p>

**AGENT STATEMENT**

- As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? .....  Yes  No  
If Yes, was a replacement form completed and a copy left with the Applicant?.....  Yes  No
- As Agent, have you complied with state replacement regulations? .....  Yes  No
- I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. ....  Yes  No

I have inquired about and have personal knowledge of the medical history of the Applicant and each Proposed Insured.

\_\_\_\_\_  
Agent's Name (please print)

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Agent's Writing Number

\_\_\_\_\_  
Date Signed

Phone (\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Premium Quoted: \$ \_\_\_\_\_

**Premium collected with Application.**

**Initial premium is to be drafted.**

Mail Policy to:  Insured  Agent

Special Request: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Accident

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## OUTLINE OF COVERAGE

POLICY FORM SERIES SL-BBIP-10

Standard Life and Accident Insurance Company

A Member of the American National Family of Companies

**Mailing Address:**

P.O. Box 696870

San Antonio, Texas 78269

Phone: 888.350.1488

(referred hereafter as “Standard Life”, “we”, “us”, “our” or “the Company”)

**THIS IS AN ACCIDENT ONLY POLICY AND DOES NOT PAY BENEFITS FOR SICKNESS. PLEASE READ CAREFULLY.**

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

If you are eligible for Medicare, you should review the *Guide to Health Insurance for People with Medicare* available from the Company.

1. **Read Your POLICY Carefully** — This outline of coverage provides a very brief description of some the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
2. Accident only coverage is designed to provide you with coverage for death, dismemberment, specified disabilities resulting from a covered accident only. Coverage is provided for the benefits outlined in section (3) if the covered injury or death occurs within [90] days of the accident. The benefits described in section (3) may be limited by section (4). No benefits are payable for fractures or dislocations when a bone degeneration disease is diagnosed before the effective date. Benefits are reduced if a bone degeneration disease is diagnosed after the effective date.
3. **BENEFITS** — The following benefits are provided for a covered accident sustained while the insurance is in force. Standard Life will pay benefits according to the level chosen by the insured in the application for coverage. A dependent child's benefit amounts are 50% of the Applicant's chosen level.

	<b>BENEFIT LEVEL</b>			
	<input type="checkbox"/> <b>Bronze</b>	<input type="checkbox"/> <b>Silver</b>	<input type="checkbox"/> <b>Gold</b>	<input type="checkbox"/> <b>Platinum</b>
<b>ACCIDENTAL DEATH BENEFIT</b>	<b>[\$5,000</b>	<b>\$10,000</b>	<b>\$20,000</b>	<b>\$30,000]</b>
<b>COMMON CARRIER BENEFIT</b>	<b>[\$10,000</b>	<b>\$20,000</b>	<b>\$40,000</b>	<b>\$60,000]</b>
<b>ACCIDENTAL DISMEMBERMENT CATEGORY</b>	<b>BENEFIT AMOUNT</b>			
Loss of two or more hands or feet	[\$5,000	\$10,000	\$20,000	\$30,000]
Loss of sight of both eyes	[\$5,000	\$10,000	\$20,000	\$30,000]
Loss of speech and hearing (in both ears)	[\$3,750	\$7,500	\$15,000	\$22,500]
Loss of one hand or foot	[\$3,750	\$7,500	\$15,000	\$22,500]
Loss of sight in one eye	[\$2,500	\$5,000	\$10,000	\$15,000]
Severance and reattachment of one hand or foot	[\$2,500	\$5,000	\$10,000	\$15,000]
Loss of speech	[\$2,500	\$5,000	\$10,000	\$15,000]
Loss of hearing (in both ears)	[\$2,500	\$5,000	\$10,000	\$15,000]
Loss of thumb and index finger of the same hand	[\$2,500	\$5,000	\$10,000	\$15,000]
Loss of all four fingers of the same hand	[\$2,500	\$5,000	\$10,000	\$15,000]
Loss of all the toes of the same foot	[\$2,500	\$5,000	\$10,000	\$15,000]
Loss of upper arm above the elbow, including hand and all fingers	[\$3,750	\$7,500	\$15,000	\$22,500]
Loss of upper leg above the knee, including foot and all toes	[\$3,750	\$7,500	\$15,000	\$22,500]
Loss of lower arm below the elbow, including hand and all fingers	[\$3,750	\$7,500	\$15,000	\$22,500]
Loss of lower leg below the knee, including foot and all toes	[\$3,750	\$7,500	\$15,000	\$22,500]
<b>Lifetime Maximum payable for all dismemberments</b>	<b>[\$5,000</b>	<b>\$10,000</b>	<b>\$20,000</b>	<b>\$30,000]</b>

If a Covered Person suffers one or more losses from the same accident for which amounts are payable under more than one benefit category, the amount payable will be limited to only one of the covered losses incurred, the largest to which the Covered Person is entitled.

<b>FRACTURE CATEGORY</b>	<b>BENEFIT AMOUNT</b>			
Spine/Vertebral Column	[\$1,875	\$3,750	\$7,500	\$11,250]
Cheekbone	[\$250	\$500	\$1,000	\$1,500]
Collarbone	[\$625	\$1,250	\$2,500	\$3,750]
Foot	[\$500	\$1,000	\$2,000	\$3,000]
Hand	[\$500	\$1,000	\$2,000	\$3,000]
Hip	[\$2,500	\$5,000	\$10,000	\$15,000]
Kneecap	[\$1,250	\$2,500	\$5,000	\$7,500]
Lower Arm	[\$500	\$1,000	\$2,000	\$3,000]
Lower Jaw	[\$625	\$1,250	\$2,500	\$3,750]
Lower Leg	[\$1,250	\$2,500	\$5,000	\$7,500]
Neck	[\$2,500	\$5,000	\$10,000	\$15,000]
Pelvis	[\$1,875	\$3,750	\$7,500	\$11,250]
Shoulder Blade	[\$625	\$1,250	\$2,500	\$3,750]
Skull	[\$2,500	\$5,000	\$10,000	\$15,000]
Sternum	[\$500	\$1,000	\$2,000	\$3,000]
Tailbone	[\$250	\$500	\$1,000	\$1,500]
Upper Arm	[\$1,250	\$2,500	\$5,000	\$7,500]
Upper Jaw	[\$625	\$1,250	\$2,500	\$3,750]
Upper Leg/Femur	[\$1,250	\$2,500	\$5,000	\$7,500]
Wrist	[\$500	\$1,000	\$2,000	\$3,000]
<b>Lifetime Maximum payable for all fractures</b>	<b>[\$2,500</b>	<b>\$5,000</b>	<b>\$10,000</b>	<b>\$15,000]</b>

In the event of multiple fractures during the same accident, only one covered fracture benefit, the largest to which the Covered Person would be eligible to receive, will be payable. The fracture must require reduction of the bone under anesthesia to be covered under this provision.

No benefits are payable for:

1. Pathological Fracture;
2. Hairline Fracture or Green Stick Fracture;
3. Fractures to the toes or fingers; or
4. Fractures when Bone Degeneration Disease was diagnosed prior to the Covered Person's effective date of coverage, regardless if the Bone Degeneration Disease contributed to the injury or not.

If a Covered Person is diagnosed as having bone degeneration disease after their policy effective date and suffers a fracture, the first fracture will be covered under the regular terms of the policy. However, after the first, all further fractures of any area payable under the policy will be reduced by 50%. This limitation applies regardless if the bone degeneration disease contributed to the injury or not.

<b>DISLOCATION CATEGORY</b>	<b>BENEFIT AMOUNT</b>			
Ankle	[\$500	\$1,000	\$2,000	\$3,000]
Collarbone	[\$500	\$1,000	\$2,000	\$3,000]
Elbow	[\$500	\$1,000	\$2,000	\$3,000]
Hip	[\$500	\$1,000	\$2,000	\$3,000]
Jaw	[\$500	\$1,000	\$2,000	\$3,000]
Knee	[\$500	\$1,000	\$2,000	\$3,000]

<b>Dislocation Category</b> <i>continued</i>	<b>Benefit Amount</b> <i>continued</i>			
Shoulder	[\$500	\$1,000	\$2,000	\$3,000]
Spine/Vertebral Column	[\$500	\$1,000	\$2,000	\$3,000]
Wrist	[\$500	\$1,000	\$2,000	\$3,000]
<b>Lifetime Maximum payable for all dislocations</b>	<b>[\$2,500</b>	<b>\$5,000</b>	<b>\$10,000</b>	<b>\$15,000]</b>

In the event of multiple dislocations during the same accident, only one covered dislocation benefit, the largest to which the Covered Person would be eligible to receive, will be payable. The dislocation must require reduction of the joint or bone to a normal position under anesthesia to be covered under this provision.

No benefits are payable for:

1. Dislocations of the toes or fingers;
2. Subsequent dislocations of the hip, shoulder or knees after the first dislocation; or
3. Dislocations when Bone Degeneration Disease was diagnosed prior to the Covered Person's effective date of coverage, regardless if the Bone Degeneration Disease contributed to the injury or not.

If a Covered Person is diagnosed as having bone degeneration disease after their policy effective date and suffers a dislocation, the first dislocation will be covered under the regular terms of the policy. However, after the first, all further dislocations of any area payable under the policy will be reduced by 50%. This limitation applies regardless if the bone degeneration disease contributed to the injury or not.

<b>BURN CATEGORY (Second or Third Degree Burns)</b>	<b>BENEFIT AMOUNT</b>			
27% or more of the body surface below neck	[\$2,500	\$5,000	\$10,000	\$15,000]
18% or more of the body surface below neck	[\$1,875	\$3,750	\$7,500	\$11,250]
9% or more of the body surface below neck	[\$1,250	\$2,500	\$5,000	\$7,500]
5% or more of the body surface below neck	[\$625	\$1,250	\$2,500	\$3,750]
50% or more of face, neck or head	[\$2,500	\$5,000	\$10,000	\$15,000]
25% or more of face, neck or head	[\$1,875	\$3,750	\$7,500	\$11,250]
10% or more of face, neck or head	[\$1,250	\$2,500	\$5,000	\$7,500]
<b>Lifetime Maximum payable for all burns:</b>	<b>[\$2,500</b>	<b>\$5,000</b>	<b>\$10,000</b>	<b>\$15,000]</b>

In the event of multiple burns during the same accident, only one covered burn benefit, the largest to which the Covered Person would be eligible to receive, will be payable.

#### 4. EXCLUSIONS, LIMITATIONS AND REDUCTIONS

Benefits otherwise payable are reduced 50% on the later of a Covered Person's age 75 or his/her 5th policy anniversary. No benefits will be paid due to any loss caused by, contributed by or related to the following and/or their treatments and/or complications thereof:

- a. an accident or injury that occurs prior to the effective date of this policy;
- b. suicide, or any attempt at suicide, or any intentionally self inflicted injury, while sane or insane;
- c. the commission of or attempt to commit an assault, or a felony, or being engaged in an illegal occupation;
- d. participation in a riot, war, or any act attributable to war, whether or not the Covered Person is in the military. The term "war" includes both declared and undeclared war;
- e. loss as a result of any sickness, illness, disease or mental condition, even though a proximate or precipitating cause of loss was an accidental injury. This includes a group of diseases that cause bone and marrow cell death and inherited diseases that weaken connective tissue;
- f. bacterial infection not occurring along with or as a result of an injury;

**Exclusions, Limitations and Reductions** *continued*

- g. alcohol abuse or addiction, or the Covered Person being intoxicated (defined as blood alcohol concentration equal to or in excess of .08 gms/dl blood alcohol). This applies whether or not the Covered Person is charged with any violation in connection with a loss and there is no need to prove a loss was caused, contributed to, or resulted from the excessive blood alcohol concentration;
- h. voluntary ingestion of alcohol, inhalation or injection of any narcotic, drug, toxins, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage. This applies even if the Covered Person did not intend to cause the harm which resulted from the action;
- i. mental or nervous disorders, that includes all disorders listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association;
- j. flight in any vehicle or device for aerial navigation, except as a fare-paying passenger on a regularly scheduled flight by a commercial airline;
- k. injury received while engaging in hazardous occupation or other activity including participating, instructing, demonstrating, guiding or accompany others in the following: professional or semi-professional sports, extreme sports, organized body contact sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, mountain climbing, bungee jumping, scuba diving, sail gliding, parasailing, parakiting, rock or mountain climbing, cave exploration, parkour, racing including stunt show or speed test of any motorized or non-motorized vehicle, rodeo activities, or similar hazardous activities. Also excluded is injury received while practicing, exercising, undergoing conditional or physical preparation for such activity;
- l. injuries intentionally inflicted by another person where the Covered Person voluntarily incurs obvious hazard or where the Covered Person places himself in a position that may be reasonably expected to bring about injury;
- m. repetitive stress injuries or syndromes precipitated by repeated or over use of a body part. Examples of this include but not limited to rotary cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis.
- n. hairline fractures or green stick fractures;
- o. loss of hearing, speech, or sight when proximate cause is comatose state.

**5. GUARANTEED RENEWABLE**

Subject to timely payment of premiums, the policy is renewable at your option. A Covered Person's coverage will terminate on the next premium due date following their 85th birthday. The Company will not refuse renewal of coverage under the policy except for reasons stated in the policy. The Company will not non-renew coverage just because of the claims you file or because of a change in the health or type of work of any Covered Person.

**6. PREMIUMS**

The Company may change premiums for coverage. Premiums may be changed and are due as stated in the policy.

The initial policy premium is \$[\_\_\_\_\_]  Annual  Semi-Annual  Quarterly  Monthly PAC

This policy has a 31 day grace period.

**This outline is a brief description of the policy terms and provisions.**

**Refer to the policy for further details.**

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SERFF Tracking Number: ANTX-127351709 State: Arkansas  
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 49467  
 Company Tracking Number:  
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
 Product Name: SLAICO Accident  
 Project Name/Number: /

**Rate Information**

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:**

Neutral

**Overall Percentage of Last Rate Revision:**

%

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

**Company Rate Information**

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Standard Life and Accident Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: ANTX-127351709 State: Arkansas  
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 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
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## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 08/08/2011	Monthly Gross Premiums and Rate Exhibit	SL-BBIP-10-AR	New		Broken Bones 2011 Rates 2011-05-11 TIP.pdf Rate Exhibit.pdf

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
ONE MOODY PLAZA GALVESTON, TEXAS 77550**

**POLICY FORM SL-BBIP-10  
MONTHLY GROSS PREMIUMS**

<b>Plan Name</b>	<b>AD&amp;D Benefit</b>	<b>Maximum Fracture Benefit</b>	<b>Issue Age</b>	<b>Individual</b>	<b>Individual &amp; Spouse</b>	<b>One Parent Family</b>	<b>Two Parent Family</b>
Bronze	5000	2500	18-44	11.05	16.14	19.98	25.07
			45-64	13.76	21.48	22.69	30.41
			65-75	19.39	32.49	28.32	41.42
Silver	10000	5000	18-44	16.14	26.32	33.99	44.17
			45-64	21.48	36.93	39.33	54.78
			65-75	32.49	58.69	50.34	76.54
Gold	20000	10000	18-44	26.32	46.69	62.03	82.39
			45-64	36.93	67.82	72.63	103.52
			65-75	58.69	111.08	94.39	146.79
Platinum	30000	15000	18-44	36.51	67.05	90.06	120.61
			45-64	52.37	98.71	105.93	152.26
			65-75	84.89	163.48	138.44	217.03

Modal Factors

Quarterly	Monthly x	3
Semi-Annual	Monthly x	6
Annual	Monthly x	12

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
ONE MOODY PLAZA GALVESTON, TEXAS 77550  
POLICY FORM SL-BBIP-10  
BENEFITS

			Bronze	Silver	Gold	Platinum
		% Of Principal Sum For Category	\$	\$	\$	\$
<b>1 ACCIDENTAL DEATH BENEFIT</b>						
	Principal Sum		5,000	10,000	20,000	30,000
<b>2 COMMON CARRIER BENEFIT</b>						
	Principal Sum	200%	10,000	20,000	40,000	60,000
<b>3 ACCIDENTAL DISMEMBERMENT BENEFIT (Percentage of ADB):</b>						
3a	Loss of Two or More hands or Feet	100%	5,000	10,000	20,000	30,000
3b	Loss of Sight of Both Eyes	100%	5,000	10,000	20,000	30,000
3c	Loss of Speech and Hearing In Both Ears	75%	3,750	7,500	15,000	22,500
3d	Loss of One Hand or One Foot	75%	3,750	7,500	15,000	22,500
3e	Loss of Sight In One Eye	50%	2,500	5,000	10,000	15,000
3f	Severance & Reattachment of 1 Hand or 1 Foot	50%	2,500	5,000	10,000	15,000
3g	Loss of Speech	50%	2,500	5,000	10,000	15,000
3h	Loss of Hearing in Both Ears	50%	2,500	5,000	10,000	15,000
3i	Loss of Thumb and Index Finger of Same Hand	50%	2,500	5,000	10,000	15,000
3j	Loss of All Four fingers of the Same Hand	50%	2,500	5,000	10,000	15,000
3k	Loss of All Toes of the Same Foot	50%	2,500	5,000	10,000	15,000
3l	Loss of Upper Arm Above Elbow Incl Hand & All Fingers	75%	3,750	7,500	15,000	22,500
3m	Loss of Upper Leg Above Knee Including Foot & All Toes	75%	3,750	7,500	15,000	22,500
3n	Loss of Lower Arm Below Elbow Incl Hand & All Fingers	75%	3,750	7,500	15,000	22,500
3o	Loss of Lower Leg Below Knee Incl Foot And All Toes	75%	3,750	7,500	15,000	22,500

			Bronze	Silver	Gold	Platinum
		% Of Principal Sum For Category	\$	\$	\$	\$
			2,500	5,000	10,000	15,000
4g	Hip	100%	2,500	5,000	10,000	15,000
4l	Neck	100%	2,500	5,000	10,000	15,000
4o	Skull	100%	2,500	5,000	10,000	15,000
4a	Back	75%	1,875	3,750	7,500	11,250
4m	Pelvis	75%	1,875	3,750	7,500	11,250
4f	Heel	50%	1,250	2,500	5,000	7,500
4h	Kneecap	50%	1,250	2,500	5,000	7,500
4k	Lower Leg	50%	1,250	2,500	5,000	7,500
4r	Thigh	50%	1,250	2,500	5,000	7,500
4s	Upper Arm	50%	1,250	2,500	5,000	7,500
4c	Collarbone	25%	625	1,250	2,500	3,750
4j	Lower Jaw	25%	625	1,250	2,500	3,750
4n	Shoulder Blade	25%	625	1,250	2,500	3,750
4u	Upper Jaw	25%	625	1,250	2,500	3,750
4d	Foot	20%	500	1,000	2,000	3,000
4e	Hand	20%	500	1,000	2,000	3,000
4i	Lower Arm	20%	500	1,000	2,000	3,000
4p	Sternum	20%	500	1,000	2,000	3,000
4t	Wrist	20%	500	1,000	2,000	3,000
4b	Cheekbone	10%	250	500	1,000	1,500
4q	Tailbone	10%	250	500	1,000	1,500

		% Of Principal Sum For Category	Bronze \$	Silver \$	Gold \$	Platinum \$
<b>5 DISLOCATION BENEFIT:</b>						
5a	Hip	20%	500	1,000	2,000	3,000
5b	Knee	20%	500	1,000	2,000	3,000
5c	Wrist	20%	500	1,000	2,000	3,000
5d	Elbow	20%	500	1,000	2,000	3,000
5e	Ankle	20%	500	1,000	2,000	3,000
5f	Shoulder	20%	500	1,000	2,000	3,000
5g	Collarbone	20%	500	1,000	2,000	3,000
5h	Jaw	20%	500	1,000	2,000	3,000
5i	Spine/Vertebral Column	20%	500	1,000	2,000	3,000
<b>6 BURN BENEFIT:</b>						
6a	27% or More of the Body Surface	100%	2,500	5,000	10,000	15,000
6b	18% or More of the Body Surface	75%	1,875	3,750	7,500	11,250
6c	9% or More of the Body Surface	50%	1,250	2,500	5,000	7,500
6d	5% or More of the Body Surface	25%	625	1,250	2,500	3,750
7a	50% or More of Face, Neck or Head	100%	2,500	5,000	10,000	15,000
7b	25% or More of Face, Neck or Head	75%	1,875	3,750	7,500	11,250
7c	10% or More of Face, Neck or Head	50%	1,250	2,500	5,000	7,500

SERFF Tracking Number: ANTX-127351709 State: Arkansas  
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 49467  
 Company Tracking Number:  
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
 Product Name: SLAICO Accident  
 Project Name/Number: /

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	08/08/2011
<b>Comments:</b>			
<b>Attachment:</b>			
READ - slaico.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	08/08/2011
<b>Bypass Reason:</b>	The application is attached under the FORM SCHEDULE		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Health - Actuarial Justification	Approved-Closed	08/08/2011
<b>Comments:</b>			
This is an actuarial memorandum in support of NEW rates for this NEW product. The rates are filed under the RATE/RULE Schedule			
<b>Attachment:</b>			
Actuarial Memo.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	08/08/2011
<b>Bypass Reason:</b>	This is attached under the FORMS TAB		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Previously approved notice	Approved-Closed	08/08/2011
<b>Comments:</b>			

SERFF Tracking Number: ANTX-127351709 State: Arkansas  
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 49467  
Company Tracking Number:  
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only  
Product Name: SLAICO Accident  
Project Name/Number: /

We will utilize this notice with the product. This notice was most recently approved by the Department under SERFF tracking number ANTX-126828895, approved 10/25/2011.

The CCN-AR3 form will be completed and mailed out with each newly issued policy.

**Attachment:**

Important\_Notice.pdf

	<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b> Statutorily required notices	Approved-Closed	<b>Date:</b> 08/08/2011
<b>Comments:</b> Replacement notice and Duplication notice		
<b>Attachments:</b> ADD_Duplication_Notice.pdf Generic Replacement Notice.pdf		

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
ONE MOODY PLAZA  
GALVESTON, TEXAS

READABILITY CERTIFICATION

We hereby certify that form(s) SL-BBIP-10-AR et. al. has (have) achieved a Flesch scale readability score that meets the minimum reading ease score as required by the state of Arkansas.

A handwritten signature in cursive script, appearing to read "James P. Stelling".

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James P. Stelling  
Vice President , Health Compliance

Date: August 3, 2011

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
ONE MOODY PLAZA GALVESTON, TEXAS 77550

ACTUARIAL MEMORANDUM

POLICY FORM SL-BBIP-10

- 1) Scope & Purpose- This filing is for the purpose of supporting the rates for the form shown. It is not intended to be used for any other purpose.
- 2) Description of Benefits- This policy form provides benefits for a range of accident related costs with 24-hour coverage. In addition to accidental death and dismemberment benefits, a schedule of benefits is provided for the treatment of various fractures, dislocations and burns. Also included are enhanced benefits for accidental death while riding in a common carrier. Benefits are halved upon attainment of age 75. Four levels of benefits will be offered. Benefit detail is shown on Exhibit I.
- 3) Renewability Clause- The policy is guaranteed renewable. However, coverage under this policy form will terminate if the insured fails to pay premiums when due. Coverage terminates at age 85.
- 4) Applicability- The proposed rates will be used for all business to be written under this new form.
- 5) Morbidity- Data from various sources was adjusted to estimate frequencies of claims for the different coverage's. Sources of data were:
  - National Safety Council: Injury facts, 2010 Edition
  - The Burden of Musculoskeletal Diseases in The United States, 2008: Chapter 6: Population Data Table 6.4
  - American Burn Association: National Burn Repository 2009
  - Agency for Healthcare Research and Quality: H-CUPNet: 2008 National Statistics
- 6) Mortality- 1990-95 Ultimate, US Society of Actuaries Basic, ANB

7) Persistency-

Policy Year	Lapse Rate
1	20.0%
2	20.4%
3	20.7%
4	21.1%
5	21.4%
6	21.8%
7	22.1%
8	22.5%
9	22.9%
10	23.2%
11	23.6%
12	23.9%
13	24.3%
14	24.6%
15	25.0%

8) Expenses-

Policy Year	Administration & Tax		Acquisition	
	% of Premium	Per Policy	Per Issue	% of Premium
1	2.1%	\$30	\$45	10.0%
2 – 10	2.1%	\$30	\$0	0.0%
11+	2.1%	\$30	\$0	0.0%

9) Commissions- Commission, as percentage of total premium is 60% for the first year, and 10% for all renewal years'.

10)Marketing Method- This product will be sold through brokers.

11)Underwriting- The application for the policy will ask about a history of osteoporosis.

12)Premium Classes- Premium rates vary by issue age group, family composition, and benefit levels.

13)Issue Age Range- The range of ages for which this policy will be issued are all ages from age 18 to age 75. The premiums are on an issue age, unisex basis.

14)Area Factors- This product does not use area factors.

15)Expected Average Annual Premium- \$390

16)Claim Liability and Reserves: - The claim liability and reserves for all incurred but unpaid claims will be developed using standard actuarial methods as prescribed by the American Academy of Actuaries.

- 17) Anticipated Loss Ratio – Overall lifetime loss ratio is expected to be 51.2%.
- 18) Distribution of business- this is a new policy form with no inforce business. The anticipated distribution by gender is 50/50 M/F with an average issue age of 50. It is expected that 30% of the policies will be on individuals, 45% on individual and spouse, 10% on single parent families, and 15% on two parent families.
- 19) Contingency and Risk Margins- The total contingency and risk margin is expected to be 8.1%.
- 20) Experience- this is a new policy form with no experience.
- 21) History of rate adjustments- there has been no rate adjustments on this new form.
- 22) Number of policyholders- there are no inforce policyholders on this new form.
- 23) Proposed Effective Date- upon approval of the form and rates.
- 24) Actuarial Certification- I certify that to the best of my knowledge and judgement, the entire rate filing is in compliance with the applicable laws of this state and with the rules of the Department of Insurance, and complies with Actuarial Standard of Practice 8, and that the benefits provided are reasonable in relation to the proposed premiums.

---



William H. Watson III FSA

May 3, 2011

## **IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION**

You should carefully read Your Application and all documents attached to this Policy. Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage. Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

The Underwriting Department may be notified at the following address and phone number:

Health Underwriting  
Standard Life and Accident Insurance Company  
PO Box 696820  
San Antonio, Texas 78269

Telephone: 1-888-350-1488

Your Application and all attached documents are part of this Policy. We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete to the best of your knowledge and belief.

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

This insurance provides limited benefits if you meet the conditions listed in the policy resulting from an accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when it pays:**

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

### **BEFORE YOU BUY THIS INSURANCE**

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or State Senior Health Insurance Program (SHIP).

**NOTICE TO APPLICANT  
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Standard Life and Accident Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under the present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

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Date

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Applicant's Signature