

SERFF Tracking Number: ERCB-127608995 State: Arkansas
Filing Company: Westport Insurance Corporation State Tracking Number: 49711
Company Tracking Number: AR-11-06112
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Excess Stop Loss
Project Name/Number: International Trade Controls Amendatory Endorsement/AR-11-06112

Filing at a Glance

Company: Westport Insurance Corporation

Product Name: Excess Stop Loss

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.004 Self-Funded Health Plan

Filing Type: Form

SERFF Tr Num: ERCB-127608995 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49711

Co Tr Num: AR-11-06112

Author: Cindy Knoll

Date Submitted: 09/02/2011

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 09/09/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: International Trade Controls Amendatory Endorsement

Project Number: AR-11-06112

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 09/09/2011

State Status Changed: 09/09/2011

Created By: Cindy Knoll

Corresponding Filing Tracking Number:

Filing Description:

Westport Insurance Corporation is filing the International Trade Controls Amendatory Endorsement for attachment to its Excess Stop Loss policy.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filings submitted
concurrently

Market Type: Group

Group Market Size: Large

Overall Rate Impact:

Deemer Date:

Submitted By: Cindy Knoll

The policy provides excess coverage at a specific retention level chosen by the self-insured employer. The maximum coverage is typically \$1 million per member per year, less the employer's specific retention.

This endorsement will be optional and will act to clarify our intent not violate U.S. sanctions law in providing excess stop loss coverage. In compliance with the Office of Foreign Assets Control (OFAC) of the US Department of the Treasury

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advisory 11-16-07, the most reliable approach for insuring risks without violating U.S. sanctions law is to insert in insurance policies an explicit exclusion for risks that would violate U.S. sanctions law.

This endorsement is adding clarification, and has no rating impact.

Company and Contact

Filing Contact Information

Cindy Knoll, Compliance Specialist cindy_knoll@swissre.com
 5200 Metcalf 800-255-6931 [Phone] 5896 [Ext]
 Overland Park, KS 66201 913-676-6226 [FAX]

Filing Company Information

Westport Insurance Corporation CoCode: 39845 State of Domicile: Missouri
 5200 Metcalf Group Code: 181 Company Type:
 Overland Park, KS 66201 Group Name: Swiss Re State ID Number:
 (800) 255-6931 ext. [Phone] FEIN Number: 48-0921045

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Westport Insurance Corporation	\$50.00	09/02/2011	51245112

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/09/2011	09/09/2011

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Disposition

Disposition Date: 09/09/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	International Trade Controls Amendatory Endorsement	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 09/09/2011	SP 5 328 0811	Policy/Cont ract/Fratern al	International Trade Controls Amendatory Endorsement	Initial		0.000	SP 5 328 0811.pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					

Westport Insurance Corporation

INTERNATIONAL TRADE CONTROLS AMENDATORY ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

- I. Section Six: Exclusions shall be amended to add Item 2 as follows:
 2. **INTERNATIONAL TRADE CONTROLS EXCLUSION.** We will not be deemed to provide coverage, nor shall we be liable to pay any claim or pay any Benefit hereunder to the extent that the provision of such coverage, payment of such claim, or provision of such Benefit would expose us to any sanction, prohibition or restriction under any United Nations resolutions or the trade or economic sanctions, laws or regulations of any jurisdiction applicable to us.

All other terms and conditions of this policy shall remain unchanged.
This endorsement forms a part of the policy to which attached, effective on the inception date of the policy unless otherwise stated herein.
(The information below is required only when this endorsement is issued subsequent to the preparation of the policy.)

**Endorsement Effective
Named Insured**

Policy No.

WESTPORT INSURANCE CORPORATION



President



Secretary

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	09/09/2011
Comments: The attached application was approved for use effective 7/1/08 (AR Reference # 39461)		
Attachment: Application SP 4 291AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	09/09/2011
Comments:		
Attachment: Flesch Reading Ease Certification.pdf		

Westport Insurance Corporation

A Stock Company
5200 Metcalf Avenue, P.O. Box 2991, Overland Park, KS 66201-1391
(913) 676-5200 / (800) 255-6931

APPLICATION FOR EXCESS MEDICAL INDEMNITY POLICY

Application is made for a Policy providing the insurance specified below:

Date Quotation Requested: _____ Effective Date Requested: _____

APPLICANT INFORMATION

Applicant Information	Name: _____	Telephone: _____
	Address: _____	Fax: _____
	Contact: _____	E-Mail: _____

List all Covered Units and number of Employees covered at each location (must be more than 50 Employees):

Nature of Business: Corporation Association Trust Industry Type: _____

REQUESTED COVERAGE

Aggregate Excess <input type="checkbox"/> Yes <input type="checkbox"/> No	Attachment Point - % of Loss Fund: <input type="checkbox"/> 120% <input type="checkbox"/> 125% <input type="checkbox"/> Other _____
	Benefits Covered: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Vision <input type="checkbox"/> Weekly Indemnity <input type="checkbox"/> Other _____
	Liability Basis: <input type="checkbox"/> (15/12) Incurred 3 months prior and paid in policy period <input type="checkbox"/> (12/12) Incurred and paid in policy period <input type="checkbox"/> (12/15) Incurred in policy period and paid within 3 months after the policy period <input type="checkbox"/> Other _____

Specific Excess <input type="checkbox"/> Yes <input type="checkbox"/> No	Retention: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$35,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other _____
	Plan Maximum: <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> Other _____
	Benefits Covered: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Vision <input type="checkbox"/> Weekly Indemnity <input type="checkbox"/> Other _____
	Liability Basis: <input type="checkbox"/> (15/12) Incurred 3 months prior and paid in policy period <input type="checkbox"/> (12/12) Incurred and paid in policy period <input type="checkbox"/> (12/15) Incurred in policy period and paid within 3 months after the policy period <input type="checkbox"/> Other _____

APPLICATION FOR EXCESS MEDICAL INDEMNITY POLICY

Current Coverage	Current Carrier: _____ <input type="checkbox"/> Insured <input type="checkbox"/> Self-Insured		
	Current Agent/TPA: _____		
	If Self-Insured, indicate current retention level, funding and monthly rates, and contract terms. _____		
	No. Eligible Employees: _____	No. Employees w/Deps.: _____	No. Employees w/o Deps.: _____
	Are Retirees covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	No. of Retirees under 65/over 65: _____	
	Are Union employees covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	No. of Union employees: _____	
How many people are covered under COBRA? _____			

Administrator of Plan	Name: _____	Phone: _____
	Address: _____	Fax: _____
	Contact Person: _____	E-Mail: _____

Paid Claims Experience	Experience Mo/Yr - Mo/Yr	Medical	Dental	Prescription Drugs	Average No. of Employees
<i>Please provide supportive back-up data for paid claims broken down by month, if possible.</i>					

Serious Claims Information	<i>If any Person has incurred \$10,000 or more claims or has a serious condition which may exceed the specific retention requested, give details below:</i>				
	Claimant's Name (EE or DEP)	Amount Paid to Date	Diagnosis	Prognosis	Case Management

Required Attachments	<input type="checkbox"/> Current plan of benefits and proposed changes <input type="checkbox"/> Complete paid claims experience for last 3 years <input type="checkbox"/> Information on claimants with claims above of \$10,000 (or with a serious condition) for last 3 years <input type="checkbox"/> Current census including date of birth, gender, coverage category (active employee, retiree, COBRA, etc.) and zip code <input type="checkbox"/> Case Management Reports for last 3 years
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APPLICATION FOR EXCESS MEDICAL INDEMNITY POLICY

Representations. The undersigned represents that the statements set forth herein are true, complete and accurate and that there has been no attempt at suppression or misstatement of any material facts known, or which should be known, and agrees that this Application shall become the basis of any coverage and a part of any Policy that may be issued by us.

Release of Information. The release of any claim information is solely for the purpose of obtaining insurance coverage, and it will be held to be confidential and not used for any other purpose.

Non-Binding. The execution of this Application does not bind the undersigned to purchase any coverage offered, nor does the review and/or receipt of this Application bind us to issue a Policy or offer coverage.

Retention of Rights. Any Policy will not be effective until we receive and accept this Application executed by the appropriate persons. We retain the right to deny any claim, adjust our underwriting terms or rescind and cancel our Policy in the event of any undisclosed, inaccurate or incomplete information.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

Name: _____
(Person with authority to sign on behalf of Applicant)

Title: _____

Signed: _____

Date: _____

FLESCH SCORE CERTIFICATION

I, David Newkirk, Vice President of Westport Insurance Corporation do certify that the Endorsement form SP 5 328 0811 has a Flesch score of at least 40.

A handwritten signature in black ink, appearing to read "David Newkirk". The signature is written in a cursive style with a large initial "D".

David Newkirk, Vice President
Westport Insurance Corporation
5200 Metcalf
Overland Park, KS 66201