

SERFF Tracking Number: AEGB-127930939 State: Arkansas  
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 50583  
Company Tracking Number: H 1011S  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
Standard Plans 2010  
Product Name: H 1011S  
Project Name/Number: H 1011S/H 1011S

## Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: H 1011S

SERFF Tr Num: AEGB-127930939 State: Arkansas

TOI: MS08I Individual Medicare Supplement -  
Standard Plans 2010

SERFF Status: Closed-Approved-  
Closed State Tr Num: 50583

Sub-TOI: MS08I.001 Plan A 2010

Co Tr Num: H 1011S

State Status: Approved-Closed

Filing Type: Form

Author: Sherri Sturtz

Reviewer(s): Stephanie Fowler

Date Submitted: 12/28/2011

Disposition Date: 01/24/2012

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: H 1011S

Status of Filing in Domicile: Pending

Project Number: H 1011S

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed concurrently.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 01/24/2012

State Status Changed: 01/24/2012

Deemer Date:

Created By: Sherri Sturtz

Submitted By: Sherri Sturtz

Corresponding Filing Tracking Number:

30822760

Filing Description:

December 27, 2011

Commissioner of Insurance

Arkansas Insurance Division

1200 West 3rd Street

Little Rock, Arkansas 72201-1904

RE; STONEBRIDGE LIFE INSURANCE COMPANY NAIC# 468-65021

SERFF Tracking Number: AEGB-127930939 State: Arkansas  
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Standard Plans 2010  
Product Name: H 1011S  
Project Name/Number: H 1011S/H 1011S

Form Number: H 1011S – Medicare Supplement Application FEIN# 03-0164230

Dear Sir/Madam:

Please find attached copies of the above referenced form. This is a new form and is not intended to replace any form previously approved by your Department. This form has been submitted in final printed form in which it will be distributed to Insureds. This form is subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officers' signatures.

Health Application – This is an individual Medicare Supplement insurance application that will be used with our Medicare Supplement portfolio.

This application will be used via paper by licensed agents. We intend to use this form in a traditional manner whereby the Owner/applicant signs the application in ink and submits the application to the Company.

We also plan to make this application form available electronically. It is our intent to use this application form in a variety of electronic environments, including a laptop and web based application process. Regardless of the application process used, we intend to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via a secured socket layer/secured line. The information contained in the application will be transmitted to our administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions act, and to the extent applicable, the Federal ESIGN Act.

We hereby certify that any electronic signature we obtain will be linked to the date on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. We also certify that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

A copy of the application, identical to the filed form, will be printed and made part of any policy issued.

We would appreciate your review and approval of this form. Should you have any questions or need any additional information, please do not hesitate to contact me.

Sincerely,

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Sherri A. Sturtz  
 Forms Management Coordinator  
 (319) 355-7965 (collect)  
 Fax #: (319) 355-2501  
 Sherri.Sturtz@Transamerica.com

## Company and Contact

### Filing Contact Information

Paige Johnson, Forms Management Coordinator  
 4333 Edgewood Road NE  
 Cedar Rapids, IA 52499  
 Paige.Johnson@Transamerica.com  
 319-355-6869 [Phone]

### Filing Company Information

Stonebridge Life Insurance Company  
 4333 Edgewood Rd. NE  
 Cedar Rapids, IA 52499  
 (319) 355-8511 ext. [Phone]  
 CoCode: 65021  
 Group Code: 468  
 Group Name:  
 FEIN Number: 03-0164230  
 State of Domicile: Vermont  
 Company Type: Life & Health  
 State ID Number:

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## Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

| COMPANY                            | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|------------------------------------|---------|----------------|---------------|
| Stonebridge Life Insurance Company | \$50.00 | 12/28/2011     | 54885305      |

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## Correspondence Summary

### Dispositions

| Status          | Created By       | Created On | Date Submitted |
|-----------------|------------------|------------|----------------|
| Approved-Closed | Stephanie Fowler | 01/24/2012 | 01/24/2012     |

### Objection Letters and Response Letters

| Objection Letters         |                  |            |                | Response Letters |            |                |
|---------------------------|------------------|------------|----------------|------------------|------------|----------------|
| Status                    | Created By       | Created On | Date Submitted | Responded By     | Created On | Date Submitted |
| Pending Industry Response | Stephanie Fowler | 01/19/2012 | 01/19/2012     | Sherri Sturtz    | 01/23/2012 | 01/24/2012     |

*SERFF Tracking Number:* AEGB-127930939      *State:* Arkansas  
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## **Disposition**

Disposition Date: 01/24/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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| Schedule            | Schedule Item                    | Schedule Item Status                | Public Access |
|---------------------|----------------------------------|-------------------------------------|---------------|
| Supporting Document | Flesch Certification             | Accepted for Informational Purposes | Yes           |
| Supporting Document | Health - Actuarial Justification |                                     | Yes           |
| Supporting Document | Outline of Coverage              |                                     | Yes           |
| Supporting Document | Statement of Variability Health  | Approved-Closed                     | Yes           |
| Supporting Document | AR - Rule and Regulation 19      | Accepted for Informational Purposes | Yes           |
| Supporting Document | Application                      | Disapproved                         | Yes           |
| Form (revised)      | Medicare Supplement              | Approved-Closed                     | Yes           |
| Form                | Medicare Supplement              | Disapproved                         | No            |

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 01/19/2012  
Submitted Date 01/19/2012  
Respond By Date 02/20/2012

Dear Paige Johnson,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Medicare Supplement, H 1011S (Form)

Comment: R & R 27, Sec. 11 prohibits the discrimination of pricing during open enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the "Personal History Questions" section since it is not required to be answered during open enrollment or a guaranteed issue period.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 01/23/2012  
 Submitted Date 01/24/2012

Dear Stephanie Fowler,

### Comments:

Hi Stephanie, thank you for reviewing my filing for the health application for Arkansas.

### Response 1

Comments: I have made the revisions and am resubmitting H 1011S AR for your review. Question 17 from page 1 has been moved to page 4 in the Personal History Section as Question 2. The following questions were then renumbered.

### Related Objection 1

Applies To:

- Medicare Supplement, H 1011S (Form)

Comment:

R & R 27, Sec. 11 prohibits the discrimination of pricing during open enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the "Personal History Questions" section since it is not required to be answered during open enrollment or a guaranteed issue period.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

| Form Name               | Form Number   | Edition Date | Form Type                      | Action  | Action Specific Data | Readability Score | Attach Document   |
|-------------------------|---------------|--------------|--------------------------------|---------|----------------------|-------------------|-------------------|
| Medicare Supplement     | H 1011S<br>AR |              | Application/Enrollment<br>Form | Initial |                      | 50.600            | H 1011S<br>AR.pdf |
| <b>Previous Version</b> |               |              |                                |         |                      |                   |                   |
| Medicare Supplement     | H 1011S       |              | Application/Enrollment         | Initial |                      | 50.600            | H                 |

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*Product Name:* H 1011S  
*Project Name/Number:* H 1011S/H 1011S

*Form*

1011S.pdf

No Rate/Rule Schedule items changed.

Stephanie, thank you for reviewing the attached. Please let me know if you have any questions.

Thanks.

Sherri Sturtz

Sincerely,

Sherri Sturtz

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## Form Schedule

**Lead Form Number: H 1011S**

| Schedule Item                 | Form Number   | Form Type   | Form Name | Action  | Action Specific Data | Readability | Attachment        |
|-------------------------------|---------------|---|-----------|---------|----------------------|-------------|-------------------|
| Approved-Closed<br>01/24/2012 | H 1011S<br>AR | Application/Medicare<br>Enrollment Supplement<br>Form |           | Initial |                      | 50.600      | H 1011S<br>AR.pdf |







7. Agents shall list any other health insurance policies/certificates they have sold to the Applicant.  
 a. List policies/certificates sold which are still in force.

| <b>APPLICANT A</b>                      | <b>APPLICANT B</b>                      |
|---|---|
| Name of Company                         | Name of Company                         |
| Policy/Certificate Number               | Policy/Certificate Number               |
| Description of Benefits                 | Description of Benefits                 |
| Effective Date of Coverage (MM/DD/YYYY) | Effective Date of Coverage (MM/DD/YYYY) |

- b. List policies/certificates sold in the past five (5) years which are no longer in force.

| <b>APPLICANT A</b>                      | <b>APPLICANT B</b>                      |
|---|---|
| Name of Company                         | Name of Company                         |
| Policy/Certificate Number               | Policy/Certificate Number               |
| Description of Benefits                 | Description of Benefits                 |
| Effective Date of Coverage (MM/DD/YYYY) | Effective Date of Coverage (MM/DD/YYYY) |

**F. Personal History Questions - Complete this section only if you are NOT applying during a guaranteed issue period.**

1. Have you been prescribed or taken any prescription medications within the past 12 months? If "YES," please indicate below. If "NO," indicate "None." Agent - This is to assist in preparing the Applicant to answer questions in sections 2 through 4.

| <b>APPLICANT A</b><br>Name of Medication, Date Prescribed and Condition<br>(Example: Vytorin, 10/2009, High Cholesterol) | <b>APPLICANT B</b><br>Name of Medication, Date Prescribed and Condition<br>(Example: Vytorin, 10/2009, High Cholesterol) |
|--|--|
|  |  |
|  |  |
|  |  |

|   | <b>APPLICANT A</b>                                       | <b>APPLICANT B</b>                                       |
|---|--|--|
| 2. Have you used tobacco in any form in the past 12 months?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you ever:   |  |  |
| a. been advised by a physician to have or are you currently waiting for an organ transplant?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been diagnosed with, treated, or advised to receive treatment for Alzheimer's Disease, dementia, mental incapacity, organic brain disease or any other cognitive disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. been diagnosed with, treated or advised to receive treatment for Lou Gehrig's disease (ALS), Huntington's disease or any terminal medical condition?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. been diagnosed with, treated or advised to receive treatment for Systemic Lupus, Osteoporosis with Fractures, kidney disease or failure requiring dialysis, used over 50 units of insulin per day to treat Diabetes, or any type of Diabetes with Complications including retinopathy, neuropathy, nephropathy, peripheral vascular disease, heart disease, stroke, transient ischemic attack (TIA), high blood pressure or skin ulcers? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. been diagnosed with, treated or advised to receive treatment for Cirrhosis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. tested positive for the antibodies to the AIDS (HIV) virus or been diagnosed with, treated, or advised to receive treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. been diagnosed, treated or advised to receive treatment for any neurological disease or disorder such as Myasthenia Gravis, Multiple or Lateral Sclerosis, or Parkinson's disease?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

|   | <b>APPLICANT A</b>                                       | <b>APPLICANT B</b>                                       |
|---|--|--|
| 4. Within the past 2 years have you:  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. been advised to or do you currently use a wheelchair?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. been advised to enter or do you reside in a nursing home, assisted living facility, long term care facility, received hospice, attended an adult day care facility, required home health care, or been bedridden?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. been admitted to a hospital 3 or more times or are you currently admitted to a hospital?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. been diagnosed, treated or advised to receive treatment for cancer (other than basal cell carcinoma)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. been diagnosed, treated or advised to receive treatment for alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. been diagnosed, treated or advised to receive treatment for heart attack, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. been diagnosed, treated or advised to receive treatment for degenerative bone disease impacting multiple joints, crippling/disabling or rheumatoid arthritis or been advised to have a joint replacement?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. been advised to have surgery, medical tests, treatment or therapy that has not yet been performed or undergone testing by a medical professional for which the results have not yet been received?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

|  |  |  |
|--|--|--|
| 5. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts or have you used or been advised to use oxygen equipment, respirator or a catheter? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|--|

**If any question in 2, 3 and 4 is answered "YES," please STOP. The Applicant is NOT eligible for underwritten Medicare Supplement.**

**G. Billing Information**

**I would like my monthly direct payment to come from my account below (check one) on the \_\_\_\_ day of the month (1<sup>st</sup>-28<sup>th</sup>):**  
 Checking **Please attach a voided check**     Savings **Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.**

|                             |               |
|-----------------------------|---------------|
| Financial Institution Name: | Phone Number: |
|-----------------------------|---------------|

Financial Institution Address:

|                         |                 |
|-------------------------|-----------------|
| Transit Routing Number: | Account Number: |
|-------------------------|-----------------|

I hereby request and authorize Stonebridge Life Insurance Company to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after that first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Stonebridge Life Insurance Company or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Stonebridge Life Insurance Company's rights in respect to each charge shall be the same as if it were a check made payable to Stonebridge Life Insurance Company and personally signed by me. If any charge is dishonored for any reason, Stonebridge Life Insurance Company shall not be under any liability even though such dishonor results in the forfeiture of insurance.

|  |   |
|--|---|
| _____  | _____   |
| Signature as it appears on financial institution records | Print name of account owner (if other than Applicant) |

\_\_\_\_\_

Date

**If the EFT premium payment method is chosen, please tape a voided check in this box.**

**H. Please Read and Sign Below**

**IMPORTANT STATEMENTS TO BE READ BY APPLICANT**

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested with 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I understand the Company may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgement will be valid for 24 months after it is signed. I acknowledge and agree that this application and any amendments shall be the basis for any insurance issued and that the agent does not have the authority to waive any question on this application.

If I am applying for a Medicare supplement insurance policy, I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each Applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Stonebridge Life Insurance Company.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.**

Dated at \_\_\_\_\_, on \_\_\_\_\_, \_\_\_\_\_  
City State Month Day Year Applicant A's Signature

Dated at \_\_\_\_\_, on \_\_\_\_\_, \_\_\_\_\_  
City State Month Day Year Applicant B's Signature (if applying)

**Premium Must Accompany Application**

I/We certify that during an interview with the proposed Applicant, I/we have truly and accurately recorded in the application the information supplied by the Applicant.

\_\_\_\_\_  
(Signature of Licensed Agent)

\_\_\_\_\_  
(Print Agent Name)

\_\_\_\_\_  
Agent Number / (Stamp)

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## Supporting Document Schedules

|                          |                                     | Item Status:                        | Status Date: |
|--------------------------|-------------------------------------|-------------------------------------|--------------|
| <b>Satisfied - Item:</b> | Flesch Certification                | Accepted for Informational Purposes | 01/24/2012   |
| <b>Comments:</b>         |                                     |                                     |              |
| <b>Attachment:</b>       | Flesch Score.pdf                    |                                     |              |
| <b>Bypassed - Item:</b>  | Health - Actuarial Justification    |                                     |              |
| <b>Bypass Reason:</b>    | Not applicable.                     |                                     |              |
| <b>Comments:</b>         |                                     |                                     |              |
| <b>Bypassed - Item:</b>  | Outline of Coverage                 |                                     |              |
| <b>Bypass Reason:</b>    | Not applicable.                     |                                     |              |
| <b>Comments:</b>         |                                     |                                     |              |
| <b>Satisfied - Item:</b> | Statement of Variability Health     | Approved-Closed                     | 01/24/2012   |
| <b>Comments:</b>         |                                     |                                     |              |
| <b>Attachment:</b>       | Statement of Variability Health.pdf |                                     |              |
| <b>Satisfied - Item:</b> | AR - Rule and Regulation 19         | Accepted for Informational Purposes | 01/24/2012   |

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**Comments:**

**Attachment:**

AR - Rule and Regulation 19.pdf

|                                      | <b>Item Status:</b> | <b>Status</b>           |
|--------------------------------------|---------------------|-------------------------|
| <b>Satisfied - Item:</b> Application | Disapproved         | <b>Date:</b> 01/24/2012 |
| <b>Comments:</b>                     |                     |                         |
| <b>Attachment:</b>                   |                     |                         |
| H 1011S.pdf                          |                     |                         |

**STONEBRIDGE LIFE INSURANCE COMPANY  
FLESCH READABILITY CERTIFICATION**

**Form Number (may vary by state)**

**Flesch Score**

P 1011S

50.6

I certify that the machine scored Flesch Readability score for the above mentioned form is accurate.

*Cheryl Bock*

---

Cheryl Bock, Assistant Vice President, Contract Development

**STONEBRIDGE LIFE INSURANCE COMPANY  
STATEMENT OF VARIABILITY**

**APPLICATION: H 1011S**

We have bracketed the variable items in this form. No change in the variability will be made which in any way expands the scope of the wording. Stonebridge Life Insurance Company reserves the right to correct, at any time, any and all typographical errors that do not impact the benefits or intent of language.

**H 1011S – Application for Individual Health Insurance**

1. **Home Office** (page 1): This may change to another location in the future.
2. **B3 Mail Policy To** (page 2): This may list either owner or agent.
3. **C2 Medicare Supplement Application** (page 2): Some marketing distributions may not charge a fee.

**Stonebridge Life Insurance Company  
Home Office: Cedar Rapids, Iowa**

**COMPLIANCE CERTIFICATION  
RULE AND REGULATION 19  
STATE OF ARKANSAS**

Form Number: H 1011S

Date: December 27, 2011

We certify that, to the best of our knowledge and belief, this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Insurance Division of the State of Arkansas.

*Cheryl Bock*

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Cheryl Bock, Assistant Vice President, Contract Development