

SERFF Tracking Number: MADS-128016821 State: Arkansas
Filing Company: Independence American Insurance Company State Tracking Number:
Company Tracking Number: SL2011 - IAIC AR
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Stop Loss
Project Name/Number: Stop Loss/SL2011

Filing at a Glance

Company: Independence American Insurance Company

Product Name: Stop Loss

SERFF Tr Num: MADS-128016821 State: Arkansas

TOI: H12 Health - Excess/Stop Loss

SERFF Status: Closed-Approved State Tr Num:

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

Co Tr Num: SL2011 - IAIC AR

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Donna Lambert

Authors: Julie Guess, Sue Long,
Cheryl Richards, Andrea Greiber

Disposition Date: 01/30/2012

Date Submitted: 01/24/2012

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 03/01/2012

State Filing Description:

General Information

Project Name: Stop Loss

Status of Filing in Domicile: Pending

Project Number: SL2011

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 01/30/2012

State Status Changed: 01/30/2012

Deemer Date:

Created By: Sue Long

Submitted By: Sue Long

Corresponding Filing Tracking Number: MADS-128016761(MNL) and

MADS-128016479 (SSL)

Filing Description:

FILING DESCRIPTION

STOP LOSS

The attached forms are new and are not intended to replace any previously approved forms. This submission includes the final printed version of the forms. Please note, the identical policy forms, with the exception of the forms numbers and the company name, are also being submitted today for our two sister insurance companies, Madison National Life Insurance Company, Inc. and SSL. Our hope is that review of the filings could be coordinated internally so that either the same examiner reviews all three, or, if assigned to different examiners, that they be informed of the submission of

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the identical filings. We think this will be beneficial to both the Department/Division and us, as it may expedite review of the filings and result in consistent changes, if any, being made to the policy forms.

The captioned forms provide stop-loss insurance coverage to employers who self-insure their employees' health benefit plans. The stop-loss policy will provide reimbursement for employer expenses that are in excess of a specific and/or aggregate stop-loss limit as defined in the policy.

Please note, the referenced filing does not provide first dollar coverage for medical expenses and is not a health benefit plan as defined by HIPAA and state law. The purpose of this product is to reimburse the employer for expenses accumulated under the employer's health plan.

Typical specific stop-loss deductibles are in the \$50,000 to \$150,000 range but may go as low as \$15,000 or as high as \$300,000 or more in the case of very large groups. Attachment points for aggregate stop-loss, if offered to the group, begin at 120% of expected medical costs under the specific stop-loss deductible.

The target market for the stop-loss policy will be employers who self-insure their employee health benefit plans through either separate accounts or the employer's general assets, as permitted by law. The policy will be solicited by independent agents.

Independence American Insurance Company is domiciled in the state of Delaware. This filing will be submitted to the Delaware Insurance Department for domiciliary approval.

Company and Contact

Filing Contact Information

Sue Long, Compliance Specialist sml@madisonlife.com
PO Box 5008 800-356-9601 [Phone] 2061 [Ext]
Madison, WI 53705 608-830-2700 [FAX]

Filing Company Information

Independence American Insurance Company CoCode: 26581 State of Domicile: Delaware
485 Madison Avenue Group Code: 450 Company Type:
New York, NY 10022 Group Name: State ID Number:
(212) 355-4141 ext. [Phone] FEIN Number: 74-1746542

Filing Fees

SERFF Tracking Number: MADS-128016821 State: Arkansas
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Fee Required? Yes
Fee Amount: \$550.00
Retaliatory? No
Fee Explanation: \$50.00 per form x 11 forms = \$550.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Independence American Insurance Company	\$550.00	01/24/2012	55740421

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/30/2012	01/30/2012

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Disposition

Disposition Date: 01/30/2012

Implementation Date: 03/01/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved	Yes
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Flesch - Certification of Flesch Reading Ease Score	Approved	Yes
Supporting Document	Actuarial Memorandum	Approved	No
Form	Policy	Approved	Yes
Form	Application	Approved	Yes
Form	Aggregating Specific Rider	Approved	Yes
Form	Aggregate Excess Loss Terminal Liability Rider	Approved	Yes
Form	Cumulative Specific Policy Rider	Approved	Yes
Form	Disclosure Statement	Approved	Yes
Form	Independent Review Organization Rider	Approved	Yes
Form	Monthly Cum Accom For AGG Exc Loss Rider	Approved	Yes
Form	Blank Rider	Approved	Yes
Form	Specific Deductible Cap Rider	Approved	Yes
Form	Speci Excess Loss Term Liabi Rider	Approved	Yes

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Form Schedule

Lead Form Number: SL2011-AR

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/30/2012	SL2011- IAIC-AR	Policy/Cont Policy ract/Fratern al Certificate	Initial		46.000	SL2011-IAIC- AR.pdf
Approved 01/30/2012	SL2011- APP-IAIC- AR	Application/ Application Enrollment Form	Initial		44.000	SL2011-APP- IAIC-AR.pdf
Approved 01/30/2012	SL2011- ASR-IAIC	Policy/Cont Aggregating Specific ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		45.000	SL2011-ASR- IAIC.pdf
Approved 01/30/2012	SL2011- ATLR-IAIC	Policy/Cont Aggregate Excess ract/Fratern Loss Terminal al Liability Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		46.000	SL2011- ATLR- IAIC.pdf
Approved 01/30/2012	SL2011- CSR-IAIC	Policy/Cont Cumulative Specific ract/Fratern Policy Rider al Certificate: Amendmen t, Insert	Initial		60.000	SL2011-CSR- IAIC.pdf

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Approval	Tracking Number	Description	Initial	Amount	File Name
Approved	SL2011-D-01/30/2012 IAIC	Other Disclosure Statement	Initial	21.000	SL2011-D-IAIC.pdf
Approved	SL2011-01/30/2012 IROR-IAIC	Policy/Cont Independent Review ract/Fratern Organization Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	20.000	SL2011-IROR-IAIC.pdf
Approved	SL2011-01/30/2012 MCAR-IAIC	Policy/Cont Monthly Cum Accom ract/Fratern For AGG Exc Loss al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	45.000	SL2011-MCAR-IAIC.pdf
Approved	SL2011-R-01/30/2012 IAIC	Policy/Cont Blank Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	60.000	SL2011-R-IAIC.pdf
Approved	SL2011-01/30/2012 SDCR-IAIC	Policy/Cont Specific Deductible ract/Fratern Cap Rider al Certificate: Amendmen t, Insert	Initial	45.000	SL2011-SDCR-IAIC.pdf

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INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)

Administrative Office:
485 Madison Avenue
New York, New York 10022
212-355-4141

POLICYHOLDER:

POLICY NUMBER:

EFFECTIVE DATE:

EXPIRATION DATE:

STATE OF DELIVERY:

This Policy is a legal contract. We issue it in consideration of: (1) Your Application, (2) Your Disclosure Statement, and (3) Your payment of premiums when due. This Policy, Your Application, Your Disclosure Statement, and a copy of the Plan form the entire agreement between You and Us.

Various provisions in this Policy restrict coverage. Read the entire Policy carefully to determine Your rights, duties and what is and is not covered.

In issuing this Policy, We have relied upon the information (including, without limitation, information in the Disclosure Statement, Your Application, and the Plan) provided to Us by: (1) You, (2) Your Administrator, and (3) Your agent or broker. We have also relied on this information being both complete and accurate. If the information was incomplete or incorrect, We shall have the immediate right: (1) to modify the Policy to reflect the complete or correct information, or (2) to terminate the Policy upon written notice.

We agree to make payments in accordance with the provisions of this Policy.

Throughout this Policy, the words "You" and "Your" refer to the Policyholder shown above. The words "We", "Us", and "Our" refer to Independence American Insurance Company.

This Policy is issued and governed by the laws of the state of delivery as indicated above.

Signed for Independence American Insurance Company as of the Effective Date.



David T. Kettig
President



Adam C. Vandervoort
Secretary

EXCESS LOSS INSURANCE POLICY
Non-Participating

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If we at Independence American Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street, Little Rock, AR 72201
Phone: (501) 371-2640, (800) 852-5494
Email: insurance.consumers@arkansas.gov

SECTION 1 - DEFINITIONS

Administrator means the person or organization, which has been retained by You and approved by Us, to provide claim and administrative services for You with respect to the Plan.

Advanced Funding means the process by which charges incurred by Covered Persons are reimbursed under the Specific Excess Loss Insurance provision of this Policy prior to funds being disbursed by the Plan.

Annual Aggregate Attachment Point means that portion of Covered Expenses Incurred and Paid during the Benefit Period that You will pay without any reimbursement from Us. This amount is not eligible for reimbursement under this Policy. The Annual Aggregate Attachment Point is the greater of:

1. the sum of the Monthly Aggregate Attachment Points of each month of the Policy Year, or
2. the Minimum Aggregate Attachment Point shown in the Application.

[whichever is greater?]

The maximum amount of Covered Expenses per Covered Person that will be applied to the Annual Aggregate Attachment Point is limited to the **Aggregate Loss Limit** shown in the Application.

Minimum Aggregate Attachment Point means an amount equal to [100%] of the product of:

1. the total number of Covered Units of the first Policy Month, multiplied by
2. the corresponding Monthly Aggregate Factors shown in the Application, multiplied by
3. [twelve].

Monthly Aggregate Attachment Point means the amount equal to the total number of Covered Units for a Policy Month multiplied by the corresponding Monthly Aggregate Factors shown in the Application.

Application means the final signed application for excess loss insurance submitted by You to Us, hereby attached to and made part of this Policy.

Benefit Percentage means the factor that determines the amount of the Maximum Benefit payable to You as shown in the Application. Separate benefit percentages may apply to either the Aggregate Excess Loss or to the Specific Excess Loss.

Benefit Period means the period of time, as shown in the Application, during which an expense must be Incurred and Paid in order to be eligible for reimbursement under this Policy.

Covered Expenses mean Reasonable and Customary Charges:

1. covered by the Plan;
2. listed as a covered benefit in the BENEFITS COVERED section of the Application;
3. Incurred during the Benefit Period by a Covered Person; and
4. Paid during the Benefit Period;

Covered Expenses do not include:

1. any payment which does not strictly comply with the provisions of the Plan;
2. any expenses which are not reimbursable under the terms, conditions, limitations and exclusions of this Policy;
3. any payment for which there is any other insurance, reinsurance or plan established pursuant to federal, state or local law or any other indemnity against Covered Expense which would, except for the existence of this Policy, indemnify the Insured;
4. extra-contractual damages of any nature, compensatory damages, exemplary and punitive damages or liabilities of any kind whatsoever, including but not limited to those resulting from negligence, intentional wrongs, fraud, bad faith or strict liability on the part of You, Your Administrator or Your agent or broker or
5. salaries paid to Your employees as well as Your claim and administrative expenses.

Covered Person means an individual eligible for coverage, and covered, under the Plan pursuant to express written provisions contained in the Plan.

Covered Unit means an employee, an employee's dependents, or such other defined unit as specifically agreed upon between You and Us.

Disclosure Statement means the disclosure statement submitted by You to Us and hereby made part of this Policy.

Deductible (Per Covered Person) means that portion of Covered Expenses for a Covered Person entirely retained by You. This amount is not eligible for reimbursement under this Policy.

[Domestic Claim means a claim for medical treatments, services or supplies that are provided to a Covered Person by a Policyholder licensed to provide such treatments, services or supplies. Domestic Claims shall not exceed [%] of the valuation (by ICD9, DRG, or CPT code) in effect as of the Effective Date of this Policy. Any subsequent change in claims valuations must be approved in advance by Us.]

[Experimental or Investigative means care, procedures, treatments, or technology that are not widely recognized and accepted as effective, safe and appropriate for the injury or illness by the medical profession in the U.S., that are in research or Investigative stage, or conducted for research or similar purposes; or for which the patient has been asked to give, or has signed, a release or other document, indicating that the treatment is Experimental or Investigative or other similar term.

In determining any of the criteria stated above We will rely on recognized medical sources such as, but not limited to the American Medical Association, the Council of Technology Assistance Program and the Council on Medical Special Services, the National Institute of Health, Medicare, the Food and Drug Administration; and other accepted medical authorities and sources.]

Incurred means the date on which the Covered Person receives a medical treatment, service or supply for which an expense is incurred.

Minimum (Aggregate/Specific) Premium means the minimum premium that must be paid for the Policy's Aggregate and/or Specific coverage to remain in force.

Paid (Pay, Payment) means that a claim has been adjudicated by Your Administrator and funds are actually disbursed by the Plan.. Payment of a claim must be unconditional and made directly to a Covered Person or their health care provider(s) prior to the expiration of the Benefit Period

Payment will be deemed made on the date that You or Your Administrator directly tenders payment by mailing, or otherwise delivering, a draft or check to the Covered Person or their health care provider(s), provided the account upon which the payment is drawn contains sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn. We may require proof of mailing or delivery of the draft or check.

[A Domestic Claim will be deemed Paid on the date the funds are disbursed by the Plan prior to the end of the Benefit Period.]

Plan means the employee benefit plan You provide Your eligible employees and their eligible dependents, which has been received and accepted by Us. Plan does not include life insurance, accidental death and dismemberment insurance, long and short-term disability insurance coverages, or fully insured major medical insurance coverages.

Policy Month is determined from the Effective Date. Each Policy Month will begin on the date of each calendar month which corresponds with the Effective Date. If there is no such date in any applicable month, then the last date of that month will be used.

Policy Year means the time period beginning on the Effective Date and ending on the Expiration Date.

Reasonable And Customary Charge means the prevailing fee for a medical treatment, service or supply in the geographical area such treatment, service or supply is provided, as determined by Medicare or another industry-recognized source of prevailing fee data which is periodically updated for inflation and adjusted for geographical location.

Run-In Expenses means Covered Expenses Incurred during the Benefit Period, but prior to the Policy Year.

Run-In Limit means the maximum amount of Run-In Expenses that will be applied to this Policy.

Run-Out Expenses means Covered Expenses Paid during the Benefit Period, but following the Policy Year.

Run-Out Limit means the maximum amount of Run-Out Expenses that will be applied to this Policy.

SECTION 2- SPECIFIC EXCESS LOSS INSURANCE

If during the Policy Year, or any part of a Policy Year, Covered Expenses for any Covered Person exceed the Deductible, We will reimburse You for such Covered Expenses in an amount equal to:

1. the amount by which Covered Expenses exceed the Deductible, multiplied by
2. the Specific Benefit Percentage.

Reimbursement under this Section shall not exceed the Specific Benefit Limit shown in the Application minus the Deductible. Further, reimbursement under this Section:

1. is determined, for any Covered Person, according to the Benefit Period;
2. is subject to all terms, conditions, limitations and exclusions in this Policy;
3. is contingent upon our receipt of proof of loss satisfactory to Us (including, without limitation, an on-site audit), and Your request for reimbursement; and
4. will not include any amounts paid or payable by Us to You for Aggregate Excess Loss Insurance according to the terms in Section 3 of this Policy.

If this Policy terminates prior to the Expiration Date, the Benefit Period will not extend past the date of termination. In addition, the deductible per Covered Person will apply as if the Policy were in force for the entire Policy Year.

SECTION 3 - AGGREGATE EXCESS LOSS INSURANCE

If at the end of a Policy Year, Covered Expenses exceed the Annual Aggregate Attachment Point, We will reimburse You for such Covered Expenses in an amount equal to:

1. the amount by which Covered Expenses exceed the Annual Aggregate Attachment Point, multiplied by
2. the Aggregate Benefit Percentage.

Reimbursement under this Section shall not exceed the Maximum Aggregate Benefit shown in the Application. Further, reimbursement under this Section:

1. is determined according to the Benefit Period;
2. is subject to all terms, conditions, limitations and exclusions in this Policy;
3. is contingent upon Our receipt of proof of loss satisfactory to Us (including, without limitation, an on-site audit), and Your request for reimbursement; and

4. will not include any amount paid or payable by Us to You for Specific Excess Loss Insurance according to the terms in Section 2 of this Policy.

If this Policy terminates prior to the Expiration Date, no Aggregate Excess Loss Benefits will be payable and premium paid will not be refundable.

SECTION 4 - EXCLUSIONS AND LIMITATIONS

Our liability under this Policy will not be increased if the Plan provides more liberal exclusions and limitations provisions.

In addition to the exclusions and limitations provided under the Plan, this Policy will not cover any of the following, unless specifically waived by rider or endorsement:

- [1. Deductibles, co-payment amounts, or any other charges which are not payable under the terms of the Plan or charges which are payable to You from any other source.]
- [2. Expenses for Experimental or Investigative services, treatments or supplies.[This exclusion does not apply if Your Plan excludes expenses for Experimental or Investigative services.]]
- [3. Expenses for drugs which have not been approved by the Food and Drug Administration.]
- [4. Any conditions for which benefits of any kind are paid or payable, by judgment or settlement, under any Worker's Compensation or occupational law, even if the Covered Person opts out of such law, or fails to claim his or her rights to such benefits.]
- [5. Expenses for a Covered Person who, on the date the Covered Person's coverage under this Policy would otherwise begin: a) is an employee who is not actively at work performing the ordinary duties of his or her job on a scheduled work day; or b) is a retired employee, or dependent of an employee, who is unable to perform the normal activities of a person of like age or sex. No reimbursement will be provided for any charges Incurred until the day after the date that such Covered Person: a) if an employee, returns to active work on a full-time basis; or b) if a retired employee or eligible dependent of an employee, is able to perform the normal activities of a person of like age and sex. This provision does not apply if Waiver of Actively at Work is approved by Us as indicated in the Application.]
- [6. Charges resulting from any extra or non-contractual damages or actions, or legal fees and expenses for the defense or litigation thereof, or any fines or statutory penalties.]
- [7. Any services furnished by an institution which is primarily a rest home, a place for the aged, a nursing home, a convalescent home, a place for custodial care, or any other place of like character.]
- [8. Legal expenses of any kind or description, including legal expenses related to or Incurred for the confinement of a Covered Person or any compulsory process to adopt, abstain from, or cease to continue a particular mode of treatment, care or therapy.]
- [9. Expenses arising out of, caused by, contributed to or in consequence of war, whether or not declared, or any act or condition incident to war. War includes civil war, insurrection, rebellion or revolution.]
- [10. Expenses for any individual covered under, or eligible for coverage under, the Consolidated Omnibus Budget Reconciliation Act (COBRA) whose continuation of coverage was not offered in accordance with COBRA regulations or any amendments thereto.]
- [11. Expenses incurred as a result of any lost savings or discounts offered by a facility or provider due to untimely Payment of the bill by You or Your Administrator.]

SECTION 5 - TERMINATION

This Policy and all coverage hereunder shall terminate upon the earliest of:

1. any premium due date, if the premium due on that date is not paid in full by the end of the Grace Period;
2. the premium due date following Our receipt of Your written notice to cancel or terminate this Policy;

3. any premium due date We specify if We give You at least [thirty-one (31) days] advance written notice to cancel or terminate this Policy;]
4. the end of the Policy Year;
5. the date of termination of the Plan or the Policy;
6. the date You suspend active business operations or become insolvent or a bankruptcy action is commenced (whether voluntary or involuntary) or You are in liquidation or receivership;
7. the date You do not Pay claims or make funds available to Pay claims as required by the Plan; or
8. the date on which Your employees are covered under another employee benefit plan or fully insured medical program.

In addition, this Policy shall automatically terminate upon the cancellation of the agreement between You and the Administrator, unless We have, prior to such cancellation, agreed in writing to Your designation of a successor Administrator.

SECTION 6 - PREMIUMS

Payment Of Premiums

No coverage under this Policy shall be in effect until the first premium for the Policy is paid. For coverage to remain in effect, each subsequent premium must be paid on or before its due date. You are responsible for paying premiums when they become due. Premium due dates are determined from the Effective Date. Each premium due date is the same day of each month corresponding with the Effective Date. If there is no such date in any applicable month, the last day of that month shall be used.

Grace Period

We will allow a [thirty-one day] Grace Period for the payment of each premium due after the payment of the first premium. During this Grace Period, this coverage shall remain in effect. If any premium is not paid within this [thirty-one day] period, coverage under this Policy will automatically terminate without further notice, and We may offset reimbursement due You against such premium. Termination will be effective as of the premium due date immediately following the end of the last period for which the minimum monthly premium has been paid.

Premium Rate Change

We have the right to modify Monthly Aggregate Factor(s) and Monthly Specific Premium Rates on any of the following dates:

1. the effective date of any change in benefits or other amendment to the Plan; or
2. the date that You acquire or dispose of any subsidiary, affiliated company, corporate division or assets relating thereto; or
3. any renewal Effective Date; or
4. any premium due date, when there is a [ten percent] or more change in the number of Covered Persons during a Policy Year; or
5. for Aggregate Excess Loss Insurance, at such time as We determine that the last [two months] of claims in the preceding Policy Year vary by more than [ten percent] from the average monthly paid claims for the prior [ten months].

SECTION 7 - YOUR DUTIES

You shall be solely responsible for investigating, auditing, calculating, adjudicating and paying all claims under the Plan, and the defense of any legal action instituted against You.

You shall maintain and make available to Us, at all times, such information and records as We may reasonably require evidencing Your proof of Payment of amounts which qualify for coverage under this Policy.

You shall maintain a record of any and all amounts paid in excess of Payments required by the Plan.

You shall prepare and submit to Us the following:

1. a monthly report of the total claims paid during the month,
2. a monthly report of the total number of Covered Units under the Plan during the month,
3. any other report as required by Us, and
4. any notice of claim as required under this Policy.

You shall maintain records reasonably required by Us and shall furnish to Us upon Our request, all pertinent data with respect to Covered Persons.

You shall immediately notify us if You acquire or dispose of any subsidiary, affiliated company, corporate division or assets relating thereto.

You shall immediately notify Us of the date that You suspend active business operations or become insolvent or a bankruptcy action is commenced (whether voluntary or involuntary) or You are in liquidation or receivership.

You may retain an Administrator as Your agent to perform any or all of the duties listed in this Section. We are not liable under this Policy for any charges or expenses that may be incurred by You and/or Your Administrator for the performance of these duties. You and the Plan acknowledge that:

1. The Administrator is not Our agent.
2. Payments by or notices from Us to the Administrator are deemed received by You upon receipt by the Administrator. Payments from You to the Administrator are not deemed received by Us. We act only as a provider of excess loss insurance coverage to the Plan. We do not act as a fiduciary. We do not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
3. We must approve, in writing, a change in Administrator prior to its occurrence. All terms and provisions of this Policy continue to apply during and after such change.

SECTION 8 - GENERAL PROVISIONS

Entire Contract

This Policy, Your Application, Your Disclosure Statement and a copy of the Plan constitute the entire contract between You and Us. We have relied upon information provided by You in issuing this Policy and You represent such information is complete and accurate. If this information is incomplete or incorrect, We have the right to terminate the Policy at any time or otherwise modify the terms, including but not limited to premiums, benefits and limitations, of this Policy as of the effective date to reflect the complete or correct information.

In the event of a conflict between the Plan and this Policy, the terms and provisions of this Policy will govern.

This Policy does not create any right or legal relationship whatsoever between Us and a Covered Person or any other beneficiary under the Plan. We shall not have any responsibility or obligation under this Policy to directly reimburse any Covered Person, or provider of professional or medical services for any benefits which are provided under the terms of the Plan. Our only liability under this Policy is to You. Only our President, Vice President or Secretary may change this Policy. No change shall be valid unless the change is agreed to by Our President, Vice President or Secretary in writing.

Other Insurance

If other insurance applies to a Covered Expense also covered under this Policy, the insurance coverage provided by this Policy shall be excess over the other insurance regardless of whether the other insurance is valid or collectible.

Offset

We reserve the right, before making payments to You under this Policy, to use the amount of payment due to offset any unpaid premiums or claims payments previously made in error.

Notice

For the purpose of any notice required under this Policy, notice to the Administrator is deemed to be notice to You, and notice to You is deemed to be notice to the Administrator.

Amendments to the Plan

You shall give Us at least 31 days written notice of any proposed Plan amendments. Amendments to the Plan are not covered under this Policy unless We have accepted the proposed change in writing, and You have agreed to pay any additional premium or to accept a higher Aggregate Monthly Factor(s) as a result of the Plan change. If You do not give Us notice of the amendment of the Plan, Our liability is limited to the lesser of the benefits payable: a) under the Plan as revised; or b) as if the Plan had not been amended.

Notice Of Potential Claim

You shall give Us written notice of any potential claim within [thirty (30) days] of the date You become aware of the existence of facts which would reasonably suggest the possibility that expenses covered under the Plan will be Incurred for which benefits may be payable under this Policy, and is equivalent to or exceeds [the lesser of [\$25,000], or][fifty percent] of the Specific Deductible amount.

This notice shall include:

1. name of the Covered Person;
2. date of accident or onset of sickness;
3. nature of injury or sickness; and
4. estimated total cost of claim.

Your failure to furnish written notice of a potential claim within [thirty (30) days] shall not invalidate or reduce the claim if it was not reasonably possible to give such notice within such time; provided that written notice is furnished to Us as soon as reasonably possible.

Claims

We shall have the sole authority to reimburse, or deny reimbursement of, Paid claims which exceed any Aggregate Attachment Point or Specific Deductible amount. Reimbursement of claims shall be administered by Us or Our authorized representative. Claims and proof of loss must be submitted within [thirty (30) days] after You have Paid Covered Expenses on behalf of any Covered Person. We are not obligated to reimburse a claim submitted after such period. However, We will reimburse such claim in the event You show that timely submission was not possible, and You made the submission as soon as possible. In no event will We reimburse claims submitted more than [one year] after the Expiration Date of the Policy .

All benefits will be paid to You as they become payable under this Policy.

Any objection, notice of legal action, or complaint, which is received on a claim processed by You or Your Administrator and on which it reasonably appears that benefits will be payable under this Policy, shall be brought to Our immediate attention.

Advanced Funding For Specific Excess Loss Insurance

The following provision applies if Advanced Funding is elected as indicated in the Application.

When a claim has been submitted to Us for reimbursement under Specific Excess Loss Insurance in compliance with all other terms and conditions of this Policy, You may request in writing, and We will consider advancing to You, the remaining eligible unpaid balance of the claim.

Advanced Funding is available only if approved in writing by Us, and is subject to the following requirements:

1. The Specific Deductible amount must be paid in full by You prior to any claims being considered for Advanced Funding. Payment of the Specific Deductible must be made at least [ten (10) business days] prior to the end of the Specific Paid Benefit Period.
2. The claim amount must be equal to or greater than \$[1,000].
3. Claims submitted for Advanced Funding must have been fully processed according to the terms of the Plan and must be ready for Payment.
4. Normal Specific claim audit procedures will be implemented prior to any checks being issued by Us.
5. Your Payment must be released to the provider within [five (5) days] of receiving the reimbursement check from Us. If these payments are not made within [five (5) days], the reimbursement check must be returned to Us.
6. Any portion of the reimbursement check not used for Payment, due to additional discounts or any other reason, must be returned to Us within [five (5) days].
7. All initial or subsequent Advance Funding claim requests must be received by Us [ten (10) business days] prior to the end of the Specific Paid Benefit Period. Any requests received after that date, are not eligible for Advance Funding and therefore, must be fully Paid by the Plan in order to be eligible for reimbursement under this Policy.

Examination Of Records

Your books and records, and the books and records of all of Your agents and representatives pertaining to the Plan and/or insurance provided by this Policy shall be available to Us and Our representatives during Your regular business hours for inspection and audit.

Clerical Error

Clerical error will not invalidate insurance otherwise in effect, expand our obligations under this Policy, or continue insurance validly terminated. A clerical error is a mistake in writing or copying, and does not include intentional acts or the failure to comply with the Plan or this Policy, including but not limited to failure to comply with disclosure requirements and with claims notification requirements.

If an clerical error is discovered, an equitable adjustment in premium will be made. If a premium and/or factor(s) adjustment involves the return of unearned premium, the amount of the return will be limited to the premium for the [twelve month] period which precedes the date that We receive proof that such an adjustment should be made.

Conformity With State Statutes

If any provision of this Policy or its Effective Date conflicts with any applicable law, the provision will be deemed to conform with the minimum requirements of such law.

Assignment

Your interest under this Policy is not assignable and any attempt to assign Your interest shall be null and void.

Non-Participating

This Policy is non-participating and does not entitle You to share in Our earnings.

Legal Action Against Us

No person or organization may bring a legal action against Us under this Policy unless:

1. There has been full compliance with all of the terms of this Policy;
2. The action is brought in the United States of America, in a court having proper jurisdiction, within [three years] after the Covered Expense for which benefits are claimed has been Incurred; and
3. [sixty (60) days] have elapsed since the date that a written request for reimbursement has been submitted to Us.

Renewal

At the end of a Policy Year, a subsequent Policy Year may be agreed to by You and Us. We may request a new Disclosure Form or additional information before approving a subsequent Policy Year. We will issue to you a new Policy face page and a new Application to show the coverage and terms in effect during each subsequent Policy Year. If, within [ninety (90) days] after the proposed Effective Date of the Renewal, We do not receive from You:

- 1) a signed copy of the Disclosure Form and additional information, if requested by Us; and
- 2) a signed copy of the Renewal Application,

any Renewal premium submitted to Us will be refunded and coverage will be automatically null and void retroactive to the proposed Effective Date.

Waiver

Our failure to require Your strict compliance with any requirement or provision of the Policy at any time, under any circumstance, shall not constitute a waiver of such requirement or provision by Us at any time under the same or different circumstances.

Subrogation

You shall pursue any and all valid claims against third parties arising out of any occurrence resulting in a Covered Expense payment under the Plan in accordance with applicable law. You shall account for any amounts recovered. Should You fail to pursue any valid claims against third parties for good cause and We then become liable to make payment to You under the terms and conditions of the Policy, then We shall be subrogated to all of Your rights to all recoveries from a third party (whether by lawsuit, settlement, or otherwise) for that portion of the total recovery which is due Us for reimbursements made to You; but only to the extent that said settlement or judgment specifically allocates a portion thereof to Covered Expenses Incurred by a Covered Person prior to the date of settlement or judgment. Our share of the recovery shall not be reduced because the Covered Person has not received the full damages claimed, unless We agree in writing to a reduction.

You shall take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our rights, and shall take no action prejudicing Our rights and interests under this Policy.

Any amounts that We recover shall be used to pay Our expenses of collection, and to reimburse Us for any amount that We may have paid, or become liable to pay, to You under the terms of this Policy. All remaining amounts shall be paid to You.

Medicare

This Policy does not provide benefits for any Covered Expense for which payment has been made or would have been made, if an application had been made or eligibility maintained, under Part A or Part B of Medicare.

Reinstatement

We may agree at Our sole option and without prejudice to Our rights under this Policy to reinstate coverage as of the effective date of cancellation, on receipt and approval of written request for reinstatement and any and all other material and/or information as We may request, including but not limited to all outstanding premiums plus interest due from the effective date of reinstatement at a rate of not less than 1.5% per month compounded monthly. No insurance shall be reinstated until We confirm such reinstatement to You in writing and any premiums have been paid.

Liability And Indemnification

Except as specifically provided in any rider or endorsement, attached to and forming part of the Policy, We have no obligation to any third party. Our liability under this Policy is limited to reimbursing You, pursuant to the terms of this Policy, for payments You make on behalf of Covered Persons for expenses covered under the Plan. You shall defend, indemnify and otherwise hold Us harmless from and against any damage, loss, claim, cost and expense asserted by any third-party: i) resulting from or in any manner

arising out of any medical treatment, service or supply; and ii) which is not caused by Our own acts or omissions. We are not responsible for any liability You assume under any contract of agreement other than the Plan.

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)

Administrative Office:
485 Madison Avenue
New York, New York 10022
212-355-4141

APPLICATION FOR EXCESS LOSS INSURANCE

1. Name of Applicant: _____
Address (Street, City, State, Zip) : _____
2. Industry/Business Type and Description: _____
3. Name and Addresses of Subsidiaries to be covered (attach additional pages if necessary):

Name	Address (City, State, Zip)
_____	_____
_____	_____
4. Number of Employees covered under the Applicant's Plan at all Locations listed above:
Single: _____ Family: _____ Composite: _____
COBRA Continuees: _____ Retirees: _____ On a Leave of Disability _____

Note: If your health insurance plan does not cover employees retired or on a leave of disability, indicate 0.
5. Name of Your Administrator: _____
Address (Street, City, State, Zip): _____
6. Policy Effective Date: _____ Policy Expiration Date: _____

ALL AMOUNTS AND NUMBERS SHOWN IN THIS APPLICATION APPLY ONLY TO THE POLICY YEAR IN EFFECT. A NEW APPLICATION WILL BE COMPLETED FOR EACH NEW POLICY YEAR.

A. SPECIFIC EXCESS LOSS INSURANCE

1. Benefits Covered: [Medical] [Prescription Drug Card]
 2. Benefit Period:
[[covered subsidiary or class (additional as needed):
Expenses Incurred from _____ through _____, and
Paid from _____ through _____.]
 3. Deductible (per Covered Person)..... \$ _____
[Except for the following:
a. [_____]: \$ _____
b. [_____]: \$ _____
c. [_____]: \$ _____]
- [Aggregating Specific Deductible \$ _____]

4. Specific Benefit Percentage %

[5. Specific Benefit Limit per Covered Person:

Lifetime Limit: \$ _____

Annual Limit: \$ _____ [for the period of ADD DATE through ADD DATE]]

[6. [Run-In/Run-Out] Limit:

a. [_____]: \$ _____

b. [_____]: \$ _____

c. [_____]: \$ _____]

[7]. Monthly Specific Premium Rate/Enrollment:

[[covered subsidiary or class (additional as needed):]

RATE:

COVERED UNITS/ENROLLMENT:

Single/Employee: _____

Single/Employee: _____

Family/Dependent: _____

Family/Dependent: _____

Composite: _____

Composite: _____]

[8]. Minimum Specific Premium (Annual / Monthly) \$ _____

B. AGGREGATE EXCESS LOSS INSURANCE

1. Benefits Covered: [Medical][Dental] [Weekly Income] [Vision] [Prescription Drug Card] [Other: _____]

2. Benefit Period

[[covered subsidiary or class (additional as needed):]

Expenses Incurred from _____ through _____, and Paid from _____ through _____.]

3. Minimum Aggregate Attachment Point..... \$ _____

4. Aggregate Loss Limit (per person) \$ _____

5. Aggregate Benefit Percentage %

6. Maximum Aggregate Benefit \$ _____

7. [Run-In/Run-out] Limit: \$ _____

8. Monthly Aggregate Factors/Enrollment:

[[covered subsidiary or class (additional as needed):]

FACTORS:

COVERED UNITS/ENROLLMENT:

Single/Employee: _____

Single/Employee: _____

Family/Dependent: _____

Family/Dependent: _____

Composite: _____

Composite: _____]

9. Aggregate Premium (Annual / Per Employee Per Month) \$ _____

10. Minimum Aggregate Premium (Annual / Monthly)..... \$ _____

11. Premium Payment Mode..... _____

C. OPTIONS*

- | | |
|---|---|
| <input type="checkbox"/> Waiver of Actively at Work | <input type="checkbox"/> Aggregating Specific Rider |
| <input type="checkbox"/> Advanced Funding | <input type="checkbox"/> Aggregate Monthly Cumulative Accommodation |
| <input type="checkbox"/> Retiree Expenses Included in Coverage
[Limited to: _____] | <input type="checkbox"/> Specific Excess Loss Terminal Liability |
| | <input type="checkbox"/> Aggregate Excess Loss Terminal Liability |
| | <input type="checkbox"/> Specific Deductible Cap Rider |
| | <input type="checkbox"/> Independent Review Organization Rider |

* Subject to approval.]

A deposit of \$ _____ is enclosed to apply to the first payment under the Policy, if issued. If the Application is not accepted, the deposit will be returned. **It is understood and agreed that:**

- a) **Any Excess Loss Insurance resulting from this Application shall be as described in and subject to the terms and provisions of the Policy, when issued, and shall not become effective until approved by the Company.** The Policy shall become effective on the date specified in this Application; provided that, including, without limitation: (1) a true and correct Disclosure Statement signed by you has been received, (2) the underwriting requirements have been satisfied, (3) the required premiums have been paid, and (4) a copy of the executed Plan is received and acceptable to Independence American Insurance Company Life Insurance Company of New York, (the "Company") pursuant to paragraph b) below. If any of these requirements are not satisfied within [90] days from the proposed effective date indicated in this Application, all premiums will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- b) The Applicant shall furnish to **[MGU NAME ("MGU") or]** the Company a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of **[MGU or]** the Company. No Policy will be effective nor claim reimbursed until such time as the Plan is received and accepted by the Company. If in the sole judgment of **[MGU or]** the Company there is a material variance between the provisions of the Plan received by **[MGU or]** the Company, and the Plan provisions upon which the terms and rates of the aggregate and specific excess coverage were based, **[MGU or]** the Company may, at its option, notify the Applicant of such variances and decline to issue the Policy until such time as an amended Plan is received and accepted. If such amended Plan is not received and accepted by **[MGU or]** the Company within [30] days of such notice, all premiums will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- c) The Applicant will provide or employ supervision and claim administration facilities acceptable to **[MGU or]** the Company to administer the Plan and to process and pay claims according to the Plan.
- d) The receipt by the Company of the deposit listed above and the deposit of any check drawn in connection with this Application shall not constitute any agreement to issue a policy or acceptance of liability. In the event that the Company does not approve this Application, its sole obligation shall be to refund the deposit to the Applicant.
- e) The Applicant represents that the statements and declarations made in this Application, the Disclosure Statement, and in the Plan referred to in this Application are true and complete and that the Policy, when issued, will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this Application, the Policy, and the Plan shall embody all agreements existing between the Applicant and the Company, or any of their respective agents, relating to this Excess Loss Insurance for which this Application is being made.
- f) If approved, this Application: 1) supersedes and replaces prior Applications approved by the Company; and 2) will be attached to and made part of the Policy issued by the Company.

By signing below, the Applicant hereby applies for the coverage stated in this Application. The Applicant represents that it has, directly or through its authorized agent, read this Application in its entirety and has been given the opportunity to ask any questions it may have. The Applicant further understands that the insurance requested does not start unless this Application is approved and accepted by **[MGU NAME or]** the Company. The Applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the Applicant may experience losses that are not covered under the policy or under any prior or subsequent coverage.

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.

Applicant: _____	_____
Signature: _____	Licensed Agent's Signature
Print Name: _____	Print Name _____
Title: _____	Date: _____
Date: _____	

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed [five thousand dollars] and the stated value of the claim for each such violation.

For applicants in ALASKA, DELAWARE, IDAHO, INDIANA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For applicants in CALIFORNIA: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For applicants in ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

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

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

For applicants in KENTUCKY, NEW HAMPSHIRE, NEW MEXICO, NORTH DAKOTA, OHIO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in MINNESOTA: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, is guilty of a crime.

For applicants in OKLAHOMA: **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claims for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For applicants in OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime.

For applicants in MAINE, TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)
("We", "Us", "Our")

AGGREGATING SPECIFIC RIDER

RIDER NUMBER:

EFFECTIVE DATE:

POLICY NUMBER:

POLICYHOLDER:

The parties shall refer to the Policy for the definitions of the terminology used in this Rider.

As of the Effective Date shown above, and regardless of anything in the Policy to the contrary, this Rider changes the Policy as follows:

You hereby agree to retain the first \$ _____ of Covered Expenses which exceed the Specific Deductible shown on the Application. This amount, Your "**Self Funded Liability**", is not eligible for reimbursement under the Policy.

Self-Funded Liability:

1. is determined at the start of the Policy Year.
2. is based on the size of the Specific Deductible and overall premium level and in accordance with Our actuarial tables.
3. includes charges due to an individual Covered Expense or multiple Covered Expenses.
4. must be Paid in its entirety by You before the balance of any Specific Excess Loss is reimbursed to You by Us in accordance with the Policy.
5. must be met only once during the Policy Year.

[Expenses incurred for the following individuals DO NOT count toward satisfaction of Your Self-Funded Liability: _____.]

The Policy is changed only as stated in this Rider. All provisions not changed by this Rider shall apply.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David T. Kettig
President



Adam C. Vandervoort
Secretary

AGREED:

Policyholder: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)
("We", "Us", "Our")

AGGREGATE EXCESS LOSS TERMINAL LIABILITY RIDER

RIDER NUMBER:

EFFECTIVE DATE:

POLICY NUMBER:

POLICYHOLDER:

The parties shall refer to the Policy for the definitions of the terminology used in this Rider.

As of the Effective Date shown above, and regardless of anything in the Policy to the contrary, this Rider changes the Policy as follows:

If, no later than [sixty (60)] days before the Expiration Date of the Policy, You notify Us of Your intent not to renew the Policy, the [Benefit Period and the] Monthly Aggregate Factor(s) shown under Section B., AGGREGATE EXCESS LOSS INSURANCE, of the Application, are changed as follows:

[a. **BENEFIT PERIOD:**
[[covered subsidiary or class (additional as needed):]
Expenses Incurred from _____ through _____ and Paid from
through _____.]

If this Policy terminates prior to the Expiration Date, no Aggregate Excess Loss Benefits will be payable and the premium paid will not be refundable.

b.] **MONTHLY AGGREGATE FACTOR(S):**
[[covered subsidiary or class (additional as needed):]
FACTORS:
Single/Employee: _____
Family/Dependent: _____
Composite: _____]

All Aggregate Excess Loss benefits payable under the Policy will be calculated based on the [Benefit Period and] Monthly Aggregate Factor(s) shown above. [Coverage will be provided under this Rider for Covered Expenses: a) only to the extent that such Covered Expenses are not eligible for coverage under any other group policy; and b) only if Covered Persons will be covered under fully-insured medical insurance immediately following the Expiration Date of the Policy.]

[Premium

This Rider is added to the Policy in consideration of the Aggregate Terminal Liability Premium, which is [\$xx.xx per Covered Person per Policy Month.][the greater of:

1. [20% of the Minimum Monthly Aggregate Premium multiplied by [twelve (12)]], or
2. [\$2,000].]

This Aggregate Terminal Liability Premium is non-refundable and payable in full on the Effective Date of the Policy.]

The Policy is changed only as stated in this Rider. All provisions not changed by this Rider shall apply.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David T. Kettig
President



Adam C. Vandervoort
Secretary

AGREED:

Policyholder: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)
(“We”, “Us”, “Our”)

CUMULATIVE SPECIFIC POLICY RIDER

RIDER:

EFFECTIVE DATE:

POLICY NUMBER:

POLICYHOLDER:

The parties shall refer to the Policy for the definitions of the terminology used in this Rider.

As of the Effective Date shown above, and regardless of anything in the Policy to the contrary, this Rider changes the Policy as follows:

Section A.5. of the Application is deleted and replaced with the following:

5. Specific Benefit Limit per Covered Person:

Lifetime Limit: \$ _____

Annual Limit: \$ _____ [for the period of ADD DATE through ADD DATE]

[Lifetime] [and] [Annual] Limit is limited to \$[xxx] per occurrence for all Covered Persons combined.

The Policy is changed only as stated in this Rider. All provisions not changed by this Rider shall apply.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David T. Kettig
President



Adam C. Vandervoort
Secretary

AGREED:

Policyholder: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)
(“We”, “Us”, “Our”)

DISCLOSURE STATEMENT

As an integral part of the application for excess loss coverage, Independence American Insurance Company (the Company) requires that the applicant provide information concerning the following individuals no earlier than [30] days prior to the requested effective date:

- a) Individuals who received medical services during the past [12] months (whether paid, pending, processed, unprocessed, denied or under appeal), the cost of which exceeds [\$25,000] or [50%] of the requested Specific Deductible amount, whichever is less.
- b) Individuals who have been identified as candidates for medical case management or have the potential to exceed, during the Policy period, [\$25,000] or [50%] of the requested Specific Deductible amount, whichever is less. “Medical case management” means a collaborative process that facilitates recommended treatment plans to assure the appropriate medical care is provided to disabled, ill or injured individuals.
- c) Individuals currently confined to a hospital or other health care facility, or currently approved for a future hospital or other health care facility admission, or had a hospital stay of 10 days or longer in the past 12 months.
- d) Employees not actively at work on a full time basis as of the date of this statement.
- e) Dependents of any Employee who are confined to a hospital, institution, or home or otherwise unable to perform the duties of a like person of the same age and sex and in good health, as of the date of this statement.
- f) Any individual who has a history of, is being evaluated for, is wait-listed for, has a condition which could lead to, an organ transplant.
- g) Any other individuals who, during the past [12] months, have been diagnosed with, or treated for, a condition represented by any of the ICD-9 codes contained in the attached list, regardless of current claim amount.
- h) Any individual receiving short term disability, long term disability, or salary continuance of any kind, and/or currently n an extension of benefits, FMLA, COBRA continuation, or any other type of leave of absence.

Please attach the following information for each individual meeting any of the above criteria:

- | | |
|---|-----------------------------|
| • NAME | • TRANSPLANT CANDIDATE |
| • DATE OF BIRTH | • DATE OF DISABILITY |
| • GENDER | • DATE EXPECTED RTW |
| • Status: EMPLOYEE, DEPENDENT,
RETIREE, COBRA BEN. | • COBRA EFFECTIVE/END DATES |
| • DIAGNOSIS | • PAID CLAIMS |
| • PROGNOSIS | • ADDITIONAL KNOWN CLAIMS |

The Employer named below, through its authorized person, hereby represents that the attached information is true, complete and accurate to the best of its knowledge and belief after due inquiry and that of its agents,

administrators, and brokers, and that nothing has been knowingly or intentionally omitted. The Employer hereby further agrees that: 1) if the information provided in this statement is not true, complete and accurate, the excess loss coverage may be re-rated from the effective date of coverage; and 2) any individual who has incurred a medical expense may be retroactively excluded from coverage, unless disclosed by Employer and approved in writing by the Company [and **MGU NAME**]. The Company reserves the right to set a higher aggregate or specific deductible on, or limit the benefit eligibility period or other policy benefits for, any individual who has or should have been listed above. The Employer represents that its administrator, utilization review vendor and large claim management service organization participated in the collection of the above data.

The Company [and **MGU NAME**] shall use the information requested herein solely for the purpose of evaluating the acceptability of this risk and shall not disclose any nonpublic personal information collected except in evaluating the acceptability of this risk.

EMPLOYER: _____ ADMINISTRATOR: _____

Date of Disclosure: _____ Date of Disclosure: _____

Authorized Representative: _____ Authorized Representative: _____

Title: _____ Signature: _____

Signature: _____

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)
(“We”, “Us”, “Our”)

INDEPENDENT REVIEW ORGANIZATION RIDER

RIDER NUMBER:

EFFECTIVE DATE:

POLICY NUMBER:

POLICYHOLDER:

The parties shall refer to the Policy for the definitions of terminology not defined in this Rider.

As of the Effective Date shown above, and regardless of anything in the Policy to the contrary, this Rider changes the Policy as follows:

In the event an Independent Review Organization (“IRO”) overturns an Adverse Benefit Determination (“ABD”), and You are required to pay the claim that is subject to the ABD, such claim will be:

- [1. deemed Paid on the date the ABD is sent to the Covered Person; and]
- [2. eligible for reimbursement under the Policy, subject to all terms, conditions, limitations and exclusions of the Policy.]

For a claim to be reimbursable under this Rider:

- [1. the ABD must be sent to the Covered Person before Paid Benefit Period expires;]
- [2. the claim must be paid within 30 days following the IRO decision to overturn the ABD; and]
- [3. We must be notified by You in writing [within 30 days following] the end of the Paid Benefit Period that the ABD, if overturned, may result in a Specific Excess Loss claim under the Policy.]

“Adverse Benefit Determination” means an adverse benefit determination as defined in 29 CFR 2560.503-1.

“Independent Review Organization” means an organization that is accredited by the Utilization Review Accreditation Committee, or by a similar nationally recognized accrediting organization, to conduct external review of Adverse Benefit Determinations in accordance with the Patient Protection and Affordable Care Act.

The Policy is changed only as stated in this Rider. All provisions not changed by this Rider shall apply.



David T. Kettig
President



Adam C. Vandervoort
Secretary

AGREED:

Policyholder: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)
("We", "Us", "Our")

MONTHLY CUMULATIVE ACCOMMODATION FOR AGGREGATE EXCESS LOSS RIDER

RIDER NUMBER:

EFFECTIVE DATE:

POLICY NUMBER:

POLICYHOLDER:

This Rider includes capitalized words and phrases that have special meaning. The Policyholder is referred to the SECTION 1 –DEFINITIONS of the Policy for the definition of the terminology used, but not defined, in this Rider.

As of the Effective Date shown above, and regardless of anything in the Policy to the contrary, this Rider changes the Policy as follows:

If, at the end of a Policy Month, Your Cumulative Covered Expenses exceed the Cumulative Aggregate Attachment Point by an amount greater than [\$1,000], We will release to You the amount by which Your Cumulative Covered Expenses exceed the Cumulative Aggregate Attachment Point for that month.

DEFINITIONS

Cumulative Aggregate Attachment Point means the greater of:

1. the sum of the Monthly Aggregate Attachment Point for all Policy Months of the Cumulative Period; or
2. the Monthly Aggregate Attachment Point for the first month of the Policy Year, times the number of Policy Months.

Cumulative Covered Expenses means the total amount that You have paid as benefits under Your Plan during the Cumulative Period.

Cumulative Covered Expenses does not include amounts:

1. We have paid to You, or You are eligible to receive, as Specific Excess Loss Insurance benefits during the Policy Year;
2. Paid under Your Plan which exceed the Specific Benefit Limit under the Policy; or
3. which are not Covered Expenses.

Cumulative Period means the period which:

1. begins on the Effective Date of the Policy or, if later, on the Date of this Rider; and
2. ends on the last day of any Policy Month after the first, and prior to the last, month of the Policy Year.

Net Amount means all amounts that We have released to You, less the amounts that You have returned to Us under this Rider.

AMOUNTS RELEASED

Amounts released by Us:

1. will at all times be considered Our funds;

2. will be subject to all the terms of the Policy, including but not limited to Our receipt of Your request for reimbursement, and proof of loss satisfactory to Us;
3. shall not exceed the Maximum Aggregate Benefit payable by Us as indicated in the Application; and
4. are not loans or advances of benefits payable under the Policy.

We will only release amounts under this Rider if You have paid to Us:

1. all premiums due through the Cumulative Period; and
2. all amounts which You are required to return to Us, in accordance with the following paragraph:

REPAYMENT OF AMOUNTS RELEASED

Amounts which We release under this Rider must be returned to Us, in part or the entire amount, if during any subsequent Policy Month Your Cumulative Aggregate Attachment Point is greater than Your Cumulative Covered Expenses.

Your refund to Us:

1. will not exceed the amount We have released to You under this Rider;
2. will not be carried over into any subsequent Policy Month, or Policy Year; and
3. is due and payable within [thirty (30)] days of the end of the prior Policy Month's reporting period.

YEAR-END ADJUSTMENT

At the end of the Policy Year, We will determine the Annual Aggregate Attachment Point without regard to this Rider.

We will reimburse You for any amount by which Cumulative Covered Expenses are in excess of the greater of:

1. the Annual Aggregate Attachment Point, or
2. the Minimum Aggregate Attachment Point less any Net Amounts previously paid.

We will reimburse You only if all premiums due have been paid, and all amounts You must return to Us under this Rider have been paid to Us.

You must reimburse Us for any amount by which the greater of:

1. the Annual Aggregate Attachment Point, or
2. the Minimum Aggregate Attachment Point exceeds the Cumulative Covered Expenses.

No benefits will be paid under the Policy or this Rider until We have received all amounts You must return to Us under this Rider. If You do not pay the amounts due within the time allowed:

1. We reserve the right to reduce any benefits payable under other terms of the Policy by such amounts;
2. You shall be liable for a monthly late penalty, equal to [1% per month] of the amount due Us; and
3. You will be liable for all costs and expenses, including attorney fees, which We incur in the collection of such amounts.

You must reimburse Us for the amounts due under this Rider within [thirty (30)] days of Our notice to You.

TERMINATION PRIOR TO END OF POLICY PERIOD

If the Policy is canceled or terminated prior to the end of the Policy Year, You must pay Us all amounts We have paid You under this Rider, and no coverage is in effect.

TERMINATION OF THIS RIDER

This Rider shall terminate automatically upon termination of the Policy or the Plan. Termination of this Rider shall not terminate Your obligation to pay Us any amounts due under this Rider.

REPORTING REQUIREMENTS

You must submit to Us, within [thirty (30)] days of the end of each Policy Month, a report of Covered Expenses Paid by You during that month.

PREMIUM

[This Rider is added to the Policy in consideration of the greater of:

- 1. [1.00 per member per month] of the Aggregate Premium payable on the premium due date of each month; or
- 2. [multiply number of employee's times 1.00 times 12] for the Policy Year.];

This Policy is changed only as stated in this Rider. All other terms and conditions of the Policy not changed by this Rider shall remain in effect.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David T. Kettig
President



Adam C. Vandervoort
Secretary

AGREED:

Policyholder: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)
("We", "Us", "Our")

SPECIFIC DEDUCTIBLE CAP RIDER

RIDER NUMBER:

EFFECTIVE DATE:

POLICY NUMBER:

POLICYHOLDER:

The parties shall refer to the Policy for the definitions of the terminology used in this Rider. As of the Effective Date and regardless of anything in the Policy to the contrary, this Rider changes the Policy as follows:

If You and We agree to a subsequent Policy Year [at the Specific Deductible level, and on the same Policy terms, in effect for the current Policy Year], such subsequent Policy Year will be issued subject to the following:

- [1. There will be no increase in Specific Deductible amounts listed in Application Section A.3., **Specific Deductible (Per Covered Person).**]
- [2. No additional Covered Persons will be added to Application Section A.3., **Specific Deductible (Per Covered Person).**]
- [3. Deductibles on Covered Persons listed in Application Section A.3. will be limited to the greater of [\$000,000] or [two times] the **Specific Deductible (Per Covered Person).**]
- [4. The premium rate for Specific Excess Loss Insurance will increase by no more than _____%.]

This Rider is added to the Policy in consideration of the Specific Deductible Cap premium, which is [\$xx.xx per Covered Person per Policy Month].

The Policy is changed only as stated in this Rider. All provisions not changed by this Rider shall apply.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David T. Kettig
President



Adam C. Vandervoort
Secretary

AGREED:

Policyholder: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)
("We", "Us", "Our")

SPECIFIC EXCESS LOSS TERMINAL LIABILITY RIDER

RIDER NUMBER:

EFFECTIVE DATE:

POLICY NUMBER:

POLICYHOLDER:

The parties shall refer to the Policy for the definitions of the terminology used in this Rider.

As of the Effective Date shown above, and regardless of anything in the Policy to the contrary, this Rider changes the Policy as follows:

If, no later than [sixty (60)] days before the Expiration Date of the Policy, You notify Us of Your intent not to renew the Policy, the Benefit Period under Section A. SPECIFIC EXCESS LOSS INSURANCE, of the Application, is changed as follows:

BENEFIT PERIOD:

[[covered subsidiary or class (additional as needed):]

Expenses Incurred from _____ through _____ and Paid from _____ through _____.]

If this Policy terminates prior to the Expiration Date, the Benefit Period will not extend past the date of termination. In addition, the deductible per Covered Person will apply as if the Policy were in force for the entire Policy Year.

All Specific Excess Loss benefits payable under the Policy will be calculated based on the Benefit Period shown above. [Coverage will be provided under this Rider for Covered Expenses: a) only to the extent that such Expenses are not eligible for coverage under any other group policy; and b) only if Covered Persons will be covered under fully-insured medical insurance immediately following the Expiration Date of the Policy.]

[Premium

This Rider is added to the Policy in consideration of the Specific Terminal Liability Premium, which is [\$xx.xx per Covered Person per Policy Month.][the greater of:

1. [20% of the Minimum Specific Premium multiplied by [twelve (12)]]; or
2. [\$2,000].]

The Specific Terminal Liability Premium is non-refundable and payable in full on the Effective Date of the Policy.]

The Policy is changed only as stated in this Rider. All provisions not changed by this Rider shall apply.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David T. Kettig
President



Adam C. Vandervoort
Secretary

AGREED:

Policyholder: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

SERFF Tracking Number: MADS-128016821 State: Arkansas
 Filing Company: Independence American Insurance Company State Tracking Number:
 Company Tracking Number: SL2011 - IAIC AR
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Stop Loss
 Project Name/Number: Stop Loss/SL2011

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Application	Approved	01/30/2012
Comments: Attached you will find the application which is a new application to be used with the policy being filed.		
Attachment: SL2011-APP-IAIC-AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved	01/30/2012
Comments:		
Attachment: Certification of 23-79-138.pdf		

	Item Status:	Status Date:
Satisfied - Item: Flesch - Certification of Flesch Reading Ease Score	Approved	01/30/2012
Comments:		
Attachment: Flesch.pdf		

	Item Status:	Status Date:
Satisfied - Item: Actuarial Memorandum	Approved	01/30/2012
Comments:		
Attachment: Actuarial Memorandum.pdf		

INDEPENDENCE AMERICAN INSURANCE COMPANY
(a Delaware Stock Property and Casualty Insurance Company)

Administrative Office:
485 Madison Avenue
New York, New York 10022
212-355-4141

APPLICATION FOR EXCESS LOSS INSURANCE

1. Name of Applicant: _____
Address (Street, City, State, Zip) : _____
2. Industry/Business Type and Description: _____
3. Name and Addresses of Subsidiaries to be covered (attach additional pages if necessary):

Name	Address (City, State, Zip)
_____	_____
_____	_____
4. Number of Employees covered under the Applicant's Plan at all Locations listed above:
Single: _____ Family: _____ Composite: _____
COBRA Continuees: _____ Retirees: _____ On a Leave of Disability _____

Note: If your health insurance plan does not cover employees retired or on a leave of disability, indicate 0.
5. Name of Your Administrator: _____
Address (Street, City, State, Zip): _____
6. Policy Effective Date: _____ Policy Expiration Date: _____

ALL AMOUNTS AND NUMBERS SHOWN IN THIS APPLICATION APPLY ONLY TO THE POLICY YEAR IN EFFECT. A NEW APPLICATION WILL BE COMPLETED FOR EACH NEW POLICY YEAR.

A. SPECIFIC EXCESS LOSS INSURANCE

1. Benefits Covered: [Medical] [Prescription Drug Card]
 2. Benefit Period:
[[covered subsidiary or class (additional as needed):
Expenses Incurred from _____ through _____, and
Paid from _____ through _____.]
 3. Deductible (per Covered Person)..... \$ _____
[Except for the following:
a. [_____]: \$ _____
b. [_____]: \$ _____
c. [_____]: \$ _____]
- [Aggregating Specific Deductible \$ _____]

4. Specific Benefit Percentage %

[5. Specific Benefit Limit per Covered Person:

Lifetime Limit: \$ _____

Annual Limit: \$ _____ [for the period of ADD DATE through ADD DATE]]

[6. [Run-In/Run-Out] Limit:

a. [_____]: \$ _____

b. [_____]: \$ _____

c. [_____]: \$ _____]

[7]. Monthly Specific Premium Rate/Enrollment:

[[covered subsidiary or class (additional as needed):]

RATE:

Single/Employee: _____

Family/Dependent: _____

Composite: _____

COVERED UNITS/ENROLLMENT:

Single/Employee: _____

Family/Dependent: _____

Composite: _____]

[8]. Minimum Specific Premium (Annual / Monthly) \$ _____

B. AGGREGATE EXCESS LOSS INSURANCE

1. Benefits Covered: [Medical][Dental] [Weekly Income] [Vision] [Prescription Drug Card] [Other: _____]

2. Benefit Period

[[covered subsidiary or class (additional as needed):]

Expenses Incurred from _____ through _____, and Paid from _____ through _____.]

3. Minimum Aggregate Attachment Point..... \$ _____

4. Aggregate Loss Limit (per person) \$ _____

5. Aggregate Benefit Percentage %

6. Maximum Aggregate Benefit \$ _____

7. [Run-In/Run-out] Limit: \$ _____

8. Monthly Aggregate Factors/Enrollment:

[[covered subsidiary or class (additional as needed):]

FACTORS:

Single/Employee: _____

Family/Dependent: _____

Composite: _____

COVERED UNITS/ENROLLMENT:

Single/Employee: _____

Family/Dependent: _____

Composite: _____]

9. Aggregate Premium (Annual / Per Employee Per Month) \$ _____

10. Minimum Aggregate Premium (Annual / Monthly)..... \$ _____

11. Premium Payment Mode..... _____

C. OPTIONS*

- | | |
|---|---|
| <input type="checkbox"/> Waiver of Actively at Work | <input type="checkbox"/> Aggregating Specific Rider |
| <input type="checkbox"/> Advanced Funding | <input type="checkbox"/> Aggregate Monthly Cumulative Accommodation |
| <input type="checkbox"/> Retiree Expenses Included in Coverage
[Limited to: _____] | <input type="checkbox"/> Specific Excess Loss Terminal Liability |
| | <input type="checkbox"/> Aggregate Excess Loss Terminal Liability |
| | <input type="checkbox"/> Specific Deductible Cap Rider |
| | <input type="checkbox"/> Independent Review Organization Rider |

* Subject to approval.]

A deposit of \$ _____ is enclosed to apply to the first payment under the Policy, if issued. If the Application is not accepted, the deposit will be returned. **It is understood and agreed that:**

- a) **Any Excess Loss Insurance resulting from this Application shall be as described in and subject to the terms and provisions of the Policy, when issued, and shall not become effective until approved by the Company.** The Policy shall become effective on the date specified in this Application; provided that, including, without limitation: (1) a true and correct Disclosure Statement signed by you has been received, (2) the underwriting requirements have been satisfied, (3) the required premiums have been paid, and (4) a copy of the executed Plan is received and acceptable to Independence American Insurance Company Life Insurance Company of New York, (the "Company") pursuant to paragraph b) below. If any of these requirements are not satisfied within [90] days from the proposed effective date indicated in this Application, all premiums will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- b) The Applicant shall furnish to **[MGU NAME** ("MGU") or] the Company a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of **[MGU or]** the Company. No Policy will be effective nor claim reimbursed until such time as the Plan is received and accepted by the Company. If in the sole judgment of **[MGU or]** the Company there is a material variance between the provisions of the Plan received by **[MGU or]** the Company, and the Plan provisions upon which the terms and rates of the aggregate and specific excess coverage were based, **[MGU or]** the Company may, at its option, notify the Applicant of such variances and decline to issue the Policy until such time as an amended Plan is received and accepted. If such amended Plan is not received and accepted by **[MGU or]** the Company within [30] days of such notice, all premiums will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- c) The Applicant will provide or employ supervision and claim administration facilities acceptable to **[MGU or]** the Company to administer the Plan and to process and pay claims according to the Plan.
- d) The receipt by the Company of the deposit listed above and the deposit of any check drawn in connection with this Application shall not constitute any agreement to issue a policy or acceptance of liability. In the event that the Company does not approve this Application, its sole obligation shall be to refund the deposit to the Applicant.
- e) The Applicant represents that the statements and declarations made in this Application, the Disclosure Statement, and in the Plan referred to in this Application are true and complete and that the Policy, when issued, will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this Application, the Policy, and the Plan shall embody all agreements existing between the Applicant and the Company, or any of their respective agents, relating to this Excess Loss Insurance for which this Application is being made.
- f) If approved, this Application: 1) supersedes and replaces prior Applications approved by the Company; and 2) will be attached to and made part of the Policy issued by the Company.

By signing below, the Applicant hereby applies for the coverage stated in this Application. The Applicant represents that it has, directly or through its authorized agent, read this Application in its entirety and has been given the opportunity to ask any questions it may have. The Applicant further understands that the insurance requested does not start unless this Application is approved and accepted by **[MGU NAME or]** the Company. The Applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the Applicant may experience losses that are not covered under the policy or under any prior or subsequent coverage.

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.

Applicant: _____	_____
Signature: _____	Licensed Agent's Signature
Print Name: _____	Print Name _____
Title: _____	Date: _____
Date: _____	

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed [five thousand dollars] and the stated value of the claim for each such violation.

For applicants in ALASKA, DELAWARE, IDAHO, INDIANA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For applicants in CALIFORNIA: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For applicants in ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

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

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

For applicants in KENTUCKY, NEW HAMPSHIRE, NEW MEXICO, NORTH DAKOTA, OHIO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in MINNESOTA: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, is guilty of a crime.

For applicants in OKLAHOMA: **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claims for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For applicants in OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime.

For applicants in MAINE, TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

INDEPENDENCE AMERICAN INSURANCE COMPANY

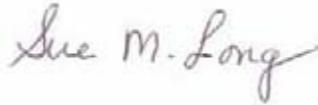
Re:

ARKANSAS 23-79-138

I hereby certify that the accompanying product is in compliance with Arkansas Insurance Code 23-79-138. Our complete address and telephone phone number is shown on the cover of the Policy. The Arkansas Department of Insurance information is found in the second page of the Policy form.

Hereby certified on this 24th day of January 2012.

By:

A handwritten signature in cursive script that reads "Sue M. Long". The signature is written in dark ink on a light-colored background.

Sue M. Long
Compliance Department

INDEPENDENCE AMERICAN INSURANCE COMPANY

CERTIFICATION OF FLESCH READING EASE SCORE

<u>Form Number (s)</u>	<u>Description</u>	<u>Score(s)</u>
SL2011-IAIC	POLICY	46
SL2011-APP-IAIC	APPLICATION	44
SL2011-ASR-IAIC	AGGREGATING SPECIFIC RIDER	45
SL2011-ATLR-IAIC	AGGREGATE EXCESS LOSS TERMINAL LIABILITY RIDER	46
SL2011-CSR-IAIC	CUMULATIVE SPECIFIC POLICY RIDER	60
SL2011-D-IAIC	DISCLOSURE STATEMENT	21
SL2011-IROR-IAIC	INDEPENDENT REVIEW ORGANIZATION RIDER	20
SL2011-MCAR-IAIC	MONTHLY CUMULATIVE ACCOMMODATION FOR AGGREGATE EXCESS LOSS RIDER	45
SL2011-R-IAIC	BLANK RIDER	60
SL2011-SDCR-IAIC	SPECIFIC DEDUCTIBLE CAP RIDER	45
SL2011-STLR-IAIC	SPECIFIC EXCESS LOSS TERMINAL LIABILITY RIDER	46

I hereby certify that the form(s) listed above meet(s) the minimum Flesch reading ease test score requirements of your state's simplified language law and/or regulation.



Adam C. Vandervoort
Secretary

Date 1/11/12