

SERFF Tracking Number: AEGB-128084089 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number:
Company Tracking Number: SLAD4102GE
TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: SLAD4102GE
Project Name/Number: SLAD4102GE (2012) Enrollment Form Filing/H046-2

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: SLAD4102GE

SERFF Tr Num: AEGB-128084089 State: Arkansas

TOI: H03G Group Health - Accidental Death &
Dismemberment

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

Sub-TOI: H03G.000 Health - Accidental Death
& Dismemberment

Co Tr Num: SLAD4102GE

State Status: Approved-Closed

Filing Type: Form

Author: Sharron Hawkins

Reviewer(s): Rosalind Minor

Date Submitted: 02/10/2012

Disposition Date: 02/10/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: SLAD4102GE (2012) Enrollment Form Filing

Status of Filing in Domicile: Not Filed

Project Number: H046-2

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: Discretionary

Overall Rate Impact:

Filing Status Changed: 02/10/2012

State Status Changed: 02/10/2012

Deemer Date:

Created By: Sharron Hawkins

Submitted By: Sharron Hawkins

Corresponding Filing Tracking Number: 3Y001008

Filing Description:

SLAD4101GE (Rev 01-2012) - Group Accident Enrollment Form

SLAD4102GE (Rev 01-2012) - Group Accident Enrollment Form

The above referenced forms are submitted for your review and approval. These enrollment forms will be used with our Group Accidental Insurance filing which was approved by your Department on 4/21/11 under SERFF Tracking number AEGX-G127127489.

SERFF Tracking Number: AEGB-128084089 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number:
 Company Tracking Number: SLAD4102GE
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
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The above referenced forms have been revised to include eligibility language that had been inadvertently omitted.

SLAD4101GE (Rev 01-2012) - Group Accident Enrollment Form, will replace form SLAD4101GE Group Accident Enrollment Form as approved on 4/21/11 under SERFF Tracking number AEGX-G127127489.

SLAD4102GE (Rev 01-2012) Group Accident Enrollment Form, is a new form.

This SERFF submission includes all required components. Your earliest consideration would be greatly appreciated.

Company and Contact

Filing Contact Information

Sharron Hawkins, Sharron.Hawkins@transamerica.com
 100 Light Street, Floor B1 410-209-5734 [Phone]
 Baltimore, MD 21202-2559

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50 x 2 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$100.00	02/10/2012	56259501

SERFF Tracking Number: AEGB-128084089 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/10/2012	02/10/2012

SERFF Tracking Number: AEGB-128084089 *State:* Arkansas
Filing Company: Stonebridge Life Insurance Company *State Tracking Number:*
Company Tracking Number: SLAD4102GE
TOI: H03G Group Health - Accidental Death & *Sub-TOI:* H03G.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: SLAD4102GE
Project Name/Number: SLAD4102GE (2012) Enrollment Form Filing/H046-2

Disposition

Disposition Date: 02/10/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGB-128084089 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number:
 Company Tracking Number: SLAD4102GE
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: SLAD4102GE
 Project Name/Number: SLAD4102GE (2012) Enrollment Form Filing/H046-2

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	SLAD4101GE (Rev 1- 2012) EOVS	Approved-Closed	Yes
Supporting Document	SLAD4102GE (Rev 1- 2012) EOVS	Approved-Closed	Yes
Form	Enrollment	Approved-Closed	Yes
Form	Enrollment	Approved-Closed	Yes

SERFF Tracking Number: AEGB-128084089 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number:
 Company Tracking Number: SLAD4102GE
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
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 Product Name: SLAD4102GE
 Project Name/Number: SLAD4102GE (2012) Enrollment Form Filing/H046-2

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/10/2012	SLAD4101 GE (Rev 1-2012)	Application/ Enrollment Form	Enrollment Form	Revised	Replaced Form #: SLAD4101GE Previous Filing #: AEGX-G127127489.	44.200	SLAD4101GE (Rev 1-2012) Enrollment.pdf
Approved-Closed 02/10/2012	SLAD4102 GE (Rev 1-2012)	Application/ Enrollment Form	Enrollment Form	Initial		44.200	SLAD4102GE (Rev 1-2012) Enrollment.pdf

[Variable Logo]
[Plan Marketing Name]

Enrollment Form

Home Office: 187 West Street, Rutland, VT 05701
 Underwritten by Stonebridge Life Insurance Company
 Administration Office: [2700 West Plano Parkway, Plano, Texas 75075]

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

[Please reply by: Month XX, 2011]

[Bar Code for Scanning Purposes]

[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

1. Select your insurance coverage (Check one box below)

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

[Plan Marketing Name]	[Plan 1]	[Plan 2]	[Plan 3]	[Plan 4]
Emergency Treatment	\$500 per visit	\$500 per visit	\$500 per visit	\$500 per visit
Accidental Death	\$100,000	\$200,000	\$300,000	\$500,000
Daily Hospitalization	\$200 per day	\$200 per day	\$200 per day	\$200 per day
Rehabilitative Therapy	\$50 per visit	\$50 per visit	\$50 per visit	\$50 per visit
Premium				
Individual	<input type="checkbox"/> \$9.30 per month	<input type="checkbox"/> \$15.30 per month	<input type="checkbox"/> \$21.30 per month	<input type="checkbox"/> \$33.30 per month
Family	<input type="checkbox"/> \$14.55 per month	<input type="checkbox"/> \$20.55 per month	<input type="checkbox"/> \$26.55 per month	<input type="checkbox"/> \$38.55 per month

2. Complete the information below [and name your beneficiary]

Customer Birth Date / /
(required) MM / DD / YYYY

Male Female

Home Phone _____

Email: _____

[Beneficiary _____]

[Relationship to Insured _____]

Check here if you are eligible to receive Medicare Benefits

3. Sign and date below

I wish to apply for this Accidental Death Insurance Plan. I understand that in order to enroll for this coverage, I must be [a [JCPenney] Credit Cardholder or the spouse of a [JCPenney] Credit Cardholder] age [45-74] and reside in a state in which this insurance coverage may legally be offered. I understand that a separate [Policy/Certificate] will be issued to each applicant and that no insurance is in effect until I am issued my [Policy/Certificate] by the underwriter Stonebridge Life Insurance Company, Administrative Office: [Plano, TX 75075] and my first premium is received by Stonebridge Life before my Certificate Effective Date and during my lifetime. If I fail to give true and complete answers on this application, I understand that benefits may be denied during the first 2 Certificate Years. To the best of my knowledge and belief the information on this entire application is true and complete. [If I sign and return this form without selecting a coverage amount, I understand that I will be automatically enrolled for [\$100,000] of [Customer][only] coverage.] This authority is to remain in effect until I cancel it by written notification to the Company at least 30 days in advance of the intended termination date of my coverage. Coverage begins on the Effective Date stated on the Certificate of Insurance [provided the first premium is paid]. I also understand that coverage reduces by fifty percent (50%) at the Insured's age [70]. [I have read the fraud notices on the back of this application.]

[By signing below, I certify that I understand coverage is limited to a total indemnity of not more than [\$1,000,000.00] for Accidental Death Insurance in effect with us or Transamerica Life Insurance Company, Stonebridge Casualty Insurance Company, Monumental Life Insurance Company or Transamerica Financial Life Insurance Company at any one time.]

Payment Information:

[The first month's coverage will be provided at no cost to me.]

[The monthly costs for the first [30] days of coverage will be paid for by [JCPenney]]

[In signing the enrollment form, I authorize the monthly premium as shown above for the coverage chosen to be billed as indicated below. [A [\$0.75] administrative fee will be added for each automatic account billing.]]

Please charge my monthly premiums to my [JCPenney] Credit Card account. (I am an authorized user.)]

Please charge my monthly premiums to my debit/credit card account identified below:
(I am an authorized user.) American Express® Discover® Card MasterCard® VISA®
Account No: _____ - _____ - _____ - _____ Exp. Date _____]

Please deduct my monthly premiums from my Checking Account: Withdrawal Date: _____
(Attached is a sample check marked VOID) (1st through 28th)]

Please bill me direct for my monthly premiums. Enclosed is my first month's premium.]

[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank] to activate my coverage.]

X _____
Signature of Customer (required)

Date (Required) ____/____/____
MM DD YYYY

INSURANCE DISCLOSURES

Certain state insurance departments require that we advise you of the following statements:

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

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

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

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

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

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

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

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

[Variable Logo]
[Plan Marketing Name]

Enrollment Form

Home Office: 187 West Street, Rutland, VT 05701
Underwritten by Stonebridge Life Insurance Company
Administration Office: [2700 West Plano Parkway, Plano, Texas 75075]

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

[Please reply by: Month XX, 2011]

[Bar Code for Scanning Purposes]

[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

1. Select your insurance coverage (Check one box below)

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

[Plan Marketing Name]	[Plan 1]	[Plan 2]	[Plan 3]	[Plan 4]
Emergency Treatment	\$500 per visit	\$500 per visit	\$500 per visit	\$500 per visit
Accidental Death	\$100,000	\$200,000	\$300,000	\$500,000
Daily Hospitalization	\$200 per day	\$200 per day	\$200 per day	\$200 per day
Rehabilitative Therapy	\$50 per visit	\$50 per visit	\$50 per visit	\$50 per visit
Premium				
Individual	<input type="checkbox"/> \$9.30 per month	<input type="checkbox"/> \$15.30 per month	<input type="checkbox"/> \$21.30 per month	<input type="checkbox"/> \$33.30 per month
Family	<input type="checkbox"/> \$14.55 per month	<input type="checkbox"/> \$20.55 per month	<input type="checkbox"/> \$26.55 per month	<input type="checkbox"/> \$38.55 per month

2. Complete the information below [and name your beneficiary]

Customer Birth Date / /
(required) MM / DD / YYYY

Male Female

Home Phone _____

Email: _____

[Beneficiary _____]

[Relationship to Insured _____]

Check here if you are eligible to receive Medicare Benefits

3. Sign and date below

I wish to apply for this Accidental Death Insurance Plan. I understand that in order to enroll for this coverage, I must be [a [JCPenney] Credit Cardholder or the spouse of a [JCPenney] Credit Cardholder] age [45-74] and reside in a state in which this insurance coverage may legally be offered. I understand that no insurance is in effect until I am issued my [Policy/Certificate] by the underwriter Stonebridge Life Insurance Company, Administrative Office: [Plano, TX 75075] and my first premium is received by Stonebridge Life Insurance Company [before][within 21 days of] my Certificate Effective Date and during my lifetime. To the best of my knowledge and belief the information on this entire application is true and complete. [If I sign and return this form without selecting a coverage amount, I understand that I will be automatically enrolled for [\$100,000] of [Customer][only] coverage.] Coverage begins on the Effective Date stated on the Certificate of Insurance [provided the first premium is paid]. I also understand that coverage reduces by fifty percent (50%) at the Insured's age [70]. [I have read the fraud notices on the back of this application.]

[By signing below, I certify that I understand coverage is limited to a total indemnity of not more than [\$1,000,000.00] for Accidental Death Insurance in effect with us or Transamerica Life Insurance Company, Stonebridge Casualty Insurance Company, Monumental Life Insurance Company or Transamerica Financial Life Insurance Company at any one time.]

Payment Information:

[The first month's coverage will be provided at no cost to me.]
[The monthly costs for the first [30] days of coverage will be paid for by [JCPenney]]

[In signing the enrollment form, I authorize the monthly premium as shown above for the coverage chosen to be billed as indicated below. [A [\$0.75] administrative fee will be added for each automatic account billing.]]

Please charge my monthly premiums to my [JCPenney] Credit Card account. (I am an authorized user.)]

Please charge my monthly premiums to my debit/credit card account identified below:
(I am an authorized user.) American Express® Discover® Card MasterCard® VISA®
Account No: _____ - _____ - _____ - _____ Exp. Date _____]

Please deduct my monthly premiums from my Checking Account: Withdrawal Date: _____
(Attached is a sample check marked VOID) (1st through 28th)]

Please bill me direct for my monthly premiums. Enclosed is my first month's premium.]

[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank], to activate my coverage.]

X _____ Date (Required) _____ / _____ / _____
Signature of Customer (required) MM DD YYYY

INSURANCE DISCLOSURES

Certain state insurance departments require that we advise you of the following statements:

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

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

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

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

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

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

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

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

SERFF Tracking Number: AEGB-128084089 State: Arkansas
 Filing Company: Stonebridge Life Insurance Company State Tracking Number:
 Company Tracking Number: SLAD4102GE
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: SLAD4102GE
 Project Name/Number: SLAD4102GE (2012) Enrollment Form Filing/H046-2

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/10/2012
Comments:			
Attachment:			
AR Readability.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	02/10/2012
Comments:			
SLAD4101GE (Rev 01-2012) - Group Accident Enrollment Form, will replace form SLAD4101GE Group Accident Enrollment Form as approved on 4/21/11 under SERFF Tracking number AEGX-G127127489.			

		Item Status:	Status Date:
Satisfied - Item:	SLAD4101GE (Rev 1- 2012) EOY	Approved-Closed	02/10/2012
Comments:			
Explanation of Variables			
Attachment:			
SLAD4101GE (Rev 1- 2012) EOY.pdf			

		Item Status:	Status Date:
Satisfied - Item:	SLAD4102GE (Rev 1- 2012) EOY	Approved-Closed	02/10/2012
Comments:			
Explanation of Variables			
Attachment:			
SLAD4102GE (Rev 1- 2012) EOY.pdf			

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Stonebridge Life Insurance Company

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

Form Number	Score
SLAD4101GE (Rev 1-2012)	44.2
SLAD4102GE (Rev 1-2012)	44.2

Signed:

Cheryl Bock

Name:

Cheryl Bock

Title:

Assistant Vice President of Contract Development

Date:

2/10/2012

EXPLANATION OF VARIABLES FOR SLAD4101GE (Rev 1-2012)

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

Variable Data	Explanation
[Variable Logo]	Marketer may use the company logo
[Plan Marketing Name]	Marketer may use with other accident only policy forms or another plan name resulting in a change in the title
[2700 West Plano Parkway, Plano, Texas 75075-8200]	Stonebridge Life Insurance Company has locations at three administrative offices. Solicitation may originate from one of the three locations, depending on the market.
[John Doe] [Jane Doe (if enrolling)] [123 Main Street] [Apartment #X] [Columbia, SC XXXXX]	Customer name and address will appear here and may be preprinted on the enrollment form.
[Please respond by: Month XX, 2011]	If the Policyholder wants to limit the time of the offer, this information and date will be included.
[Bar code for scanning purposes]	This is for managing customer information
[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]	These are company codes used internally to process enrollments and to uniquely identify solicitations.
The monthly costs for the first [30] days of coverage will be paid for by [ABC Bank].	The policyholder determines if the coverage will be paid for 30, 60 or 90 days and disclose they are paying for the coverage.
[Plan 1 Name], [Plan 2 Name]	The Marketer may offer one or more plans and give them a descriptive name such as Basic, Enhanced, Deluxe or Platinum. Benefit amounts may change based on the plan offered
[Family] [Individual]	Premium amounts and frequency of payment will depend on the offer and a tracking code will be associated with each. Marketer may want to say Customer only or Member only depending on the offer and group type
[Email Address: _____]	Marketer may choose to ask for email address
Beneficiary _____] Relationship to Insured _____]	Customer may provide this information
[a [JCPenney] Credit Cardholder or the spouse of a [JCPenney] Credit Cardholder]	The eligibility language will change based on who the master policyholder will be.

<p>[If I sign and return this form without selecting a coverage amount, understand that I will be automatically enrolled for [\$100,000] of [Customer][only] coverage.]</p>	<p>Plan name determined by Marketer.</p>
<p>[provided the first premium is paid]. decrease at age [70].</p>	<p>Policyholder will determine age of reduction and may or may not include this information.</p>
<p>[I have read the fraud notices on the back of this application].</p>	<p>Will be included or excluded depending on if the enrollment page is more than one page and this sentence will be included when there are disclosures to be acknowledged.</p>
<p>[By signing below, I certify that I understand coverage is limited to a total indemnity of not more than [\$1,000,000.00] for Accidental Death Insurance in effect with us or Transamerica Life Insurance Company, Stonebridge Casualty Insurance Company, Monumental Life Insurance Company or Stonebridge Life Insurance Company at any one time.]</p>	<p>Discloses coverage limitations when the policyholder or company wants to limit total amount of coverage for a single insured who purchases Accidental Death Indemnity coverage.</p>
<p>The items under the Payment Information section will be included will be included or excluded depending upon the selection made.</p>	<p>Will be included or excluded</p>
<p>[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank] to activate my coverage.]</p>	<p>Will be included or excluded</p>

EXPLANATION OF VARIABLES FOR SLAD4102GE (Rev 1-2012)

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

Variable Data	Explanation
[Variable Logo]	Marketer may use the company logo
[Plan Marketing Name]	Marketer may use with other accident only policy forms or another plan name resulting in a change in the title
[2700 West Plano Parkway, Plano, Texas 75075-8200]	Stonebridge Life Insurance Company has locations at three administrative offices. Solicitation may originate from one of the three locations, depending on the market.
[John Doe] [Jane Doe (if enrolling)] [123 Main Street] [Apartment #X] [Columbia, SC XXXXX]	Customer name and address will appear here and may be preprinted on the enrollment form.
[Please respond by: Month XX, 2011]	If the Policyholder wants to limit the time of the offer, this information and date will be included.
[Bar code for scanning purposes]	This is for managing customer information
[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]	These are company codes used internally to process enrollments and to uniquely identify solicitations.
The monthly costs for the first [30] days of coverage will be paid for by [ABC Bank].	The policyholder determines if the coverage will be paid for 30, 60 or 90 days and disclose they are paying for the coverage.
[Plan 1 Name], [Plan 2 Name]	The Marketer may offer one or more plans and give them a descriptive name such as Basic, Enhanced, Deluxe or Platinum. Benefit amounts may change based on the plan offered
[Family] [Individual]	Premium amounts and frequency of payment will depend on the offer and a tracking code will be associated with each. Marketer may want to say Customer only or Member only depending on the offer and group type
[Email Address: _____]	Marketer may choose to ask for email address
Beneficiary _____] Relationship to Insured _____]	Customer may provide this information
[a [JCPenney] Credit Cardholder or the spouse of a [JCPenn Credit Cardholder]	The eligibility language will change based on who the master policyholder will be.

<p>[If I sign and return this form without selecting a coverage amount, understand that I will be automatically enrolled for [\$100,000] of [Customer][only] coverage.]</p>	<p>Plan name determined by Marketer.</p>
<p>[provided the first premium is paid]. decrease at age [70].</p>	<p>Policyholder will determine age of reduction and may or may not include this information.</p>
<p>[I have read the fraud notices on the back of this application].</p>	<p>Will be included or excluded depending on if the enrollment page is more than one page and this sentence will be included when there are disclosures to be acknowledged.</p>
<p>[By signing below, I certify that I understand coverage is limited to a total indemnity of not more than [\$1,000,000.00] for Accidental Death Insurance in effect with us or Transamerica Life Insurance Company, Stonebridge Casualty Insurance Company, Monumental Life Insurance Company or Stonebridge Life Insurance Company at any one time.]</p>	<p>Discloses coverage limitations when the policyholder or company wants to limit total amount of coverage for a single insured who purchases Accidental Death Indemnity coverage.</p>
<p>The items under the Payment Information section will be included will be included or excluded depending upon the selection made.</p>	<p>Will be included or excluded</p>
<p>[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank] to activate my coverage.]</p>	<p>Will be included or excluded</p>