

SERFF Tracking Number: RSLI-128046802 State: Arkansas
Filing Company: Reliance Standard Life Insurance Company State Tracking Number:
Company Tracking Number: LRS-9101-01-0511
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
Product Name: Excess Loss Indemnity
Project Name/Number: Excess Loss Indemnity/

Filing at a Glance

Company: Reliance Standard Life Insurance Company

Product Name: Excess Loss Indemnity

SERFF Tr Num: RSLI-128046802 State: Arkansas

TOI: H12 Health - Excess/Stop Loss

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

Sub-TOI: H12.001 Accident & Sickness

Co Tr Num: LRS-9101-01-0511

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Jennifer Santucci

Disposition Date: 02/01/2012

Date Submitted: 01/30/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Excess Loss Indemnity

Status of Filing in Domicile: Pending

Project Number:

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: 02/01/2012

State Status Changed: 02/01/2012

Deemer Date:

Created By: Jennifer Santucci

Submitted By: Jennifer Santucci

Corresponding Filing Tracking Number:

Filing Description:

Submitting:

LRS-9101-01-0511, et al – Excess Loss Indemnity Group Policy

LRS-9102-0511 – Request for Excess Loss Indemnity Coverage

LRS-9466-0511 – Aggregate Terminal Liability Endorsement

LRS-9467-0511 – Specific Terminal Liability Endorsement

LRS-9471-1011 – Aggregating Specific Deductible

Dear Sir/Madam:

SERFF Tracking Number: RSLI-128046802 State: Arkansas
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We are submitting the above forms for your review and approval. The policy, LRS-9101-01-0511, will replace LRS-9101-01-1001 which was approved by your Department on April 4, 2002. The new policy form does not differ significantly from LRS-9101-01-1001 except for some tightening of language, the addition of an Aggregating Specific Deductible shown on the Schedule of Benefits and the Aggregating Specific Deductible endorsement along with a few additional endorsements as listed above. The new Request for Excess Loss Indemnity Coverage will replace LRS-9102-1001 that was approved when the policy was approved.

The following endorsements that were originally approved with LRS-9101-01-1001 will continue to be used with LRS-9101-01-0511:

LRS-8351-01-0887 – Blank Amendment Rider
LRS-9107-1001 – Named Individuals Excluded
LRS-9108-1001 – Consent to Plan Document Changes
LRS-9109-1001 – Named Individuals Excluded Under Specific Excess Risk Coverage-Limited
Under Aggregate Excess Risk Coverage
LRS-9110-1001 – Named Individuals Excluded Under Specific Excess Risk Coverage
LRS-9111-1001 – Special Specific Deductible Amount and Aggregate Coverage Limitation
For Claims on Named Individuals
LRS-9112-1001 – Special Specific Deductible Amount for Claims on Named Individuals
LRS-9113-1001 – Waiver of Actively at Work Requirement
LRS-9119-0202 – Waiver of Actively at Work Requirement
LRS-9120-0202 – Specific Advance Option
LRS-9121-0202 – Aggregate Accommodation Option

It is hoped that you will find our filing acceptable. We look forward to your approval but if you have questions, please feel free to contact us.

Company and Contact

Filing Contact Information

Jennifer Santucci, Compliance Specialist jennifer.santucci@rsli.com
2001 Market Street 267-256-3724 [Phone]
Suite 1500 267-256-3546 [FAX]
Philadelphia, PA 19103-7090

Filing Company Information

Reliance Standard Life Insurance Company CoCode: 68381 State of Domicile: Illinois
2001 Market Street Group Code: Company Type:

SERFF Tracking Number: RSLI-128046802 State: Arkansas
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Product Name: Excess Loss Indemnity
Project Name/Number: Excess Loss Indemnity/

Suite 1500 Group Name: State ID Number:
Philadelphia, PA 19103-7090 FEIN Number: 36-0883760
(800) 351-7500 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$250.00
Retaliatory? Yes
Fee Explanation: \$50.00 per form x five forms
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reliance Standard Life Insurance Company	\$250.00	01/30/2012	55921894

SERFF Tracking Number: RSLI-128046802 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/01/2012	02/01/2012

SERFF Tracking Number: RSLI-128046802 State: Arkansas
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Product Name: Excess Loss Indemnity
Project Name/Number: Excess Loss Indemnity/

Disposition

Disposition Date: 02/01/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *RSLI-128046802* State: *Arkansas*
 Filing Company: *Reliance Standard Life Insurance Company* State Tracking Number:
 Company Tracking Number: *LRS-9101-01-0511*
 TOI: *H12 Health - Excess/Stop Loss* Sub-TOI: *H12.001 Accident & Sickness*
 Product Name: *Excess Loss Indemnity*
 Project Name/Number: *Excess Loss Indemnity/*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Excess Loss Indemnity Group Policy	Approved-Closed	Yes
Form	Request for Excess Loss Indemnity Coverage	Approved-Closed	Yes
Form	Aggregate Terminal Liability Endorsement	Approved-Closed	Yes
Form	Specific Terminal Liability Endorsement	Approved-Closed	Yes
Form	Aggregating Specific Deductible	Approved-Closed	Yes

SERFF Tracking Number: RSLI-128046802 State: Arkansas
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 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
 Product Name: Excess Loss Indemnity
 Project Name/Number: Excess Loss Indemnity/

Form Schedule

Lead Form Number: LRS-9101-01-0511

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/01/2012	LRS-9101-01-0511	Policy/Cont ract/Fratern al	Excess Loss Indemnity Group Policy Certificate	Initial		52.000	LRS-9101-01-0511 Filing Copy for Arkansas.pdf
Approved-Closed 02/01/2012	LRS-9102-0511	Application/ Enrollment Form	Request for Excess Loss Indemnity Coverage	Initial		51.000	LRS-9102-0511-Request for Excess Loss Indemnity Coverage.pdf
Approved-Closed 02/01/2012	LRS-9466-0511	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Aggregate Terminal Liability Endorsement	Initial		51.000	Aggregate Terminal Liability Endorsement-LRS-9466-0511.pdf
Approved-Closed 02/01/2012	LRS-9467-0511	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Specific Terminal Liability Endorsement	Initial		51.000	Specific Terminal Liability Endorsement-LRS-9467-0511.pdf
Approved-Closed 02/01/2012	LRS-9471-1011	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Aggregating Specific Deductible	Initial		51.000	Aggregating Specific Deductible-LRS-9471-1011.pdf

RELIANCE STANDARD

Life Insurance Company

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

INSURED: [ABC Company / RSL Employer Trust]
(Herein called the Policyholder)

POLICY NUMBER: [XX12345]

EFFECTIVE DATE: [November 1, 2011]

DATE OF ISSUE: [November 1, 2011]

STATE OF ISSUE: [Delaware]

Throughout this Policy, "you" and "your" refer to the [Policyholder/Participating Unit].

Reliance Standard Life Insurance Company is referred to as "we", "our", "us" or "the Company" in this Policy.

We will pay you when you have a claim and provide other rights and privileges, subject to all the terms and conditions of this Policy.

This Policy is issued in consideration of [the Policyholder's application,] your application and your payment of premiums.

This Policy is delivered in the State of Issue, and is governed by the laws of that state. Your [Participation Agreement and] Request for Excess Loss Indemnity Coverage, along with a copy of your Employee Benefit Plan document, are part of this Policy.

This Policy is signed for us by:



Secretary



President

EXCESS LOSS INDEMNITY GROUP POLICY

SCHEDULE OF INSURANCE

5. Claims Basis – Benefit Period

Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date will be limited to:
\$_____ for all covered persons combined.

[6. Additional Benefits

Aggregate Accommodation Option: Yes () No ()
Aggregate Terminal Liability Option: Yes () No ()]

[B. SPECIFIC EXCESS RISK INSURANCE

1. Company Limit of Liability

- a. []% of Paid Specific Losses which are in excess of the Specific Deductible Amount, subject to a maximum limit per covered person of [\$_____].
- b. [\$_____] Specific Deductible Amount (per person) [after an Aggregating Specific Deductible of [\$_____] has been satisfied for the entire group.]

2. Covered Plan Benefits (Applicable only if an entry is specified herein.)

() Medical () Dental () Vision () Weekly Accident and Sickness
() Prescription Drug () Other (as indicated)_____.

3. Claims Basis – Benefit Period

Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date will be limited to:
\$_____ for all covered persons combined.

[4. Loss Reduction for Insured Hospitals

If the Participating Unit named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by you shall be multiplied by []% when determining Paid Specific Losses.]

[5. Additional Benefits:

Specific Advance Option: Yes () No ()
Specific Terminal Liability Option: Yes () No ()]

SCHEDULE OF INSURANCE

C. PREMIUM

[1. Aggregate Excess Risk Premium

[Deposit Premium:
Aggregate Premium Rate:
Minimum Premium:
Annual Premium: \$_____]

[Aggregate Accommodation Option Premium: \$_____]
[Aggregate Terminal Liability Option Premium: \$_____]]

[2. Specific Excess Risk Premium

[Specific Premium Rate: \$____ per Employee.
\$ ____ per Employee & Dependent]

[Specific Advance Option Premium: \$_____]
[Specific Terminal Liability Option Premium: \$_____]]

D. SPECIAL RISK LIMITATIONS:

Coverage under this Policy will be based on the current employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:

[_____[An unlimited maximum for the medical plan will be covered as of 01-01-2011]_____]

_____]

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GENERAL DEFINITIONS

["Actively at Work/Active" means that an employee is performing the ordinary duties of his or her job in the place and in the manner in which the job is normally performed and is not confined at home or to a hospital or other health care facility. Dependents [and COBRA Continuees][retirees] will be considered "Active" if he or she is able to perform the normal activities of a person of like age and sex.]

["COBRA Continuee" means any person who was insured under this Policy whose coverage is being continued in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).]

"Employee Benefit Plan" means the master plan document belonging to you which provides [medical expense benefits and/or weekly accident and sickness benefits] to your covered person(s), and dependents of such covered person(s), in effect on the Effective Date of this Policy, a copy of which is attached to and made a part of this Policy.

"Paid" means that funds are actually disbursed by the [Policyholder/Participating Unit] or the [Policyholder's/Participating Unit's] agent in payment of a claim. Payment of a claim is the unconditional and direct payment of a claim to a covered person or their health care provider.

["Usual, Customary and Reasonable Charges" is the amount which a provider routinely charges for goods and services provided, and is considered to be derived in conformity with the charge methodology of other similar or like providers within a geographic area, and is considered to represent a fair market value for the goods and services provided.]

"us, we, our, the Company" mean Reliance Standard Life Insurance Company.

"you, yours" mean the [Policyholder/Participating Unit] and any subsidiaries, divisions or affiliates.

[INSURING PROVISIONS

[AGGREGATE EXCESS RISK INSURANCE: We will pay you a percentage of the amount by which the Aggregate Losses you have Paid under your Employee Benefit Plan exceed your Aggregate Attachment Point.

The percentage we will pay, and our Limit of Liability, are stated in your Schedule of Insurance. We will pay you as soon as reasonably possible after the end of your Policy Period, subject to satisfactory proof of loss.]

[SPECIFIC EXCESS RISK INSURANCE: We will pay you a percentage of the amount by which the Specific Losses you have Paid under your Employee Benefit Plan exceed the Specific Deductible Amount stated in your Schedule of Insurance.

The percentage we will pay and our Limit of Liability are also stated in your Schedule of Insurance. We will pay you as soon as reasonably possible after you have requested reimbursement, subject to satisfactory proof of loss.]

["AGGREGATE LOSSES" means the total amount of money you have actually Paid during the Benefit Period as indicated in the Schedule of Insurance, or on behalf of, all covered persons under your Employee Benefit Plan. Aggregate Losses, however, cannot include any payments you made to, or on behalf of, a covered person:

1. for covered expenses which are reimbursable under the Specific Excess Risk Insurance provision; or
2. which were in excess of the maximum amount chargeable as stated in your Schedule of Insurance; or
3. which were not incurred within the Benefit Period as indicated in the Schedule of Insurance.

An expense will be deemed to be incurred by a covered person on the date that the service, treatment, or supply is provided.

Your payments must have been made in accordance with the provisions of your Employee Benefit Plan document currently filed with us and included as a part of this Policy. Payment shall be deemed to have been Paid by you when both of the following are satisfied:

1. You have directly tendered payment by mailing, or otherwise delivering, a check or draft in payment of a covered expense; and
2. the account upon which payment is drawn contains, and continues to contain, sufficient funds in order to honor such payment.

If the account upon which payment is drawn does not contain sufficient funds to cover all outstanding checks and drafts against the account, then we may consider, in our sole discretion, any particular checks or drafts as not having been Paid, but only to the extent of the total amount representing the difference between the funds in the account and the total of outstanding checks and drafts.]

["SPECIFIC LOSSES" means the total amount of money you have actually Paid during the Benefit Period as indicated in the Schedule of Insurance, or on behalf of, any one covered person under your Employee Benefit Plan. Specific Losses, however, cannot include any payments you made to, or on behalf of, a covered person which were not incurred within the Benefit Period as indicated in the Schedule of Insurance.

An expense will be deemed to be incurred by a covered person on the date that the service, treatment, or supply is provided.

Your payments must have been made in accordance with the provisions of your Employee Benefit Plan document currently filed with us and included as a part of this Policy; and shall be deemed to have been Paid by you when both of the following are satisfied:

1. you have directly tendered payment by mailing, or otherwise delivering, a check or draft in payment of a covered expense; and
2. the account upon which payment is drawn contains, and continues to contain, sufficient funds in order to honor such payment.]

If the account upon which payment is drawn does not contain sufficient funds to cover all outstanding checks and drafts against the account, then we may consider, in our sole discretion, any particular checks or drafts as not having been Paid, but only to the extent of the total amount representing the difference between the funds in the account and the total of outstanding checks and drafts.]

[INSURING PROVISIONS, (Continued)]

[AGGREGATE ATTACHMENT POINT

Your Aggregate Attachment Point will be determined at the end of your Policy Period. The Aggregate Attachment Point will be the greater of:

1. The Aggregate Attachment Point which is calculated as follows: At the beginning of each month during your Policy Period, the number of your employees, their dependents and other covered individuals, as agreed upon between you and us, who are covered under your Employee Benefit Plan will be multiplied by the corresponding Attachment Factor stated in your Schedule of Insurance; or
2. The Minimum Aggregate Attachment Point shown in your Schedule of Insurance. Your Minimum Attachment Point will be applicable regardless of how long your coverage remains in force.]

EXCLUSIONS AND LIMITATIONS OF LIABILITY

1. Our liability under this Policy is limited to reimbursement of payments you have made to, or on behalf of, covered persons under your Employee Benefit Plan for covered expenses Paid under your Employee Benefit Plan. We are not liable for punitive, exemplary, or consequential damages, and you must hold us harmless from damages of any kind which are not caused by our own acts or omissions. You will indemnify us for all expenses, including attorney fees incurred in defending claims or legal actions brought against us by a person covered under your Employee Benefit Plan.
- [2. We will not be liable for expenses incurred by persons who became covered under your Employee Benefit Plan more than [31] days after their date of eligibility.]
- [3. We will not be liable for expenses incurred by a covered person for the care or treatment of a sickness or injury which is caused by war, declared or undeclared, or any act of war.]
4. We will not be liable for payments you have made to covered persons under any plan of benefits which has not been specifically identified as Covered Plan Benefits in your Schedule of Insurance.
5. We will not be liable to reimburse you for payments you have made to, or on behalf of, covered persons if your request for reimbursement is received by us more than [365] days following the expiration of the applicable Policy Period.
- [6. If the Participating Unit named in this Policy is a licensed hospital, our liability for expenses incurred by a covered person as a result of services and charges provided by you shall be as specified in items your Schedule of Insurance.]
- [7. We will not reimburse expenses incurred by individuals who, on the latter of the Effective Date of their coverage under the Employee Benefit Plan or the Effective Date of this Policy are not Actively at Work. Benefits will not be paid until: (a) the employee is Actively at Work for at least one (1) full day; or (b) a dependent [or COBRA Continuee][or retiree] is considered Active.]
- [8. We will not be liable for expenses resulting from services which are billed in excess of the Usual, Customary and Reasonable Charges.]
9. We will not be liable for expenses resulting from treatment, services or procedures which:
 - (a) are not accepted as standard medical treatment for the illness, disease or injury being treated by physicians normally practicing the specific medical specialty; or
 - (b) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; or
 - (c) have not been granted, at the time services were rendered, any required approval by an appropriate federal or state governmental agency; or
 - (d) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.
- [10. We will not be liable for expenses related to an injury or sickness arising out of or in the course of any occupation for wage or profit or for which a covered person would be entitled to a benefit under any Workers' Compensation plan, U.S. Longshoreman and Harbor Workers' Compensation plan or other occupational disease legislation or policy, whether or not such policy is actually in force.]
11. We will not be liable for expenses covered by amendments to the Employee Benefit Plan that were incurred prior to our written approval of such amendment.
12. We will not be liable for expenses that are covered under any Coordination of Benefits provision.

EXCLUSIONS AND LIMITATIONS OF LIABILITY, (continued)

13. We will not be liable for expenses incurred by or on behalf of an employee or dependent of an employee of an affiliate or subsidiary company not included in the Request for Excess Loss Indemnity Coverage unless added to this Policy by endorsement.
14. We will not be liable for expenses incurred by or on behalf of a COBRA Continuee, retiree or retiree's dependent unless included in the Request for Excess Loss Indemnity Coverage or added to this Policy by endorsement.
- [15. We will not be liable for expenses arising from commission of a felony.]
- [16. We will not be liable for expenses incurred by any COBRA continuee whose COBRA continuation coverage was not offered in a timely manner.]
- [17. We will not be liable for the cost of administration of claim payments including[, but not limited to PPO Access Fees, or] expense of litigation with individual claimants.]
18. We will not be liable for your Third Party Administrator's (TPA) failure to provide timely payment to providers which results in the loss of any discounted fees for services or supplies. We will reimburse only for the discounted charge for services had timely payment been made by your TPA.]
19. We will not be liable for expenses incurred by or on behalf of an employee or dependent of an employee connected with solid organ, tissue, stem cell or bone marrow transplants.]
- [20. We will not be liable for expenses incurred by or on behalf of an employee or dependent of an employee that has reached the maximum under the current plan of benefits.]
- [21. We will not be liable for expenses incurred by or on behalf of an employee or dependent of an employee who had a qualifying event but did not elect COBRA within the required time frame or whose COBRA benefit extension is exhausted.]

PREMIUMS

[AGGREGATE EXCESS RISK PREMIUM: The deposit premium shown in the Schedule of Insurance is payable by you on the Inception Date of the Policy Period.]

[SPECIFIC EXCESS RISK PREMIUM: Premiums are payable by you on a monthly basis.]

The first premium is due on the Inception Date of your Policy Period, and subsequent premiums are due on the first day of each month thereafter.

OFFSET: We will be entitled to offset claim reimbursements to you against premiums due and unpaid by you.

RENEWAL

Your coverage may be renewed only if renewal is mutually agreeable to both you and us. If we refuse to renew, we must give you written notice [31] days prior to your expiration date. Your renewal is subject to our receipt and approval of a new Request For Excess Loss Indemnity Coverage. If approved, a new Schedule of Insurance will be issued to reflect any changes agreed upon by you and us.

GENERAL PROVISIONS

1. ACCESS TO RECORDS

We reserve the right to inspect and audit all records maintained by you and your Plan Supervisor with respect to your Employee Benefit Plan and with respect to this Policy. These records must be available to the Company or its designated Underwriting Manager for determination of plan benefits, proof of loss and proof of payment of plan benefits. Inspections and audits will be done during normal business hours.

2. AMENDMENT

This Policy may be amended from time to time by mutual consent of you and us. Any such amendment will be without prejudice to any claim arising prior to the date of change. No agent or other person, except the President, a Vice President or the Secretary of the Company, has authority to waive any conditions or restrictions of this Policy, to extend the time for paying a premium, or, to make or modify this Policy. No change in this Policy will be valid unless evidenced by an endorsement to it signed by you and by one of the aforesaid officers of the Company except those changes listed in the Group Specifications Changes provision.

3. ASSIGNMENT

You shall not assign any of your rights under this Policy without our prior written consent. Any assignment without prior written consent shall be void.

4. CHANGE OF YOUR EMPLOYEE BENEFIT PLAN

Your Employee Benefit Plan cannot be changed by you while you are covered under this Policy without our written consent.

[Should you elect to change your Employee Benefit Plan, we reserve the right to change the [Specific Excess premium rates and/or the Aggregate Attachment Factor,] to reflect the effect of such changes.]

5. CLERICAL ERROR

Clerical error, whether by you or us, in keeping any records pertaining to this coverage, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

6. ENTIRE CONTRACT

This Policy as issued to you, together with your application, entitled Request for Excess Loss Indemnity Coverage, the Participating Agreement, any amendments, and a copy of your Employee Benefit Plan, constitute the entire contract.

We have relied upon the underwriting information provided by you or your agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would affect the rates, deductibles, terms or conditions of coverage, we will have the right to revise such rates, deductibles, terms or conditions as of the Effective Date of this Policy.

7. GRACE PERIOD

If any premium is not paid in full on or prior to its premium due date, a grace period of [31] days following the premium due date shall be granted for the payment of that premium. Your coverage will continue in full force and effect during the grace period. You will be liable to the Company for all premiums remaining unpaid on the date of termination of your coverage, including premium for the days of the grace period during which your coverage remained in force.

GENERAL PROVISIONS, (continued)

8. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, or dissolution of the Participating Unit or your Plan Supervisor shall not impose upon us any liability other than the liability defined in this Policy. Your insolvency shall not make us liable to your creditors, including any covered person.

9. MISREPRESENTATION

In effecting this Policy, we shall be entitled to rely upon information provided by you or on your behalf. If that information proves not to have been correct as submitted, we have the right to rescind the coverage provided to you under this Policy as of its Effective Date or as of its last annual renewal date, if later. In lieu of rescission, we have the right to adjust the [Specific Deductible Amount, the premium rates, the Aggregate Attachment Factor, and the Minimum Aggregate Attachment Point] to those levels that we would have established if we had been initially provided with the correct information.

10. PAYMENT OF PREMIUMS

All premiums must be remitted to us at our Administrative Office. Except as otherwise provided under the provision entitled Grace Period, your coverage under this Policy will automatically terminate if any premium is not paid when due.

11. POLICY PERIOD: DURATION

Your Policy Period will begin on the Inception Date shown in your Schedule of Insurance. It will end, and all coverage provided by the Policy with respect to you will cease, on the earliest of the following dates:

1. the Expiration Date shown in your Schedule of Insurance;
2. the end of the Grace Period if any premium remains unpaid;
3. the date your Employee Benefit Plan terminates, or the date it changes, except as provided in the Change of Your Employee Plan provision;
4. the first day of any month specified by you following [30 days] prior written notice to us;
5. the date you withdraw from the trust; or
6. the date the Plan Supervisor named in your Schedule of Insurance is changed, except as provided in the Plan Supervisor provision.
7. The date you do not pay claims or make available funds to pay claims as required by this Policy.

12. PLAN SUPERVISOR

You have appointed the Plan Supervisor named in the Schedule of Insurance to perform administrative services for your Employee Benefit Plan, including the payment of claims.

The Plan Supervisor is your agent and is not the agent of the Policyholder or Company. Neither the Policyholder or we are liable for any acts or omissions of the Plan Supervisor. Any requests or notices we send to the Plan Supervisor will be deemed as a request or notice sent to you.

You will enter into a written agreement with the Plan Supervisor. A copy of the written agreement will be furnished to us prior to the Inception Date of your Policy Period, or as soon as reasonably possible thereafter. The agreement will require your Plan Supervisor to fulfill the following duties and responsibilities:

- a. Administration and adjustment of all claims under the Employee Benefit Plan and verification of their validity, accuracy and computation; and
- b. Maintenance of accurate records of all claims payments; and
- c. Proper handling of and accounting for monies transmitted to and from you and us; and
- d. Payment of all claims within [31] days from the date satisfactory proof of loss has been established; and
- e. Submission to us within [15] days after the close of each Policy month, on a form supplied by us, a report containing all of the following information;

1. the total number of covered persons for the month reported; and
2. a statement of paid claims for the month reported.

GENERAL PROVISIONS, (continued)

f. Satisfactory reporting and provision of proof requirements reasonably imposed by us.

The Plan Supervisor named in the Schedule of Insurance may not be changed unless prior written consent is obtained from us.

13. SEVERABILITY

Any provision deemed void, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, shall not render any of the remaining provisions of this Policy invalid.

14. TAXES

You shall hold us harmless from any state premium taxes which may be assessed against us with respect to benefits paid under your Employee Benefit Plan or this Policy, and shall reimburse us for such taxes, if any.

[15. WORKERS' COMPENSATION INSURANCE

Coverage provided under this Policy applies only to covered expenses under your Employee Benefit Plan for non-occupational accidents or illnesses. It is not the intent of this Policy to provide benefits for covered expenses provided by your Employee Benefit Plan in lieu of Workers' Compensation Insurance.]

16. GROUP SPECIFICATIONS CHANGES

The Company reserves the right to revise rates, deductibles, terms or conditions of the Contract on any of the following dates:

1. When you add or delete a subsidiary or affiliate; or
2. When there is a change in the geographical area in which you are located; or
3. When there is a change in the nature of business in which you are engaged; or
4. When there is an increase or decrease in the number of covered persons which exceeds [10%] in any one month or [20%] over any period of [three (3)] consecutive months

CLAIMS PROVISIONS

[NOTICE OF CLAIM

You are required, either directly, or through your Plan Supervisor, to provide immediate written notice to us when Specific Losses reach or are reasonably expected to exceed 50% of the specific deductible amount.

When Specific Losses exceed the specified deductible amount, proof of loss must be immediately submitted to us. Such proof will be provided on a form supplied by us, and shall include that information reasonably required to establish satisfactory proof of loss. Such information shall include, but is not limited to:

1. A completed proof of loss form;
2. Proof of the covered person's eligibility under the Employee Benefit Plan;
3. Proof of payment under your Employee Benefit Plan for those covered expenses being applied towards the satisfaction of the Specific Deductible Amount and for which reimbursement is being requested; and
4. Copies of all medical reports pertaining to this request for reimbursement.]

WARRANTY

Upon presentation of proof of loss to us, you warrant that all monies necessary to pay for services and supplies have been Paid to the respective providers of medical services or supplies to which the claim for reimbursement relates.

LEGAL ACTION

No action at law or in equity will be brought to recover on this Policy prior to the expiration of [sixty (60)] days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of [five (5)] years after the time written proof of loss is required to be furnished.

If any time limitation in this Policy with respect to bringing an action at law or in equity to recover on this Policy is less than that permitted by the law of the jurisdiction of issue, that limitation is hereby extended to agree with the minimum period permitted by that law.

PAYMENT OF CLAIM

We will pay all benefits as they become payable under this Policy to you. All expenses as they become payable under the Employee Benefit Plan shall be Paid by you. We shall pay the claim within a reasonable time after receiving fully executed written proof of loss and the documentation reasonably necessary to evaluate the eligibility and extent of the claim.

[ARBITRATION

Any dispute or claim arising out of or relating to this Policy and our determination of claims payable thereunder, shall be settled by arbitration in accordance with the rules of the American Arbitration Association, with the express stipulation that the arbitrator(s) shall strictly abide by the terms of this Policy and shall strictly apply rules of law which are applicable. All matters shall be decided by a panel of three (3) arbitrators. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination or expiration of this Policy. The parties may alter any of the terms of this provision only by express written agreement, although such alteration may be before or after any rights or obligations arise under this provision.]

[SUBROGATION

You shall prosecute any and all valid claims that you may have against third parties arising out of any occurrence resulting in a loss payment by you and to account for any amounts recovered. Should you fail to prosecute any valid claims against third parties and we become liable to make payments to you under the terms and conditions of this Policy, then we shall assume all your rights to prosecute any valid claims against third parties. You will be responsible for any legal expenses incurred in the course of the prosecution.]

RELIANCE STANDARD

Life Insurance Company

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

[RSL EMPLOYER TRUST] REQUEST FOR EXCESS LOSS INDEMNITY COVERAGE

Proposal Date: [Date on Proposal]

Group Policy Number: [XX12345]

GENERAL INFORMATION

1. Full Legal Name of [Policyholder/Participating Unit]: [ABC Company]

Principal Address: [123 Anywhere Street, Providence, RI 20000]

2. Nature of Business: [Manufacturing]

3. Full Legal Name of Appointed Plan Supervisor: [DEF Administrators]

Address: [123 Any St., Any Town, AS 00000]

4. If Employee Benefit Plan of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business.

[Not Applicable]

5. Enter the full name of your Employee Benefit Plan(s) and enclose a copy with this request: [ABC Company – Employee Benefit Plan]

6. Disabled Lives: Covered () Not Covered ()
Retired Lives: Covered () Not Covered ()
COBRA Continuee: Covered () Not Covered ()

7. Excess Loss Indemnity Policy Provisions

[A. Aggregate Excess Risk Insurance

1. Company Limit of Liability: [_____] % of paid Aggregate Losses which are in excess of the Aggregate Attachment Point, subject to an Aggregate Limit of Liability of \$[_____].

In addition, the Maximum amount chargeable per covered person to Aggregate Losses is subject to a maximum limit of \$[_____].

[2. Minimum Aggregate Attachment Point of \$[_____], with an Attachment Factor of [\$_] per employee per month.

3. Additional Benefits:

Aggregate Accommodation Option: Yes () No ()

Aggregate Terminal Liability Option: Yes () No ()

(Continued)

4. Premiums:
 Deposit Premium: []
 Aggregate Premium Rate: []
 Minimum Premium Rate: []

[Aggregate Accommodation Option Premium: []
 Aggregate Terminal Liability Option Premium: []]

5. Claims Basis – Benefit Period

Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date will be limited to:
 \$ _____ for all covered persons combined.

6. Covered Plan Benefits (Applicable only if an entry is specified herein.)

() Medical; () Dental; () Vision; () Weekly Accident & Sickness;
 () Prescription Drug; () Other (as indicated)_____.

7. Loss Reduction For Insured Hospitals

If the [Policyholder/Participating Unit] named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by the Participating Unit shall be multiplied by __% when determining paid Aggregate Losses.]

[B. Specific Excess Risk Insurance

1. Company Limit of Liability:

- a. _____% of paid Specific Losses which are in excess of a specific deductible of \$____, subject to a Maximum Limit of Liability per covered person of \$_____.
- b. \$_____ Specific Deductible Amount (per person) after an aggregate corridor of \$_____ has been satisfied for the entire group.

2. Additional Benefits:

Specific Advance Option: Yes () No ()
 Specific Terminal Liability Option: Yes () No ()

3. Premiums: Specific Premium Rate(s) [\$____ per employee
 [\$____per employee w/dep.]

[Specific Advance Option Premium: [\$_____]
 [Specific Terminal Liability Option Premium: [\$_____]

(Continued)

4. Claims Basis – Benefit Period

Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date will be limited to:
\$ _____ for all covered persons combined.

5. Covered Plan Benefits (Applicable only if an entry is specified herein.)

() Medical; () Dental; () Vision () Weekly Accident & Sickness;
() Prescription Drug Card; () Other (as indicated)_____.

6. Loss Reduction For Insured Hospitals

If the Participating Unit named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by the Participating Unit shall be multiplied by ____% when determining paid Specific Losses.

7. Amount accompanying this request as an advance Payment on the premium for insurance applied for \$_____.

8. Inception Date: _____ Expiration Date : _____

9. As a condition of acceptance, the [Policyholder/Participant] has conducted a thorough review of experience developed under its Employee Benefit Plan, and as a result thereof, represents that there are no covered persons with known disabilities, or other known conditions expected to result in paid claims in excess of the Specific Deductible Amount during the Benefit Period, other than those previously disclosed as the basis for proposed coverage.]

C. Special Risk Limitations:

Coverage under this Policy will be based on the current employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:

[[An unlimited maximum for the medical plans will be covered as of 01/01/2011] _____

_____]

[RSL Employer Trust] accepts this request for the above coverage. Coverage is in effect for the period shown in item 7. Renewal of this request for a further period must be submitted on a new form.

Accepted for: _____ Participant _____

RELIANCE STANDARD LIFE INSURANCE COMPANY By _____
Signature

By:  Title: _____
Authorized Signature

Date: _____ Date: _____

RELIANCE STANDARD LIFE INSURANCE COMPANY
Administrative Office: Philadelphia, Pennsylvania

Aggregate Terminal Liability

In consideration of the Aggregate Terminal Liability premium paid, as shown on the Schedule of Benefits, Reliance Standard Life insurance Company has issued this Endorsement as a part of the Policy to which it is attached.

You and We agree that if the Policy to which this Endorsement is attached is terminated by the [Policyholder/Participating Unit] at the end of the Policy Period, then:

1. The Insuring Provisions are amended as follows:

“AGGREGATE ATTACHMENT POINT” means the Attachment Factor multiplied by the number of all covered persons multiplied by the number of months during the Policy Period, multiplied by ____% or the Minimum Aggregate Attachment Point multiplied by ____%, whichever is greater.

2. The Plan Benefits Paid period found in the Claims Basis - Benefit Period section shown on the Schedule of Benefits under AGGREGATE EXCESS RISK INSURANCE, is amended to read, “Paid during the Policy Period or within [three (3) months] immediately thereafter.”

This Endorsement is only applicable when termination occurs at the end of the Policy Period. To be eligible for the full benefits, the [Policyholder/Participating Unit] may not participate in any other self-insured or self-funded benefit plan within [one (1) year] from the date of termination. We will reduce this benefit by the amount of benefits paid for the same losses by any other policy or contract.

ALL OTHER TERMS AND PROVISIONS OF THE POLICY TO WHICH THIS ENDORSEMENT IS ATTACHED REMAIN THE SAME.

Signed for RELIANCE STANDARD LIFE INSURANCE COMPANY


Secretary

Endorsement Number: _____

Effective Date: _____

Excess Loss Policy Number: _____

[Policyholder/Participating Unit Name: _____

[Policyholder's/Participating Unit's] Authorized Representative: _____
Signature

Authorized Representative's Title: _____

Date Signed: _____

RELIANCE STANDARD LIFE INSURANCE COMPANY
Administrative Office: Philadelphia, Pennsylvania

Specific Terminal Liability

In consideration of the Specific Terminal Liability premium paid, as shown on the Schedule of Benefits, Reliance Standard Life insurance Company has issued this Endorsement as a part of the Policy to which it is attached.

You and We agree that if the Policy to which this Endorsement is attached is terminated by the [Policyholder/Participating Unit] at the end of the Policy Period, then:

The Plan Benefits Paid period found in the Claims Basis - Benefit Period section shown on the Schedule of Benefits under SPECIFIC EXCESS RISK INSURANCE, is amended to read, "Paid during the Policy Period or within [three (3) months] immediately thereafter."

This Endorsement is only applicable when termination occurs at the end of the Policy Period. To be eligible for the full benefits, the [Policyholder/Participating Unit] may not participate in any other self-insured or self-funded benefit plan within [one (1) year] from the date of termination. We will reduce this benefit by the amount of benefits paid for the same losses by any other policy or contract.

ALL OTHER TERMS AND PROVISIONS OF THE POLICY TO WHICH THIS ENDORSEMENT IS ATTACHED REMAIN THE SAME.

Signed for RELIANCE STANDARD LIFE INSURANCE COMPANY


Secretary

Endorsement Number: _____

Effective Date: _____

Excess Loss Policy Number: _____

[Policyholder/Participating Unit Name]: _____

[Policyholder's/Participating Unit's] Authorized Representative: _____

Signature

Authorized Representative's Title: _____

Date Signed: _____

RELIANCE STANDARD LIFE INSURANCE COMPANY
Administrative Office: Philadelphia, Pennsylvania

Aggregating Specific Deductible

This Endorsement is issued as a part of the Policy to which it is attached and amends the Insuring Provisions as follows:

SPECIFIC EXCESS RISK INSURANCE: We will pay you a percentage of the amount by which the Specific Losses you have Paid under your Employee Benefit Plan exceed the Specific Deductible Amount and the Aggregating Specific Deductible stated in your Schedule of Benefits.

ALL OTHER TERMS AND PROVISIONS OF THE POLICY TO WHICH THIS ENDORSEMENT IS ATTACHED REMAIN THE SAME.

Signed for RELIANCE STANDARD LIFE INSURANCE COMPANY



Secretary

Endorsement Number: _____

Effective Date: _____

Excess Loss Policy Number: _____

[Policyholder/Participating Unit Name]: _____

[Policyholder's/Participating Unit's] Authorized Representative: _____

Signature

Authorized Representative's Title: _____

Date Signed: _____

LRS-9471-1011

SERFF Tracking Number: RSLI-128046802 State: Arkansas
 Filing Company: Reliance Standard Life Insurance Company State Tracking Number:
 Company Tracking Number: LRS-9101-01-0511
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
 Product Name: Excess Loss Indemnity
 Project Name/Number: Excess Loss Indemnity/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Attachment: LRS-9102-0511-Request for Excess Loss Indemnity Coverage.pdf	Approved-Closed	02/01/2012

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR Flesch Score.pdf	Approved-Closed	02/01/2012

RELIANCE STANDARD

Life Insurance Company

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

[RSL EMPLOYER TRUST] REQUEST FOR EXCESS LOSS INDEMNITY COVERAGE

Proposal Date: [Date on Proposal]

Group Policy Number: [XX12345]

GENERAL INFORMATION

1. Full Legal Name of [Policyholder/Participating Unit]: [ABC Company]

Principal Address: [123 Anywhere Street, Providence, RI 20000]

2. Nature of Business: [Manufacturing]

3. Full Legal Name of Appointed Plan Supervisor: [DEF Administrators]

Address: [123 Any St., Any Town, AS 00000]

4. If Employee Benefit Plan of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business.

[Not Applicable]

5. Enter the full name of your Employee Benefit Plan(s) and enclose a copy with this request: [ABC Company – Employee Benefit Plan]

6. Disabled Lives: Covered () Not Covered ()
Retired Lives: Covered () Not Covered ()
COBRA Continuee: Covered () Not Covered ()

7. Excess Loss Indemnity Policy Provisions

[A. Aggregate Excess Risk Insurance

1. Company Limit of Liability: [_____] % of paid Aggregate Losses which are in excess of the Aggregate Attachment Point, subject to an Aggregate Limit of Liability of \$[_____].

In addition, the Maximum amount chargeable per covered person to Aggregate Losses is subject to a maximum limit of \$[_____].

[2. Minimum Aggregate Attachment Point of \$[_____], with an Attachment Factor of [\$_] per employee per month.

3. Additional Benefits:

Aggregate Accommodation Option: Yes () No ()

Aggregate Terminal Liability Option: Yes () No ()

(Continued)

4. Premiums:
 Deposit Premium: []
 Aggregate Premium Rate: []
 Minimum Premium Rate: []

[Aggregate Accommodation Option Premium: []
 Aggregate Terminal Liability Option Premium: []]

5. Claims Basis – Benefit Period

Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date will be limited to:
 \$ _____ for all covered persons combined.

6. Covered Plan Benefits (Applicable only if an entry is specified herein.)

() Medical; () Dental; () Vision; () Weekly Accident & Sickness;
 () Prescription Drug; () Other (as indicated)_____.

7. Loss Reduction For Insured Hospitals

If the [Policyholder/Participating Unit] named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by the Participating Unit shall be multiplied by __% when determining paid Aggregate Losses.]

[B. Specific Excess Risk Insurance

1. Company Limit of Liability:

- a. _____% of paid Specific Losses which are in excess of a specific deductible of \$____, subject to a Maximum Limit of Liability per covered person of \$_____.
- b. \$_____ Specific Deductible Amount (per person) after an aggregate corridor of \$_____ has been satisfied for the entire group.

2. Additional Benefits:

Specific Advance Option: Yes () No ()
 Specific Terminal Liability Option: Yes () No ()

3. Premiums: Specific Premium Rate(s) [\$____ per employee
 [\$____per employee w/dep.]

[Specific Advance Option Premium: [\$_____]
 [Specific Terminal Liability Option Premium: [\$_____]

(Continued)

4. Claims Basis – Benefit Period

Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date will be limited to:
\$ _____ for all covered persons combined.

5. Covered Plan Benefits (Applicable only if an entry is specified herein.)

() Medical; () Dental; () Vision () Weekly Accident & Sickness;
() Prescription Drug Card; () Other (as indicated)_____.

6. Loss Reduction For Insured Hospitals

If the Participating Unit named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by the Participating Unit shall be multiplied by ____% when determining paid Specific Losses.

7. Amount accompanying this request as an advance Payment on the premium for insurance applied for \$_____.

8. Inception Date: _____ Expiration Date : _____

9. As a condition of acceptance, the [Policyholder/Participant] has conducted a thorough review of experience developed under its Employee Benefit Plan, and as a result thereof, represents that there are no covered persons with known disabilities, or other known conditions expected to result in paid claims in excess of the Specific Deductible Amount during the Benefit Period, other than those previously disclosed as the basis for proposed coverage.]

C. Special Risk Limitations:

Coverage under this Policy will be based on the current employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:

[[An unlimited maximum for the medical plans will be covered as of 01/01/2011] _____

_____]

[RSL Employer Trust] accepts this request for the above coverage. Coverage is in effect for the period shown in item 7. Renewal of this request for a further period must be submitted on a new form.

Accepted for: _____ Participant _____

RELiance STANDARD LIFE INSURANCE COMPANY By _____
Signature

By:  Title: _____
Authorized Signature

Date: _____ Date: _____

Name of Company: RELIANCE STANDARD LIFE INSURANCE COMPANY

This is to certify that the forms on the attached list (or as described in submission letter) have obtained the score indicated by the Flesch reading ease method.

A. Option Selected

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is ____.
2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are:

<u>Form Number</u>	<u>Form</u>	<u>Flesch Score</u>
Excess Loss Indemnity Group Policy	LRS-9101-01-0511	52
Request for Excess Loss Indemnity Coverage	LRS-9102-0511	51
Aggregate Terminal Liability Endorsement	LRS-9466-0511	51
Specific Terminal Liability Endorsement	LRS-9467-0511	51
Aggregating Specific Deductible	LRS-9471-1011	51

B. Test Option Selected

1. Test was applied to entire policy form(s).
2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards of Certification

A Checked block indicates the standard has been achieved.

1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
2. It is printed in not less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables.)
3. The layout and spacing of the policy separates the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in bold face or otherwise stand out, significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)



Officer's Name
Charles Denaro

Vice President, Secretary and Deputy General Counsel
Officer's Title

Date: January 30, 2012

FGILH-0687