

SERFF Tracking Number: ANTX-128238526 State: Arkansas  
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number:  
 Company Tracking Number: APPLICATION  
 TOI: H08G Group Health - Intensive Care - Limited Sub-TOI: H08G.000 Health - Intensive Care - Limited  
 Benefit Benefit  
 Product Name: Limited Benefit Application  
 Project Name/Number: /

## Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: Limited Benefit Application SERFF Tr Num: ANTX-128238526 State: Arkansas  
 TOI: H08G Group Health - Intensive Care - Limited Benefit SERFF Status: Closed-Approved- Closed State Tr Num:  
 Sub-TOI: H08G.000 Health - Intensive Care - Limited Benefit Co Tr Num: APPLICATION State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Rosalind Minor  
 Author: Tommie Geddes Disposition Date: 04/10/2012  
 Date Submitted: 04/09/2012 Disposition Status: Approved-Closed  
 Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: 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: Association Overall Rate Impact:  
 Filing Status Changed: 04/10/2012  
 State Status Changed: 04/10/2012 Deemer Date:  
 Created By: Tommie Geddes Submitted By: Tommie Geddes  
 Corresponding Filing Tracking Number:  
 Filing Description:

We are submitting for review, form SLAICOERF, ENROLLMENT FORM, for use with our previously approved, guarantee issue group association product, form SL-EXCHBA, which was approved by the Department on 9/27/2011, SERFF tracking number ANTX-127618823. Form SLAICOERF will be used IN ADDITION TO the enrollment form approved under the referenced SERFF tracking number. This additional enrollment form will only be used for electronic or online enrollment of group association members applying for coverage. Since the approved product is already guarantee issue, this additional enrollment form is only used to collect basic information. There is a bracketed Beneficiary section, which we will not currently utilize. However, we have added it in the event we decide to add a life

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benefit or some other benefit to the product which would require this information. We would, of course, seek Departmental approval prior to adding any benefits to this previously approved product.

State Narrative:

## Company and Contact

### Filing Contact Information

Tommie Sue Geddes, Compliance Analyst tommiesue.geddes@anico.com  
 One Moody Plaza SSH MP, Ste. 200 281-538-4839 [Phone]  
 Galveston, TX 77550 409-766-6526 [FAX]

### Filing Company Information

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Texas  
 One Moody Plaza, SSH MP, Ste. 200 Group Code: 408 Company Type: Health Insurance  
 Galveston, TX 77550 Group Name: State ID Number:  
 (281) 538-4842 ext. [Phone] FEIN Number: 73-0994234

## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$50.00	04/09/2012	57823948

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/10/2012	04/10/2012

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
rate information	Note To Reviewer	Tommie Geddes	04/09/2012	04/09/2012

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## Disposition

Disposition Date: 04/10/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Rate	Limited Benefit Policy	Withdrawn	No
Rate	Optional Riders - Critical Illness and AD&D	Withdrawn	No
Rate	Optional Rider - Accident	Withdrawn	No

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**Note To Reviewer**

**Created By:**

Tommie Geddes on 04/09/2012 02:13 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

04/10/2012 09:31 AM

**Subject:**

rate information

**Comments:**

Please disregard rate information under the rate tab. I failed to delete this part from the cloned file.

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**Post Submission Update Request Processed On 04/10/2012**

**Status:** Allowed  
**Created By:** Tommie Geddes  
**Processed By:** Rosalind Minor  
**Comments:**

**Rate Information:**

Field Name	Requested Change	Prior Value
Rate Data Applies	No	Yes
Filing Method		serff
Rate Change Type		Neutral
Overall Pct. of Last Revision		0.000%
Effective Date of Last revision		07/28/2011
Filing Method of Last Filing		new

**Company Rate Information:**

**Company Name:** Standard Life and Accident Insurance Company

Field Name	Requested Change	Prior Value
Overall % Indicated Change		0.000%
Overall % Rate Impact		0.000%
Written Premium Change for this Program		\$0
# of Policy Holders Affected for this Program		0
Written Premium for this Program		\$0
Maximum %Change (where required)		0.000%
Minimum %Change (where required)		0.000%

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## Form Schedule

**Lead Form Number: SLAICOERF**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SLAICOERF	Application/Enrollment Form	Application/Enrollment Form	Initial		50.100	Enrollment Form.pdf

# STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

## ENROLLMENT FORM

Group Policy Holder \_\_\_\_\_ Requested Effective Date \_\_\_\_\_

Enrollee Name \_\_\_\_\_

Enrollee Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_

Gender  Male  Female D.O.B. \_\_\_\_\_ E-mail Address \_\_\_\_\_

### PLAN OPTIONS

Plan Selection: \_\_\_\_\_

Coverage:  Member Only  Member & Spouse  Member & Child(ren)  Family

### SPOUSE AND DEPENDENT INFORMATION (If other than Member Only coverage applied for.)

Dependent Name	Date of Birth	Social Security Number
(Spouse) _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

[Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_]

(The enrollee will be the beneficiary for his or her spouse and /or dependent children if dependent coverage is selected unless designated otherwise.)

I agree that my voice or electronic signature serves as my original signature.

Voice/Electronic Signature

\_\_\_\_\_  
Enrollee's Signature Date

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## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Withdrawn 04/10/2012	Limited Benefit Policy	SL-EXCHBP	New		RATES - EXHIBIT 1 - BASE POLICY - GENERIC.pdf RATES - EXHIBIT 4 - GENERIC.pdf
Withdrawn 04/10/2012	Optional Riders - Critical Illness and AD&D	SL-EXCHADR and SL-EXHCIR	New		RATES - EXHIBIT 3 - CRIT ILL RIDER AND AD&D - GENERIC.pdf
Withdrawn 04/10/2012	Optional Rider - Accident	SL-EXCAMER	New		RATES - EXHIBIT 2 - AME RIDER - GENERIC.pdf

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> Readability Certification.pdf	Approved-Closed	04/10/2012

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> <b>Attachment:</b> Enrollment Form.pdf	Approved-Closed	04/10/2012



## READABILITY CERTIFICATION

We hereby certify that the following forms have achieved a Flesch scale readability score which meets the minimum reading ease score as required by your state:

SLAICOERF

James P.  
Stelling

Digitally signed by James P. Stelling  
DN: cn=James P. Stelling, c=US,  
ou=Health Compliance  
Date: 2012.04.09 12:06:00 -05'00'

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James P. Stelling, J.D.  
Vice President, Health Compliance

April 9, 2012

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Date of Signature

# STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

## ENROLLMENT FORM

Group Policy Holder \_\_\_\_\_ Requested Effective Date \_\_\_\_\_

Enrollee Name \_\_\_\_\_

Enrollee Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_

Gender  Male  Female D.O.B. \_\_\_\_\_ E-mail Address \_\_\_\_\_

### PLAN OPTIONS

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(Spouse) _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

[Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_]

(The enrollee will be the beneficiary for his or her spouse and /or dependent children if dependent coverage is selected unless designated otherwise.)

I agree that my voice or electronic signature serves as my original signature.

Voice/Electronic Signature

\_\_\_\_\_  
Enrollee's Signature Date