

SERFF Tracking Number: ICCI-128148540 State: Arkansas  
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number:  
Company Tracking Number: SSL EEAPP TCP 0312  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO  
Product Name: SSL EEAPP TCP 0312  
Project Name/Number: SSL EEAPP TCP 0312/SSL EEAPP TCP 0312

## Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: SSL EEAPP TCP 0312 SERFF Tr Num: ICCI-128148540 State: Arkansas  
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved State Tr Num:  
Sub-TOI: H16G.003A Small Group Only - PPO Co Tr Num: SSL EEAPP TCP 0312 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Donna Lambert  
Author: Brenda Dawson Disposition Date: 04/27/2012  
Date Submitted: 04/26/2012 Disposition Status: Approved  
Implementation Date Requested: On Approval Implementation Date: 04/27/2012  
State Filing Description:

## General Information

Project Name: SSL EEAPP TCP 0312 Status of Filing in Domicile:  
Project Number: SSL EEAPP TCP 0312 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  
Group Market Type: Employer, Trust Overall Rate Impact:  
Filing Status Changed: 04/27/2012  
State Status Changed: 04/27/2012 Deemer Date:  
Created By: Brenda Dawson Submitted By: Brenda Dawson  
Corresponding Filing Tracking Number:  
PPACA: Not PPACA-Related  
PPACA Notes: null  
Healthcare.gov ID:  
Filing Description:

Enclosed for review and approval for use in your state is Employee Enrollment form SSL EEAPP TCP 0312-AR. This form is new and is not intended to replace any form previously approved by your Department. This form will be used with Group Major Medical Expense Policy form SSL MMC 0205 previously approved by your Department on June 30, 2005.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Standard Security Life Insurance Company of New York. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance

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Consultants, Inc.

This form will be used by the employee to enroll for coverage.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

These documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the non-variable text of the forms or to the general print size.

State Narrative:

## Company and Contact

### Filing Contact Information

Brenda Dawson, Authorized Representative      Brendadawson@inscompliance.com  
3925 East State Street, Suite 200              815-316-6714 [Phone]  
Rockford, IL 61108                              815-986-2355 [FAX]

### Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Standard Security Life Insurance Company of      CoCode: 69078                      State of Domicile: New York  
New York  
485 Madison Avenue, 14th Floor              Group Code: 450                      Company Type:  
New York, NY 10022                      Group Name:                      State ID Number:  
(212) 355-4141 ext. [Phone]              FEIN Number: 13-5679267

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## Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Security Life Insurance Company of New York	\$50.00	04/26/2012	58575977

SERFF Tracking Number: ICCL-128148540 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	04/27/2012	04/27/2012

SERFF Tracking Number: *ICCI-128148540* State: *Arkansas*  
Filing Company: *Standard Security Life Insurance Company of New York* State Tracking Number:  
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## **Disposition**

Disposition Date: *04/27/2012*

Implementation Date: *04/27/2012*

Status: *Approved*

HHS Status: *HHS Approved*

State Review: *Not Reviewed*

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *ICCI-128148540* State: *Arkansas*  
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved	Yes
<b>Supporting Document</b>	Authorization Letter	Approved	Yes
<b>Form</b>	Employee Enrollment form	Approved	Yes

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## Form Schedule

**Lead Form Number: SSL EEAPP TCP 0312-AR**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 04/27/2012	SSL EEAPP TCP 0312- AR	Application/ Employee Enrollment	Initial Enrollment form Form				AR SSL EEAPP TCP 0312-AR.pdf

# Standard Security Life Insurance Company of New York

[485 Madison Avenue, New York, NY 10022-5872]

## Employee Enrollment Form

- New group  
 Addition to existing group

Group # \_\_\_\_\_

Group Name: \_\_\_\_\_ Requested effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### A. Employee Information

Last name		First name		MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Social Security Number		Date of birth		Height	Weight		Tobacco use in last 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No
Home address				City		State	ZIP code
Telephone number—best number to reach you				This number is for my <input type="checkbox"/> work <input type="checkbox"/> home <input type="checkbox"/> mobile		Best time to call _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Email address				Date of full-time employment		Hours worked per week	
Job title/occupation				Location/Department			
How would you like to receive your Explanation of Benefits? <input type="checkbox"/> Email only <input type="checkbox"/> U.S. mail	Compensation basis <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Commission		Employee status <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Owner/partner		Current status <input type="checkbox"/> Actively at work <input type="checkbox"/> Continuation or COBRA - termination date: _____ <input type="checkbox"/> Other (such as leave of absence, disability, etc.) _____		

### B. Application Intentions

Enrolling for medical coverage for:			Waiving medical coverage for:		
Myself/Employee	Spouse	Children	Myself/Employee	Spouse	Children
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### C. Spouse and Dependent Children Information—only those ENROLLING for coverage

Spouse name (last, first, MI)				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Tobacco use in last [12] months <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Security Number		Date of birth		Height		Weight	
Child(ren) name (last, first)	Date of birth	Sex	Height	Weight	Relationship	Social Security Number	
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted <input type="checkbox"/> Other		
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted <input type="checkbox"/> Other		
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted <input type="checkbox"/> Other		
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted <input type="checkbox"/> Other		

#### Application Instructions:

- If you and all eligible dependents are enrolling for medical coverage, complete all sections of the application except Section D, Request to Waiver Coverage. Be sure to sign and date at the bottom of Section [I].
- If you and all dependents are waiving/declining coverage, complete Section D. Be sure to sign and date at the bottom of Section D.
- If you are enrolling for coverage but have eligible dependents waiving, complete all sections of the application.

Administrative Use Only	Timely EE	Spec Enroll	Late Enroll	24-hour cov	PCEFD T	Pre-Ex Ends	Eff Date	UW Apprvl	Part #	Entered by
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**D. Request to Waive Coverage**

I, and/or my dependents, request to decline coverage because of:

	Other group coverage	Covered under individual medical	Covered under government-sponsored plan	COBRA coverage	Other	No coverage
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Insurance

If waiving due to other coverage, please list the name and phone number of the insurance company (or employer if covered through a self-funded plan):

Name of insurance company	Phone number	Primary insured	Family members covered
			<input type="checkbox"/> Myself/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
			<input type="checkbox"/> Myself/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)

This is to acknowledge I have been given the opportunity to apply for the coverages available to me and my dependents (if any) and have elected not to enroll myself or my dependents (if any). I understand that by applying for coverage at a later date, a dependent of mine or I may be considered a late applicant. I understand that a late applicant will be subject to a[n] [18]-month pre-existing exclusion limitation period. I acknowledge that I have not been persuaded to waive coverage by my employer or the producing agent.

I understand that if I waive coverage for myself or my dependents because of being covered under other health insurance coverage, I may, in the future, be able to enroll myself or my dependents in this plan if the other health insurance coverage terminates. The other health coverages must have terminated because of either: 1) the "loss of eligibility" for coverage, or 2) the termination of the employer plan by the employer. I understand that I must apply for coverage within 30 days of a qualifying life event or termination of other coverage to be eligible for a special enrollment period. "Loss of eligibility" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. Loss of eligibility does not include an individual's failure to pay premiums on a timely basis or in the event of termination of coverage for cause. Examples of a loss of coverage for cause include the making of a fraudulent claim or an intentional misrepresentation of fact in connection with a group health plan.

In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll myself and certain dependents, provided that I apply within 30 days after the marriage, 90 days after birth, and within 60 days of having filed a petition to adopt a minor.

X

\_\_\_\_\_  
Signature of employee (if declining coverage)

\_\_\_\_\_  
Date

**E. Health Questions**

Please provide complete details to any question marked "Yes" in the appropriate space provided in section F. We may need to request additional information regarding your health history from you and/or your attending physician.

1. In the last [12] months, have you or any dependents applying for coverage incurred medical expenses over \$[10,000]?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you or any dependent applying for coverage:	
A. Currently pregnant, or undergoing or contemplating fertility treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Considering or been advised of a future surgery, hospitalization, organ or bone marrow transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Currently disabled (physically or mentally unable to perform the normal activities of the occupation that you are qualified to perform based on your training and experience)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past [five] years, have you or any dependent applying for coverage consulted with a medical professional, been diagnosed with or been advised of any of the following conditions? If yes, please mark those conditions that apply and provide details below in section F.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Heart, blood, circulatory conditions, including heart attack or stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Neoplasm <input type="checkbox"/> Tumor or undiagnosed growth <input type="checkbox"/> Joint disorder or arthritic conditions <input type="checkbox"/> Neurological or muscular disorders	<input type="checkbox"/> Neoplasm <input type="checkbox"/> Tumor or undiagnosed growth <input type="checkbox"/> Emphysema or lung disease <input type="checkbox"/> Lupus <input type="checkbox"/> Hepatic or liver disorder <input type="checkbox"/> Diabetes or kidney disorder
4. In the past [five] years, have you or any dependent applying for coverage tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) Related Complex, or AIDS caused by the Human Immunodeficiency Virus infection or other sickness or condition derived from such an infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**F. Health History Details, (details required for "Yes" answers above).**

Ques. #	Person's name	Condition and treatment	Date of onset Mo/Yr	Recovery date Mo/Yr	Complete name and address of physicians and hospitals

**G. Prior Insurance Coverage Information**

1. Have you and all dependents enrolling been covered by this employer's <b>major medical</b> plan for the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you and all dependents enrolling been covered under a <b>major medical</b> plan with another carrier(s) other than your current employer coverage within the past 12 months? <i>If "Yes", attach a copy of the certification of group health insurance plan coverage or other documentation of creditable coverage AND complete the following:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name(s) of covered family member	Effective date	Termination date (if applicable)	<i>Type of Coverage</i>				
			Employer group coverage	Individual medical	Government-sponsored plan	COBRA	Other
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Prior **medical** insurance carrier company name, phone number and policy number

**[H. Preferred Provider Network**

Network selected]

## I. Agreement and Signature

**Fraud Warning:** 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 may be guilty of a crime and may be subject to fines and confinement in prison and/or denial of insurance benefits.

**[Arkansas Residents:** 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.]

**[Ohio Residents:** Any person who, with intent to defraud or knowing that he 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.

**[Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application 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 subject such person to criminal and civil penalties.]

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

**[Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

**[Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.]

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

This group health plan contains a pre-existing condition exclusion period of 12 months ([18] months for late enrollees). This exclusion period can be reduced by the number of days you maintained prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, the plan will not take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you must **submit a certificate of creditable coverage**. Creditable coverage can include coverage under another group health plan, an individual medical health policy, short-term health plans, student health plans, Medicare, Medicaid, TriCare (formally CHAMPUS), a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, a health plan issued under the Peace Corp Act or an S-CHIP. You may request a certificate of creditable coverage from a previous employer's insurance company or Health Maintenance Organization (HMO). If you submit a certificate of creditable coverage (or documentation of creditable coverage through other means) then we will make a determination regarding the length of any pre-existing condition exclusion that applies to you or your dependents. If you cannot obtain a copy of your certificate of creditable coverage, you may contact the plan administrator for assistance. We reserve the right to modify an initial determination of creditable coverage if we determine that your claimed coverage is in error, provided that we send you a notice of reconsideration. Until the final determination is made, we will, for the purpose of pre-certification under the plan, act in a manner consistent with the initial determination.

**Premium Payment:** I authorize my employer to deduct the requested premium contribution, if any, from my earnings.

**Full-Time Employment:** I understand that one of the requirements for eligibility on the effective date and for continued eligibility under the plan is that I am actively at work and employed full-time (at least 30 hours per week) at my employer's place of business.

**[Precertification:** I understand that failure to precertify treatment results in reduced benefits pursuant to the terms of the group master policy.]

**Benefit Availability:** I understand that my benefits under this plan begin with a specific effective date of coverage applicable to me and coverage ends at the end of a month in which due premium has not been paid. I understand if I attempt to utilize the benefit plan or prescription drug card when coverage is no longer effective under the plan, I will be personally responsible for those expenses incurred and can be billed by the providers or insurance company for those services.

**U.S. Resident:** I understand that the coverage under this plan is available for United States residents and benefits are not payable for medical expenses outside of the United States except for emergency care when traveling.

**Pre-existing condition limitation provisions:** I understand that my coverage and that of my dependents, if approved, may be subject to pre-existing conditions limitation provisions regardless of the medical conditions disclosed on the application pursuant to the terms of the group master policy.

**My answers are true and correct:** I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any intentional material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my dependents. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or instruct me not to disclose any particular medical condition on the Application. I understand that no agent is authorized or has authority to alter the terms of the group master policy.

**Application for Group:** I understand that my employer agreed to participate in the group to which the group policy was issued, and I am simultaneously applying for insurance for which I am now or may be eligible for under the provisions of the group policy issued to that group by Standard Security Life Insurance Company of New York. I understand that my insurance will not be in force until the application is approved by Standard Security Life Insurance Company of New York or their authorized administrator in accordance with the underwriting guidelines in effect.

X

\_\_\_\_\_  
Signature of employee (and parent if applicant is under age 18)

\_\_\_\_\_  
Date

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved	04/27/2012
<b>Comments:</b>		
<b>Attachment:</b> Cert of Comp. with Rule 19 SSL EEAPP TCP 0312.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved	04/27/2012
<b>Comments:</b> see form schedule tab		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved	04/27/2012
<b>Bypass Reason:</b> NA		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Authorization Letter	Approved	04/27/2012
<b>Comments:</b>		
<b>Attachment:</b> ICC Authorization letter SSL 2012.pdf		

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s): SSL EEAPP TCP 0312 AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Rachel Lipari

Name

President

Title

April 26, 2012

Date



January 1, 2011

Mr. Brian Camling  
President  
Insurance Compliance Consultants, Inc.  
3925 East State Street, Suite 200  
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Standard Security Life Insurance Company of New York regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Standard Security may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in cursive script that reads "Rachel Lipari".

Rachel Lipari