

**State:** Arkansas **Filing Company:** Standard Insurance Company  
**TOI/Sub-TOI:** H111 Individual Health - Disability Income/H111.004 Other  
**Product Name:** IDI ERISA Claims Endorsements  
**Project Name/Number:** Discretionary Clause Removal/12611

## Filing at a Glance

Company: Standard Insurance Company  
Product Name: IDI ERISA Claims Endorsements  
State: Arkansas  
TOI: H111 Individual Health - Disability Income  
Sub-TOI: H111.004 Other  
Filing Type: Form  
Date Submitted: 01/09/2013  
SERFF Tr Num: STAN-128841351  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 12611  
  
Implementation: On Approval  
Date Requested:  
Author(s): Ruth Ansin  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 01/28/2013  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** Standard Insurance Company  
**TOI/Sub-TOI:** H111 Individual Health - Disability Income/H111.004 Other  
**Product Name:** IDI ERISA Claims Endorsements  
**Project Name/Number:** Discretionary Clause Removal/12611

## General Information

Project Name: Discretionary Clause Removal

Project Number: 12611

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Ruth Ansin

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Forms are specific to Arkansas only.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 01/28/2013

State Status Changed: 01/28/2013

Created By: Ruth Ansin

Corresponding Filing Tracking Number:

Filing Description:

The forms in this submission, previously approved by your office, are revised to remove the "Allocation of Authority" provision (please refer to "markup" copies provided as supporting documentation, in which the revisions are highlighted). This revision is required by recently promulgated Arkansas Rule 101 prohibiting discretionary clauses in In disability income policies issued or renewed on and after March 1, 2013. For ease of implementation in our systems, we wish to place these revised forms into use upon your approval, rather than waiting until march 1, 2013.

Besides removal of the discretionary clause, we have updated the form numbers of both forms and our company officers' names and signatures on form 12611-505(2/10)AR. No other changes have been made to these forms.

The forms are as follows:

12611(2/13)AR - ERISA Claims Procedures Policy Endorsement - previous form number 12611(7/10) approved Oct. 8, 2010 (SERFF Trk Num STAN-126741941).

12611-505(2/13)AR - ERISA Claims Procedures Policy Endorsement - previous form number 12611(5/05) approved June 24, 2005 (paper filing).

We appreciate your time and we look forward to your response.

Thank you.

## Company and Contact

### Filing Contact Information

Ruth Ansin, Senior Compliance Analyst      ransin@standard.com  
1100 SW Sixth Avenue                              971-321-8514 [Phone]  
P6D    971-321-7805 [FAX]  
Portland, OR 97204

**State:** Arkansas **Filing Company:** Standard Insurance Company  
**TOI/Sub-TOI:** H111 Individual Health - Disability Income/H111.004 Other  
**Product Name:** IDI ERISA Claims Endorsements  
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**Filing Company Information**

Standard Insurance Company	CoCode: 69019	State of Domicile: Oregon
1100 SW 6th Avenue	Group Code: 1348	Company Type: Life
Portland, OR 97204	Group Name: SIC	Insurance
(971) 321-6823 ext. [Phone]	FEIN Number: 93-0242990	State ID Number:

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: Arkansas fee is \$50 per form. This submission contains 2 forms.  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Standard Insurance Company	\$100.00	01/09/2013	66408024

State: Arkansas Filing Company: Standard Insurance Company  
TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.004 Other  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/28/2013	01/28/2013

**State:** Arkansas  
**TOI/Sub-TOI:** H111 Individual Health - Disability Income/H111.004 Other  
**Product Name:** IDI ERISA Claims Endorsements  
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## Disposition

Disposition Date: 01/28/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	12611(2/13)AR Markup Showing Revisions	Approved-Closed	Yes
Supporting Document	12611-505(2/13)AR Markup Showing Revisions	Approved-Closed	Yes
Form	ERISA Claims Procedures Policy Endorsement	Approved-Closed	Yes
Form	ERISA Claims Procedures Policy Endorsement	Approved-Closed	Yes

State: Arkansas

Filing Company:

Standard Insurance Company

TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.004 Other

Product Name: IDI ERISA Claims Endorsements

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## Form Schedule

### Lead Form Number: 12611(2/13)AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/28/2013	ERISA Claims Procedures Policy Endorsement	12611(2/13)AR	POLA	Initial		50.000	12611ar_0213.pdf
2	Approved-Closed 01/28/2013	ERISA Claims Procedures Policy Endorsement	12611-505(2/13)AR	POLA	Initial		51.000	12611ar_505_0213.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

STANDARD INSURANCE COMPANY

**ERISA CLAIMS PROCEDURES POLICY ENDORSEMENT**

This endorsement is part of the policy shown below.

Insured: [Name]

Policy Number: [Number]

Owner: [Owner]

Effective Date of this Endorsement: [Date]

This endorsement includes mandatory claims language for policies covered by requirements of the Employee Retirement Income Security Act ("ERISA").

The policy is amended by completely removing the **CLAIMS** section of the policy and replacing it with the following:

**CLAIMS**

**NOTICE OF CLAIM**

You or the Owner, or your authorized personal representative, must send written notice of claim within 30 days after your Disability {or your Loved One's Serious Health Condition} starts, or as soon as is reasonably possible. Written notice must be given to us at our Home Office or to any of our authorized sales representatives. It must include your name and the Policy Number.

**CLAIM FORMS**

After we receive written notice of claim, we will provide our claim form(s) to be completed and submitted as part of the required Proof Of Loss. If we do not provide our form(s) within 15 days after we receive written notice of claim, you may submit a letter of claim to our Home Office. The letter must include the date the Disability {or Serious Health Condition} began, and the cause and nature of the Disability {or Serious Health Condition}.

**PROOF OF LOSS**

You are responsible for providing Proof Of Loss. We must receive Proof Of Loss within 90 days after the end of each monthly period for which you claim benefits. If that is not reasonably possible, the claim will not be affected, provided written proof is furnished as soon as is reasonably possible. However, unless you lack legal capacity, we must be given written proof within one year after the 90th day referred to above, for that claim to be valid.

**Proof Of Loss** means written proof that you are or were Disabled and entitled to benefits under this policy. In addition to the completed claim form(s), or your letter of claim, Proof Of Loss includes proof that:

- You became Disabled while this policy was in force; and

- Your Disability was a Continuous Disability through the Benefit Waiting Period and the Commencement Date; and
- You are or were under the regular care of a Physician appropriate for your Injury or Sickness.

{For purposes of the Compassionate Disability Benefit, Proof Of Loss means written proof that, while this policy was in force and continuous through the Benefit Waiting Period, your Loved One had a Serious Health Condition; and you worked reduced hours and had reduced earnings during that Loved One's Serious Health Condition.}

Proof Of Loss for any claim may also include any information and documentation we may reasonably require in order to substantiate and evaluate your claim, including but not limited to:

- medical records and physician's notes or statements;
- medical examinations;
- documentation of your prior and current income, including tax returns;
- examination(s) of financial and operational records.

If any required information or documentation is not provided within 45 days after we send our request, your claim may be denied.

Except for medical or financial records examinations, you are responsible for all costs of providing Proof Of Loss.

We will require written authorization for us to obtain the information or documentation we require as Proof Of Loss. We will also require you to submit additional documentation of your claim at your expense at reasonable intervals while you are receiving benefits.

## **EXAMINATIONS**

As part of the required Proof Of Loss, we have the right to require periodic examinations to determine your eligibility for benefits. These examinations will be done at our expense. We will choose examiner(s) appropriate for the evaluation of your claim. Examinations may include but are not limited to:

- independent medical and psychiatric examinations by physicians or specialists;
- functional capacity examinations and occupational and vocational evaluations;
- examinations and analyses of your financial and operational records and those of any business in which you have an interest. Such records may include tax returns, financial statements, billing and expense information, bank statements, cancelled checks or other documents.

We may defer or suspend payment of benefits if you fail to submit to an examination, or if you fail to cooperate with the person conducting the examination. Benefits may be resumed, provided that the required examination occurs within a reasonable time and benefits are otherwise payable.

## **TIME OF PAYMENT**

After we receive satisfactory written Proof Of Loss and all other conditions are met, we will pay benefits under this policy. Any accrued benefits will be paid immediately. Any benefits due thereafter will be paid monthly. For periods of less than one month, we will pay a prorated portion of the monthly benefit for each day benefits are payable. Payment will be subject to our receipt of continued Proof Of Loss.

Once your claim is approved, benefits will continue until the end of the period for which you have provided us with satisfactory written Proof Of Loss, subject to the terms and limits of this policy. We will require you to submit additional Proof Of Loss at reasonable intervals while you are continuing to receive benefits.

## **PAYMENT OF CLAIMS**

We will pay all benefits to the Owner or the Owner's estate, unless the Owner names a payee to receive such benefits. Designation of a payee, or change of a previously named payee, must be in writing and signed by the Owner. At the Owner's request we will provide a form for naming or changing a payee.

We can pay total benefits of up to \$1,000 to any relative of the Owner we believe is entitled to them if any benefit is payable to the Owner's estate, or if the Owner or any payee lacks legal capacity to give a valid release.

We will not be liable to anyone to the extent we make payment in good faith.

## **OVERPAYMENT OF BENEFITS**

We have the right to be reimbursed for any overpayment of benefits under this policy. We will notify the Owner promptly upon the discovery of any overpayment. After such notice, any and all overpayments that have not been reimbursed will become a debt due and payable to us. We will withhold the unreimbursed portion of any overpayments from any benefit payments due under the policy, regardless of the payee, until all overpayment amounts are repaid in full.

## **INVESTIGATION OF YOUR CLAIM**

We may conduct an investigation of your claim at any time. We will pay benefits only after we have had a reasonable time to conduct an investigation of your claim, and we have determined that benefits are payable.

## **NOTICE OF DECISION ON CLAIM**

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (1) A written decision on your claim; or (2) A notice that we are extending the period to decide your claim by 30 days. By the end of the extension we will send you: (1) A written decision on your claim; or (2) A notice that we are extending the period to decide your claim for another 30 days.

If we extend the period to decide your claim, we will notify you of the following: (1) The reasons for the extension; (2) When we expect to decide your claim; (3) An explanation of the standards on which entitlement to benefits are based; (4) The unresolved issues; and (5) Any additional information we need to resolve those issues. If we request additional information, you have 45 days to: (1) Provide the information; or (2) Otherwise respond to our request.

If an extension is due to your failure to provide necessary claim information, the extended time period for deciding Your claim will not begin until you: (1) Provide the information; or (2) Otherwise respond. However, if you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- The reasons for our decision; and
- Reference to the parts of the policy on which our decision is based; and
- A description of any additional information needed to support your claim; and
- Reference to any internal rule or guideline relied upon in making our decision; and
- Information concerning your right to:
  - a. A review of our decision; and
  - b. Bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.

## **REVIEW PROCEDURE FOR DENIED CLAIMS**

If all or part of your claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

Our review will be subject to the following:

1. The review will not give deference to the initial decision; and
2. The person conducting the review (the Reviewer) will be someone other than the person who denied your claim; and
3. The Reviewer will not be subordinate to the person who denied your claim; and
4. If the denial was based on a medical judgment, the Reviewer will consult with a qualified health care professional other than the person who made the original medical judgment; and
5. The health care professional referenced in number 4 immediately above will not be subordinate to the person who made the original medical judgment.

You may:

- Send us written comments or other items to support your claim; and
- Review and receive copies of any non-privileged information that relates to your request for review. There will be no charge for such copies; and
- Request the names of medical or vocational experts who provided advice to us about your claim.

We will review your claim promptly after we receive your request. Within 45 days after we receive your request for review we will send you: (1) Our written decision; or (2) A notice that we are extending the review period for 45 days. Our review will include any written comments or other items you submit to support your claim.

If our review is extended, we will notify you of the following: (1) The reasons for the extension; (2) When we expect to decide your claim on review; and (3) Any additional information we need to decide your claim.

If we request additional information, you have 45 days to: (1) Provide that information; or (2) Otherwise respond to our request.

If an extension is due to your failure to provide necessary claim review information, the extended time period for claim decision review will not begin until you: (1) Provide the information; or (2) Otherwise respond. However, if you do not provide the requested information within 45 days, we may conclude our review of your claim based on the information we have received.

If we deny any part of your claim on review, you will receive a written notice of our denial. It will contain:

- The reasons for our decision; and
- Reference to the parts of the policy on which our decision is based; and
- Reference to any internal rule or guideline relied upon in making our decision; and
- Information concerning your right to:
  - Review and receive free of charge copies of non-privileged documents and records relevant to your claim; and
  - Bring a civil action for benefits under Section 502(a) of ERISA.

The policy does not provide voluntary alternative dispute resolution options. However, you may contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency for assistance.

**PART OF POLICY**

This endorsement is part of the policy to which it is attached. All policy terms and conditions will apply to this endorsement if they have not been changed by this endorsement and do not conflict with this endorsement.

{ \_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_\_  
Signature of Proposed Insured City State Date

\_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_\_  
Signature of Owner (If Other than Proposed Insured) City State Date

Sign in duplicate. SIGN ORIGINAL IN THE POLICY. Return signed copy to:

Individual Policy Issue Department  
1100 S.W. Sixth Avenue Portland, Oregon 97204  
(800) 247-6888}

STANDARD INSURANCE COMPANY

By



J. Greg Ness  
President



Holley Y. Franklin  
Corporate Secretary

Standard Insurance Company

**ERISA CLAIMS PROCEDURES  
POLICY ENDORSEMENT**

This endorsement is part of the policy shown below.

Insured: [Name]

Policy Number: [Number]

Policyowner: [Owner]

Effective Date of this Endorsement: [Date]

This endorsement includes mandatory claims language for policies covered by requirements of the Employee Retirement Income Security Act ("ERISA").

The policy is amended by completely removing the **CLAIMS** section of the policy and replacing it with the following:

**CLAIMS**

**TIME OF LOSS** – We will pay benefits under this policy only for a Loss which occurs while this policy is in force. Except as noted in the definition of Maximum Benefit Period (see Definitions) termination of the policy will not affect any claim for Disability, provided that:

1. Your Disability begins within 30 days after the date of the Injury or Sickness causing Your Disability; and
2. Your Injury or Sickness occurs while this policy is in force. (See Policy Termination.)

**WRITTEN NOTICE OF CLAIM** – We must be given written notice of claim by You or the Owner:

1. Within 30 days after a Loss starts; or
2. As soon as is reasonably possible.

Written notice must be given:

1. To Us at Our home office; or
2. To any of Our authorized sales representatives.

Written notice must include Your name and the policy number.

**CLAIM FORMS** – We will send the Owner a claim statement within 15 days after We receive written notice of claim. If You do not receive Our forms within 15 days after You ask for them, You may submit Your claim in a letter sent to Us at Our home office. The letter should include the date the Disability began and the cause and nature of the Disability.

**WRITTEN PROOF OF LOSS** – We must receive written proof of Loss within 90 days after the end of any period for which benefits are being claimed. If that is not reasonably possible, the claim will not be affected, provided written proof is furnished as soon as is reasonably possible. However, unless You lack legal capacity, We must be given written proof within one year after the 90th day referred to above, for that claim to be valid.

Each of the following elements of proof of Loss must be provided to Us at Your expense. We will not pay any Disability Benefits until We receive satisfactory written proof of all of the following:

1. You became Disabled while insured under this policy and while it was in force;
2. Your Disability was a Continuous Disability through the Waiting Period and the Commencement Date; and
3. You are under the regular care of a Physician appropriate for Your Injury or Sickness.

You must also submit all of the following documents at Your expense:

1. A completed claim statement signed by You.
2. A completed claim statement signed by Your Physician.
3. A written authorization for Us to obtain records and information needed to determine Your eligibility for Disability Benefits. This must be:
  - a. On a form satisfactory to Us; and
  - b. Signed by You.
4. Such other documents and information as We may reasonably require in connection with Your claim.

In any event if any required documentation is not provided within 45 days after We send Our request for such documentation, Your claim may be denied.

Once Your claim is approved, no Disability Benefits will be continued beyond the end of the period for which You have provided Us with satisfactory written proof of Loss.

We will require You to submit additional documentation of Your claim at Your expense at reasonable intervals while You are receiving Disability Benefits.

**PROOF OF INCOME** – We can require any proof We consider necessary to establish Your current and prior incomes. We have the right to examine Your financial records, including Your tax returns, as often as We may reasonably require. These financial records may cover any period for which You claim to be Disabled.

**INVESTIGATION OF YOUR CLAIM** – We may conduct an investigation of Your claim at any time. We will not pay any Disability Benefits until: (1) We have had a reasonable time to conduct any investigation of Your claim; and (2) We have determined that Disability Benefits are payable.

**NOTICE OF DECISION ON CLAIM** – We will evaluate Your claim promptly after You file it. Within 45 days after We receive Your claim We will send You: (1) A written decision on Your claim; or (2) A notice that We are extending the period to decide Your claim by 30 days. By the end of the extension We will send You: (1) A written decision on Your claim; or (2) A notice that We are extending the period to decide Your claim for another 30 days.

If We extend the period to decide Your claim, We will notify You of the following: (1) The reasons for the extension; (2) When We expect to decide Your claim; (3) An explanation of the standards on which entitlement to benefits are based; (4) The unresolved issues; and (5) Any additional information We need to resolve those issues. If We request additional information, You have 45 days to: (1) Provide the information; or (2) Otherwise respond to Our request.

If an extension is due to Your failure to provide necessary claim information, the extended time period for deciding Your claim will not begin until You: (1) Provide the information; or (2) Otherwise respond. However, if You do not provide the requested information within 45 days, We may decide Your claim based on the information We have received.

If We deny any part of Your claim, You will receive a written notice of denial containing:

1. The reasons for Our decision;
2. Reference to the parts of the policy on which Our decision is based;
3. A description of any additional information needed to support Your claim;
4. Reference to any internal rule or guideline relied upon in making Our decision; and
5. Information concerning Your right to:
  - a. A review of Our decision; and
  - b. Bring a civil action for benefits under section 502(a) of ERISA if Your claim is denied on review.

**REVIEW PROCEDURE FOR DENIED CLAIMS** – If all or part of Your claim is denied, You may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

Our review will be subject to the following:

1. The review will not give deference to the initial decision;
2. The person conducting the review (the Reviewer) will be someone other than the person who denied Your claim;
3. The Reviewer will not be subordinate to the person who denied Your claim;
4. If the denial was based on a medical judgment, the Reviewer will consult with a qualified health care professional other than the person who made the original medical judgment; and
5. The health care professional referenced in number 4 immediately above will not be subordinate to the person who made the original medical judgment.

You may:

1. Send Us written comments or other items to support Your claim;
2. Review and receive copies of any non-privileged information that relates to Your request for review. There will be no charge for such copies; and
3. Request the names of medical or vocational experts who provided advice to Us about Your claim.

We will review Your claim promptly after We receive Your request. Within 45 days after We receive Your request for review We will send You: (1) Our written decision; or (2) A notice that We are extending the review period for 45 days. Our review will include any written comments or other items You submit to support Your claim.

If Our review is extended, We will notify You of the following: (1) The reasons for the extension; (2) When We expect to decide Your claim on review; and (3) Any additional information We need to decide Your claim.

If We request additional information, You have 45 days to: (1) Provide that information; or (2) Otherwise respond to Our request.

If an extension is due to Your failure to provide necessary claim review information, the extended time period for claim decision review will not begin until You: (1) Provide the information; or (2) Otherwise respond. However, if You do not provide the requested information within 45 days, We may conclude Our review of Your claim based on the information We have received.

If We deny any part of Your claim on review, You will receive a written notice of Our denial. It will contain:

1. The reasons for Our decision;
2. Reference to the parts of the policy on which Our decision is based;
3. Reference to any internal rule or guideline relied upon in making Our decision; and
4. Information concerning Your right to:
  - a. Review and receive free of charge copies of non-privileged documents and records relevant to Your claim; and
  - b. Bring a civil action for benefits under section 502(a) of ERISA.

The policy does not provide voluntary alternative dispute resolution options. However, You may contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency for assistance.

**MEDICAL EXAM** – We can have Physicians or specialists examine You, at Our expense, as often as reasonably necessary while You claim to be Disabled. Any such examination will be conducted by one or more Physicians or specialists We choose.

We may defer or suspend payment of benefits if: (1) You fail to attend an examination; or (2) You fail to cooperate with the person conducting the examination. Benefits may be resumed, provided that the required examination occurs within a reasonable time and benefits are otherwise payable.

**TIME OF PAYMENT** – After We receive satisfactory written proof of Loss and all other conditions are met, We will pay benefits under this policy. Any accrued benefits will be paid immediately. Any benefits due thereafter will be paid monthly. Payment will be subject to our receipt of continued written proof of Loss.

**PAYMENT OF CLAIMS** – We will pay all benefits to the Owner or the Owner’s estate, unless the Owner names a payee to receive such benefits. Designation of a payee, or change of a previously named payee, must be in writing and signed by the Owner. At the Owner’s request We will provide a form for naming or changing a payee.

We can pay total benefits of up to \$1,000 to any relative of the Owner We believe is entitled to them, if:

- 1. Any benefit is payable to the Owner’s estate; or
- 2. The Owner or any payee lacks legal capacity to give a valid release.

We will not be liable to anyone to the extent We make payment in good faith.

**OVERPAYMENT OF BENEFITS** – We have the right to be reimbursed for any overpayment of benefits under this policy. We will notify the Owner promptly upon the discovery of any overpayment. After such notice, any and all overpayments that have not been reimbursed will become a debt due and payable to Us. We will offset the unreimbursed portion of any overpayments against any benefit payments due under the policy, regardless of the payee, until all overpayment amounts are repaid in full.

**PART OF POLICY** – This endorsement is part of the policy to which it is attached. All policy terms and conditions will apply to this endorsement if they:

- 1. Have not been changed by this endorsement; and
- 2. Do not conflict with this endorsement.

{ \_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of Proposed Insured City State Date

\_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of Owner (If Other than Proposed Insured) City State Date}

Sign in duplicate. SIGN ORIGINAL IN THE POLICY. Return signed copy to:

Individual Policy Issue Department  
1100 S.W. Sixth Avenue Portland, Oregon 97204  
(800) 247-6888}

STANDARD INSURANCE COMPANY

By



J. Greg Ness  
President



Holley Y. Franklin  
Corporate Secretary

SERFF Tracking #:

STAN-128841351

State Tracking #:

Company Tracking #:

12611

State: Arkansas

Filing Company:

Standard Insurance Company

TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.004 Other

Product Name: IDI ERISA Claims Endorsements

Project Name/Number: Discretionary Clause Removal/12611

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/28/2013
Comments:			
Attachment(s):			
ReadabilityCertif.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/28/2013
Bypass Reason:	Filing does not include a policy. The only forms in this submission are two previously approved endorsement forms now revised to comply with Arkansas Rule 101 regarding discretionary clauses.		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/28/2013
Bypass Reason:	There are no rates in this submission and the forms in this submission have no associated rates.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/28/2013
Bypass Reason:	Filing does not include a policy. The only forms in this submission are two previously approved endorsement forms now revised to comply with Arkansas Rule 101 regarding discretionary clauses.		
		Item Status:	Status Date:
Satisfied - Item:	12611(2/13)AR Markup Showing Revisions	Approved-Closed	01/28/2013
Comments:			
Attachment(s):			
12611ar_0213_markup.pdf			
		Item Status:	Status Date:
Satisfied - Item:	12611-505(2/13)AR Markup Showing Revisions	Approved-Closed	01/28/2013
Comments:			

**SERFF Tracking #:**

STAN-128841351

**State Tracking #:**

**Company Tracking #:**

12611

**State:**

Arkansas

**Filing Company:**

Standard Insurance Company

**TOI/Sub-TOI:**

H111 Individual Health - Disability Income/H111.004 Other

**Product Name:**

IDI ERISA Claims Endorsements

**Project Name/Number:**

Discretionary Clause Removal/12611

Attachment(s):

12611AR\_505\_0213\_markup.pdf

Standard Insurance Company

1100 SW SIXTH AVENUE  
PORTLAND, OR 97204

CERTIFICATION OF READABILITY

I hereby certify that to the best of my knowledge and belief, the below-referenced form(s) meet or exceed the minimum reading ease score and all other readability requirements of any applicable insurance laws and regulations in this State.

  
C. Elizabeth Sloan \_\_\_\_\_ Date 1/9/2013

2nd VP and Associate Counsel, ISG - Legal

<u>Form Number</u>	<u>Flesch Reading Ease Score</u>
12611(2/13)AR	50
12611-505(2/13)AR	51

STANDARD INSURANCE COMPANY

**ERISA CLAIMS PROCEDURES POLICY ENDORSEMENT**

This endorsement is part of the policy shown below.

Insured: [Name]

Policy Number: [Number]

Owner: [Owner]

Effective Date of this Endorsement: [Date]

This endorsement includes mandatory claims language for policies covered by requirements of the Employee Retirement Income Security Act ("ERISA").

The policy is amended by completely removing the **CLAIMS** section of the policy and replacing it with the following:

**CLAIMS**

**NOTICE OF CLAIM**

You or the Owner, or your authorized personal representative, must send written notice of claim within 30 days after your Disability {or your Loved One's Serious Health Condition} starts, or as soon as is reasonably possible. Written notice must be given to us at our Home Office or to any of our authorized sales representatives. It must include your name and the Policy Number.

**CLAIM FORMS**

After we receive written notice of claim, we will provide our claim form(s) to be completed and submitted as part of the required Proof Of Loss. If we do not provide our form(s) within 15 days after we receive written notice of claim, you may submit a letter of claim to our Home Office. The letter must include the date the Disability {or Serious Health Condition} began, and the cause and nature of the Disability {or Serious Health Condition}.

**PROOF OF LOSS**

You are responsible for providing Proof Of Loss. We must receive Proof Of Loss within 90 days after the end of each monthly period for which you claim benefits. If that is not reasonably possible, the claim will not be affected, provided written proof is furnished as soon as is reasonably possible. However, unless you lack legal capacity, we must be given written proof within one year after the 90th day referred to above, for that claim to be valid.

**Proof Of Loss** means written proof that you are or were Disabled and entitled to benefits under this policy. In addition to the completed claim form(s), or your letter of claim, Proof Of Loss includes proof that:

- You became Disabled while this policy was in force; and

- Your Disability was a Continuous Disability through the Benefit Waiting Period and the Commencement Date; and
- You are or were under the regular care of a Physician appropriate for your Injury or Sickness.

{For purposes of the Compassionate Disability Benefit, Proof Of Loss means written proof that, while this policy was in force and continuous through the Benefit Waiting Period, your Loved One had a Serious Health Condition; and you worked reduced hours and had reduced earnings during that Loved One's Serious Health Condition.}

Proof Of Loss for any claim may also include any information and documentation we may reasonably require in order to substantiate and evaluate your claim, including but not limited to:

- medical records and physician's notes or statements;
- medical examinations;
- documentation of your prior and current income, including tax returns;
- examination(s) of financial and operational records.

If any required information or documentation is not provided within 45 days after we send our request, your claim may be denied.

Except for medical or financial records examinations, you are responsible for all costs of providing Proof Of Loss.

We will require written authorization for us to obtain the information or documentation we require as Proof Of Loss. We will also require you to submit additional documentation of your claim at your expense at reasonable intervals while you are receiving benefits.

## **EXAMINATIONS**

As part of the required Proof Of Loss, we have the right to require periodic examinations to determine your eligibility for benefits. These examinations will be done at our expense. We will choose examiner(s) appropriate for the evaluation of your claim. Examinations may include but are not limited to:

- independent medical and psychiatric examinations by physicians or specialists;
- functional capacity examinations and occupational and vocational evaluations;
- examinations and analyses of your financial and operational records and those of any business in which you have an interest. Such records may include tax returns, financial statements, billing and expense information, bank statements, cancelled checks or other documents.

We may defer or suspend payment of benefits if you fail to submit to an examination, or if you fail to cooperate with the person conducting the examination. Benefits may be resumed, provided that the required examination occurs within a reasonable time and benefits are otherwise payable.

## **TIME OF PAYMENT**

After we receive satisfactory written Proof Of Loss and all other conditions are met, we will pay benefits under this policy. Any accrued benefits will be paid immediately. Any benefits due thereafter will be paid monthly. For periods of less than one month, we will pay a prorated portion of the monthly benefit for each day benefits are payable. Payment will be subject to our receipt of continued Proof Of Loss.

Once your claim is approved, benefits will continue until the end of the period for which you have provided us with satisfactory written Proof Of Loss, subject to the terms and limits of this policy. We will require you to submit additional Proof Of Loss at reasonable intervals while you are continuing to receive benefits.

## **PAYMENT OF CLAIMS**

We will pay all benefits to the Owner or the Owner's estate, unless the Owner names a payee to receive such benefits. Designation of a payee, or change of a previously named payee, must be in writing and signed by the Owner. At the Owner's request we will provide a form for naming or changing a payee.

We can pay total benefits of up to \$1,000 to any relative of the Owner we believe is entitled to them if any benefit is payable to the Owner's estate, or if the Owner or any payee lacks legal capacity to give a valid release.

We will not be liable to anyone to the extent we make payment in good faith.

## **OVERPAYMENT OF BENEFITS**

We have the right to be reimbursed for any overpayment of benefits under this policy. We will notify the Owner promptly upon the discovery of any overpayment. After such notice, any and all overpayments that have not been reimbursed will become a debt due and payable to us. We will withhold the unreimbursed portion of any overpayments from any benefit payments due under the policy, regardless of the payee, until all overpayment amounts are repaid in full.

## **INVESTIGATION OF YOUR CLAIM**

We may conduct an investigation of your claim at any time. We will pay benefits only after we have had a reasonable time to conduct an investigation of your claim, and we have determined that benefits are payable.

## **NOTICE OF DECISION ON CLAIM**

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (1) A written decision on your claim; or (2) A notice that we are extending the period to decide your claim by 30 days. By the end of the extension we will send you: (1) A written decision on your claim; or (2) A notice that we are extending the period to decide your claim for another 30 days.

If we extend the period to decide your claim, we will notify you of the following: (1) The reasons for the extension; (2) When we expect to decide your claim; (3) An explanation of the standards on which entitlement to benefits are based; (4) The unresolved issues; and (5) Any additional information we need to resolve those issues. If we request additional information, you have 45 days to: (1) Provide the information; or (2) Otherwise respond to our request.

If an extension is due to your failure to provide necessary claim information, the extended time period for deciding Your claim will not begin until you: (1) Provide the information; or (2) Otherwise respond. However, if you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- The reasons for our decision; and
- Reference to the parts of the policy on which our decision is based; and
- A description of any additional information needed to support your claim; and
- Reference to any internal rule or guideline relied upon in making our decision; and
- Information concerning your right to:
  - a. A review of our decision; and
  - b. Bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.

## **REVIEW PROCEDURE FOR DENIED CLAIMS**

If all or part of your claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

Our review will be subject to the following:

1. The review will not give deference to the initial decision; and
2. The person conducting the review (the Reviewer) will be someone other than the person who denied your claim; and
3. The Reviewer will not be subordinate to the person who denied your claim; and
4. If the denial was based on a medical judgment, the Reviewer will consult with a qualified health care professional other than the person who made the original medical judgment; and
5. The health care professional referenced in number 4 immediately above will not be subordinate to the person who made the original medical judgment.

You may:

- Send us written comments or other items to support your claim; and
- Review and receive copies of any non-privileged information that relates to your request for review. There will be no charge for such copies; and
- Request the names of medical or vocational experts who provided advice to us about your claim.

We will review your claim promptly after we receive your request. Within 45 days after we receive your request for review we will send you: (1) Our written decision; or (2) A notice that we are extending the review period for 45 days. Our review will include any written comments or other items you submit to support your claim.

If our review is extended, we will notify you of the following: (1) The reasons for the extension; (2) When we expect to decide your claim on review; and (3) Any additional information we need to decide your claim.

If we request additional information, you have 45 days to: (1) Provide that information; or (2) Otherwise respond to our request.

If an extension is due to your failure to provide necessary claim review information, the extended time period for claim decision review will not begin until you: (1) Provide the information; or (2) Otherwise respond. However, if you do not provide the requested information within 45 days, we may conclude our review of your claim based on the information we have received.

If we deny any part of your claim on review, you will receive a written notice of our denial. It will contain:

- The reasons for our decision; and
- Reference to the parts of the policy on which our decision is based; and
- Reference to any internal rule or guideline relied upon in making our decision; and
- Information concerning your right to:
  - Review and receive free of charge copies of non-privileged documents and records relevant to your claim; and
  - Bring a civil action for benefits under Section 502(a) of ERISA.

The policy does not provide voluntary alternative dispute resolution options. However, you may contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency for assistance.

## **ALLOCATION OF AUTHORITY**

We have full and exclusive authority to: (1) Control and manage the policy; (2) Administer claims; (3) Interpret the policy; and (4) Resolve all questions arising in the administration, interpretation, and application of the policy.

Our authority includes, but is not limited to:

- The right to resolve all matters when a review has been requested; and
- The right to establish and enforce rules and procedures for the administration of the policy and any claim under it; and
- The right to determine:
  - a. Eligibility for insurance;
  - b. Entitlement to benefits;

~~c. The amount of benefits payable; and~~

~~d. The sufficiency and amount of information we may reasonably require to determine a, b, or c, above.~~

~~Subject to the review procedures of the policy, any decision we make in the exercise of our authority is conclusive and binding. This provision will not restrict any legal right you may have to challenge a claim decision under Section 502(a) of ERISA.~~

**PART OF POLICY**

This endorsement is part of the policy to which it is attached. All policy terms and conditions will apply to this endorsement if they have not been changed by this endorsement and do not conflict with this endorsement.

{ \_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_\_  
Signature of Proposed Insured City State Date

\_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_\_  
Signature of Owner (If Other than Proposed Insured) City State Date

Sign in duplicate. SIGN ORIGINAL IN THE POLICY. Return signed copy to:

Individual Policy Issue Department  
1100 S.W. Sixth Avenue Portland, Oregon 97204  
(800) 247-6888}

STANDARD INSURANCE COMPANY

By



J. Greg Ness  
President



Holley Y. Franklin  
Corporate Secretary

Standard Insurance Company

**ERISA CLAIMS PROCEDURES  
POLICY ENDORSEMENT**

This endorsement is part of the policy shown below.

Insured: [Name]

Policy Number: [Number]

Policyowner: [Owner]

Effective Date of this Endorsement: [Date]

This endorsement includes mandatory claims language for policies covered by requirements of the Employee Retirement Income Security Act ("ERISA").

The policy is amended by completely removing the **CLAIMS** section of the policy and replacing it with the following:

**CLAIMS**

**TIME OF LOSS** – We will pay benefits under this policy only for a Loss which occurs while this policy is in force. Except as noted in the definition of Maximum Benefit Period (see Definitions) termination of the policy will not affect any claim for Disability, provided that:

1. Your Disability begins within 30 days after the date of the Injury or Sickness causing Your Disability; and
2. Your Injury or Sickness occurs while this policy is in force. (See Policy Termination.)

**WRITTEN NOTICE OF CLAIM** – We must be given written notice of claim by You or the Owner:

1. Within 30 days after a Loss starts; or
2. As soon as is reasonably possible.

Written notice must be given:

1. To Us at Our home office; or
2. To any of Our authorized sales representatives.

Written notice must include Your name and the policy number.

**CLAIM FORMS** – We will send the Owner a claim statement within 15 days after We receive written notice of claim. If You do not receive Our forms within 15 days after You ask for them, You may submit Your claim in a letter sent to Us at Our home office. The letter should include the date the Disability began and the cause and nature of the Disability.

**WRITTEN PROOF OF LOSS** – We must receive written proof of Loss within 90 days after the end of any period for which benefits are being claimed. If that is not reasonably possible, the claim will not be affected, provided written proof is furnished as soon as is reasonably possible. However, unless You lack legal capacity, We must be given written proof within one year after the 90th day referred to above, for that claim to be valid.

Each of the following elements of proof of Loss must be provided to Us at Your expense. We will not pay any Disability Benefits until We receive satisfactory written proof of all of the following:

1. You became Disabled while insured under this policy and while it was in force;
2. Your Disability was a Continuous Disability through the Waiting Period and the Commencement Date; and
3. You are under the regular care of a Physician appropriate for Your Injury or Sickness.

You must also submit all of the following documents at Your expense:

1. A completed claim statement signed by You.
2. A completed claim statement signed by Your Physician.
3. A written authorization for Us to obtain records and information needed to determine Your eligibility for Disability Benefits. This must be:
  - a. On a form satisfactory to Us; and
  - b. Signed by You.
4. Such other documents and information as We may reasonably require in connection with Your claim.

In any event if any required documentation is not provided within 45 days after We send Our request for such documentation, Your claim may be denied.

Once Your claim is approved, no Disability Benefits will be continued beyond the end of the period for which You have provided Us with satisfactory written proof of Loss.

We will require You to submit additional documentation of Your claim at Your expense at reasonable intervals while You are receiving Disability Benefits.

**PROOF OF INCOME** – We can require any proof We consider necessary to establish Your current and prior incomes. We have the right to examine Your financial records, including Your tax returns, as often as We may reasonably require. These financial records may cover any period for which You claim to be Disabled.

**INVESTIGATION OF YOUR CLAIM** – We may conduct an investigation of Your claim at any time. We will not pay any Disability Benefits until: (1) We have had a reasonable time to conduct any investigation of Your claim; and (2) We have determined that Disability Benefits are payable.

**NOTICE OF DECISION ON CLAIM** – We will evaluate Your claim promptly after You file it. Within 45 days after We receive Your claim We will send You: (1) A written decision on Your claim; or (2) A notice that We are extending the period to decide Your claim by 30 days. By the end of the extension We will send You: (1) A written decision on Your claim; or (2) A notice that We are extending the period to decide Your claim for another 30 days.

If We extend the period to decide Your claim, We will notify You of the following: (1) The reasons for the extension; (2) When We expect to decide Your claim; (3) An explanation of the standards on which entitlement to benefits are based; (4) The unresolved issues; and (5) Any additional information We need to resolve those issues. If We request additional information, You have 45 days to: (1) Provide the information; or (2) Otherwise respond to Our request.

If an extension is due to Your failure to provide necessary claim information, the extended time period for deciding Your claim will not begin until You: (1) Provide the information; or (2) Otherwise respond. However, if You do not provide the requested information within 45 days, We may decide Your claim based on the information We have received.

If We deny any part of Your claim, You will receive a written notice of denial containing:

1. The reasons for Our decision;
2. Reference to the parts of the policy on which Our decision is based;
3. A description of any additional information needed to support Your claim;
4. Reference to any internal rule or guideline relied upon in making Our decision; and
5. Information concerning Your right to:
  - a. A review of Our decision; and
  - b. Bring a civil action for benefits under section 502(a) of ERISA if Your claim is denied on review.

**REVIEW PROCEDURE FOR DENIED CLAIMS** – If all or part of Your claim is denied, You may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

Our review will be subject to the following:

1. The review will not give deference to the initial decision;
2. The person conducting the review (the Reviewer) will be someone other than the person who denied Your claim;
3. The Reviewer will not be subordinate to the person who denied Your claim;
4. If the denial was based on a medical judgment, the Reviewer will consult with a qualified health care professional other than the person who made the original medical judgment; and
5. The health care professional referenced in number 4 immediately above will not be subordinate to the person who made the original medical judgment.

You may:

1. Send Us written comments or other items to support Your claim;
2. Review and receive copies of any non-privileged information that relates to Your request for review. There will be no charge for such copies; and
3. Request the names of medical or vocational experts who provided advice to Us about Your claim.

We will review Your claim promptly after We receive Your request. Within 45 days after We receive Your request for review We will send You: (1) Our written decision; or (2) A notice that We are extending the review period for 45 days. Our review will include any written comments or other items You submit to support Your claim.

If Our review is extended, We will notify You of the following: (1) The reasons for the extension; (2) When We expect to decide Your claim on review; and (3) Any additional information We need to decide Your claim.

If We request additional information, You have 45 days to: (1) Provide that information; or (2) Otherwise respond to Our request.

If an extension is due to Your failure to provide necessary claim review information, the extended time period for claim decision review will not begin until You: (1) Provide the information; or (2) Otherwise respond. However, if You do not provide the requested information within 45 days, We may conclude Our review of Your claim based on the information We have received.

If We deny any part of Your claim on review, You will receive a written notice of Our denial. It will contain:

1. The reasons for Our decision;
2. Reference to the parts of the policy on which Our decision is based;
3. Reference to any internal rule or guideline relied upon in making Our decision; and
4. Information concerning Your right to:
  - a. Review and receive free of charge copies of non-privileged documents and records relevant to Your claim; and
  - b. Bring a civil action for benefits under section 502(a) of ERISA.

The policy does not provide voluntary alternative dispute resolution options. However, You may contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency for assistance.

~~**ALLOCATION OF AUTHORITY** – We have full and exclusive authority to: (1) Control and manage the policy; (2) Administer claims; (3) Interpret the policy; and (4) Resolve all questions arising in the administration, interpretation, and application of the policy.~~

~~Our authority includes, but is not limited to:~~

- ~~1. The right to resolve all matters when a review has been requested;~~
- ~~2. The right to establish and enforce rules and procedures for the administration of the policy and any claim under it; and~~
- ~~3. The right to determine:
  - ~~a. Eligibility for insurance;~~
  - ~~b. Entitlement to benefits;~~
  - ~~c. The amount of benefits payable; and~~
  - ~~d. The sufficiency and amount of information we may reasonably require to determine a, b, or c, above.~~~~

~~Subject to the review procedures of the policy, any decision We make in the exercise of Our authority is conclusive and binding. This provision will not restrict any legal right You may have to challenge a claim decision under section 502(a) of ERISA.~~

**MEDICAL EXAM** – We can have Physicians or specialists examine You, at Our expense, as often as reasonably necessary while You claim to be Disabled. Any such examination will be conducted by one or more Physicians or specialists We choose.

We may defer or suspend payment of benefits if: (1) You fail to attend an examination; or (2) You fail to cooperate with the person conducting the examination. Benefits may be resumed, provided that the required examination occurs within a reasonable time and benefits are otherwise payable.

**TIME OF PAYMENT** – After We receive satisfactory written proof of Loss and all other conditions are met, We will pay benefits under this policy. Any accrued benefits will be paid immediately. Any benefits due thereafter will be paid monthly. Payment will be subject to our receipt of continued written proof of Loss.

**PAYMENT OF CLAIMS** – We will pay all benefits to the Owner or the Owner’s estate, unless the Owner names a payee to receive such benefits. Designation of a payee, or change of a previously named payee, must be in writing and signed by the Owner. At the Owner’s request We will provide a form for naming or changing a payee.

We can pay total benefits of up to \$1,000 to any relative of the Owner We believe is entitled to them, if:

- 1. Any benefit is payable to the Owner’s estate; or
- 2. The Owner or any payee lacks legal capacity to give a valid release.

We will not be liable to anyone to the extent We make payment in good faith.

**OVERPAYMENT OF BENEFITS** – We have the right to be reimbursed for any overpayment of benefits under this policy. We will notify the Owner promptly upon the discovery of any overpayment. After such notice, any and all overpayments that have not been reimbursed will become a debt due and payable to Us. We will offset the unreimbursed portion of any overpayments against any benefit payments due under the policy, regardless of the payee, until all overpayment amounts are repaid in full.

**PART OF POLICY** – This endorsement is part of the policy to which it is attached. All policy terms and conditions will apply to this endorsement if they:

- 1. Have not been changed by this endorsement; and
- 2. Do not conflict with this endorsement.

{ \_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of Proposed Insured City State Date

\_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of Owner (If Other than Proposed Insured) City State Date}

Sign in duplicate. SIGN ORIGINAL IN THE POLICY. Return signed copy to:

Individual Policy Issue Department  
1100 S.W. Sixth Avenue Portland, Oregon 97204  
(800) 247-6888}

STANDARD INSURANCE COMPANY

By



Eric E. Parsons



Michael T. Winslow



J. Greg Ness  
President



Holley Y. Franklin  
Corporate Secretary