

SERFF Tracking Number: AEX-125445397 State: Arkansas
Filing Company: Stonebridge Casualty Insurance Company State Tracking Number: #7210030970 \$50
Company Tracking Number: OC AR0003823F01
TOI: 33.0 Other Lines of Business Sub-TOI: 33.0001 Other Personal Lines
Product Name: Other Personal Liability
Project Name/Number: Other Personal Liability/OC AR0003823F01

Filing at a Glance

Company: Stonebridge Casualty Insurance Company

Product Name: Other Personal Liability SERFF Tr Num: AEX-125445397 State: Arkansas
TOI: 33.0 Other Lines of Business SERFF Status: Closed State Tr Num: #7210030970 \$50
Sub-TOI: 33.0001 Other Personal Lines Co Tr Num: OC AR0003823F01 State Status: Fees verified and received
Filing Type: Form Co Status: Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding
Author: SPI ADMSPC Disposition Date: 02/07/2008
Date Submitted: 01/22/2008 Disposition Status: Approved
Effective Date Requested (New): Effective Date (New):
Effective Date Requested (Renewal): Effective Date (Renewal):
State Filing Description:

General Information

Project Name: Other Personal Liability Status of Filing in Domicile:
Project Number: OC AR0003823F01 Domicile Status Comments:
Reference Organization: Reference Number:
Reference Title: Advisory Org. Circular:
Filing Status Changed: 02/07/2008
State Status Changed: 02/07/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:

Attached for your review and approval are new forms. These forms do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion and variable information is printed in red and bracketed. An effective date coinciding with your date of approval is requested.

GC541 offers Disability Income as a result of a covered accident or sickness and Involuntary Unemployment . Coverage terminates on the Insured's 71st birthday. Single and Joint coverage is available.

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the insurance coverage may legally be offered.

The group policy is also contemplated for issue to various discretionary groups that are situated in your state. We certify: (1) the issuance of the group policy is not contrary to the best interest of the public; (2) the issuance of the group policy would be actuarially sound; (3) the issuance of the group policy would result in economies of acquisition or administration; and (4) the benefits are reasonable in relation to the premium charged.

This product will be marketed without an illustration.

I respectfully request your favorable review and approval. We appreciate your consideration of these forms. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6783 or contact me by e-mail at chammon1@aegonusa.com.

Company and Contact

Filing Contact Information

Cindy Hammonds, Senior Contract Analyst chammon1@aegonusa.com
 2700 W. Plano Pkwy (972) 881-6000 [Phone]
 Plano, TX 75075 (972) 881-4097[FAX]

Filing Company Information

Stonebridge Casualty Insurance Company	CoCode: 10952	State of Domicile: Ohio
100 South Third Street	Group Code: 468	Company Type:
Columbus, OH 43215	Group Name:	State ID Number:
(410) 685-5500 ext. [Phone]	FEIN Number: 31-4423946	

Filing Fees

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

SERFF Tracking Number: AEXX-125445397 State: Arkansas
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CHECK NUMBER	CHECK AMOUNT	CHECK DATE
7210030970	\$50.00	01/14/2008

SERFF Tracking Number: AEXX-125445397 State: Arkansas
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TOI: 33.0 Other Lines of Business Sub-TOI: 33.0001 Other Personal Lines
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	02/07/2008	02/07/2008

SERFF Tracking Number: *AEXX-125445397* *State:* *Arkansas*
Filing Company: *Stonebridge Casualty Insurance Company* *State Tracking Number:* *#7210030970 \$50*
Company Tracking Number: *OC AR0003823F01*
TOI: *33.0 Other Lines of Business* *Sub-TOI:* *33.0001 Other Personal Lines*
Product Name: *Other Personal Liability*
Project Name/Number: *Other Personal Liability/OC AR0003823F01*

Disposition

Disposition Date: 02/07/2008

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEXX-125445397 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Disability and Unemployment Certificate	Approved	Yes
Form	Accident Only Disability and Unemployment Certificate	Approved	Yes
Form	Accident Hospital Confinement Rider	Approved	Yes
Form	Accidental Death Benefit Rider	Approved	Yes
Form	Family Leave Benefit Rider	Approved	Yes
Form	Enrollment Form	Approved	Yes
Form	Enrollment Form	Approved	Yes
Form	Group Master Policy	Approved	Yes
Form	Group Master Application	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type	Action	Action Specific Data	Readability	Attachment
Approved	Disability and Unemployment Certificate	GC541		Certificate	New		46.80	GC541.PDF
Approved	Accident Only Disability and Unemployment Certificate	GC542		Certificate	New		47.10	GC542.PDF
Approved	Accident Hospital Confinement Rider	GR924		Other	New		40.00	GR924.PDF
Approved	Accidental Death Benefit Rider	GR925		Other	New		44.30	GR925.PDF
Approved	Family Leave Benefit Rider	GR926		Other	New		43.60	GR926.PDF
Approved	Enrollment Form	GGA285		Application/Binder/Enrollment	New		0.00	GGA285.PDF
Approved	Enrollment Form	GGA286		Application/Binder/Enrollment	New		0.00	GGA286.PDF
Approved	Group Master Policy	MPCAS001		Policy/Coverage Form	New		0.00	MPCAS001.PDF
Approved	Group Master Application	MACAS001		Application/Binder/Enrollment	New		0.00	MACAS001.PDF

Stonebridge Casualty Insurance Company

A STOCK COMPANY

Home Office: Columbus, Ohio

[Administrative Office: 2700 West Plano Parkway, Plano, Texas 75075]

CERTIFICATE OF INSURANCE

Person(s) insured and Schedule of Insurance are shown on the Schedule Page. Place the Schedule Page with Your Certificate for safekeeping.

Stonebridge Casualty Insurance Company (herein called "We," "Us" or "Our") has issued Policy No [25757 GC541] to [Wells Fargo Bank, N.A.] (herein called "Policyholder") which makes available Disability Income and Involuntary Loss of Employment insurance for eligible persons.

We agree to pay the benefits herein provided with respect to the person(s) insured hereunder, subject to all terms of the Policy.

RIGHT TO EXAMINE CERTIFICATE

If You are not satisfied with this insurance, You may void it by returning this Certificate to Our Administrative Office within [30/60/90] days after You receive it. You will receive a full refund of any premium You have paid.

[This Certificate supersedes any Certificate previously issued to You under the Policy [with the Participating Group named on the Schedule Page]. You may qualify under one Certificate only. If any person is insured under more than one Certificate, We will consider that person to be insured under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, We will refund any duplicated payments which may have been made on behalf of that person. The records maintained by the Policyholder shall determine the insurance provided under the Policy for any Insured. Important provisions of the Policy are outlined herein.]



President



Secretary

DISABILITY AND INVOLUNTARY LOSS OF EMPLOYMENT

Stonebridge Casualty Insurance Company

SCHEDULE OF INSURANCE

This Schedule of Insurance is part of Your Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. [25757 GC541] to [Wells Fargo Bank, N.A.]

[POLICYHOLDER: Wells Fargo Bank, N.A.]

[GROUP POLICY NUMBER: 25491 GC902]

[CERTIFICATE NUMBER: 123-123-123-123]

[EFFECTIVE DATE: 09/01/02]

[INSURED JOHN DOE]
[1234 EASY STREET]
[ANY CITYDE 12345]

[DATE OF BIRTH: 08/15/67]

[COVERAGE TYPE: JOINT]

[INSURANCE TERMINATION AGE: 71]

[PARTICIPATING GROUP NUMBER: 25451

PARTICIPATING GROUP: XXXXXXXXXX]

[MONTHLY PREMIUM RATE: \$ 4.06]

[For the (1)(2)(3) month(s), Your premium will be paid by the Policyholder / Participating Group.]

	[MONTHLY BENEFIT]	[MAXIMUM NUMBER OF PAYMENTS]
[DISABILITY	\$500	24]
[INVOLUNTARY EMPLOYMENT	LOSS OF \$500	5]

[For questions, service, or to make a claim, call 1-800- 527-9027]

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DEFINITIONS

EFFECTIVE DATE means the date Your coverage begins, as shown on the Schedule of Insurance, provided You are alive on that date.

FAMILY MEMBER means You, Your Spouse, son, daughter or parent.

FULL-TIME EMPLOYMENT INCOME means salary, fees, wages or profit compensated while actively working for one employer at least 30 hours per week in a non-seasonal occupation.

YOU AND YOUR means the Insured only if Single Coverage is indicate on the Schedule of Insurance. If Joint Coverage is indicated You and Your means the Insured and the spouse of the Insured, provided coverage has become effective.

[PARTICIPATING GROUP means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by Us. The name of such group is shown in the Schedule of Insurance Page.]

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat sickness or accidental injury. Such person must be providing services within the scope of his or her license. A Physician may not be You or a Family Member.

WHEN YOUR INSURANCE BEGINS

Insurance starts at 12:01 a.m., Standard Time on the Effective Date as shown in the Schedule of Insurance provided We receive the initial premium [before][within 21 days of] the Effective Date and while You are alive.

WHEN YOUR INSURANCE ENDS

This Certificate may be canceled by:

1. Your giving Us or the Policyholder prior written notice stating when cancellation is to be effective; or
2. Us or the Policyholder by giving You 45 days written notice prior to the renewal date stating when cancellation will be effective.

The mailing of such notice is sufficient proof of notice. Delivery of such notice shall be equivalent to mailing.

The coverage provided by this Certificate will end at 12:01 a.m., Standard Time, on the earliest of the following dates:

1. the first Policy renewal date, on or after the date We receive Your request to end coverage;
2. when the premium is due and unpaid, subject to the 31 day Grace Period; or
3. the first Certificate renewal date on or after You reach the Insurance Termination Age shown in the Schedule of Insurance; or
4. the date of the Insured's death; or
5. the date the Group Policy terminates.

If the Certificate is canceled, such cancellation will not affect any claim then in progress or loss commencing for which We are liable at the time of such cancellation. We will not be liable for losses that begin after the effective date of cancellation.

WHO IS INSURED

You are insured for the terms of this Certificate as of the Effective Date shown in the Schedule of Insurance.

PREMIUMS

Payment Of Premium: All premiums due by the terms of the Policy shall be paid by the [Policyholder / Participating Group] to Our Administrative Office on or prior to the day they are due.

[For the first 30 / 60 / 90 days of coverage, the premium will be paid by the Policyholder / Participating Group.]

You are required to contribute 100 percent of the premium payable under this Certificate [after the 30/60/90 days]. If at any time the [Policyholder / Participating Group] refuses to accept such contributions and pay the premium for You, You may pay such premium directly to Our Administrative Office on or prior to the day it is due.

[If no initial premium is requested by Us with Your enrollment form, You shall have 21 days from the Effective Date shown on the Schedule of Insurance to pay the first premium. If the first premium is not paid within such 21-day period, the Certificate shall be considered void from the beginning and no benefits will be paid for any loss.]

[PAYING YOUR PREMIUMS]

[PREMIUM PAYMENTS: You keep coverage in force by paying the Premiums. Your first Premium is due prior to the Certificate Effective Date. All Premiums after the first Premium must be paid in advance. Three payment methods are available: (1) We bill You directly; (2) You pay by credit card; or (3) You pay by automatic deductions from Your bank account. (NOTE: Credit Card Payment may not be permitted in New Hampshire.)]

1. **[WE BILL YOU:** If We bill You directly, We will send You Premium reminders. Premiums can be paid in advance. All Premiums are payable to Stonebridge Life Insurance Company, at Our Administrative Office. Premiums are also payable to an authorized agent in exchange for an official receipt signed by Our President and Secretary.]
2. **[YOU PAY BY CREDIT CARD:** If credit card payment is used, Our receipt of Your credit card billing authorization is treated as receipt of payment. The credit card company assumes the duty to pay each Premium when due. You are billed by them through the credit card. Premiums are paid for as long as You authorize payment and Your credit card remains in effect. This is subject to the option of the credit card company not to make payment if Your credit card account is over limit or past due. We will bill You directly if payment is not made by the credit card company. (NOTE: Credit Card Payment may not be permitted in New Hampshire.)]
3. **[YOU PAY BY AUTOMATIC BANK ACCOUNT:** If bank account payment is used, Our receipt of Your authorization to deduct premiums from Your bank account is treated as receipt of payment. The bank pays each Premium when due. Premiums are paid for as long as You authorize payment, provided there are enough funds in Your bank account to pay the Premium. We will bill You directly if payment cannot be automatically deducted from Your bank account.]

Premium Change: The premium is subject to change. If We increase the rate, We will give You at least 45 days written notice of any premium change. Premium changes will always be effective on Your Certificate renewal date.

BENEFICIARY

Benefits will be paid on a monthly basis to You, if living. Otherwise

1. to Your beneficiary; or
2. if You do not have one, to Your living spouse; or
3. if You do not have one, in equal shares to Your living, lawful children; or
4. if there are none, in equal shares to Your living, lawful parents; or
5. if there are none, in equal shares to Your living, lawful brothers and sisters; or
6. if there are none, to Your estate.

Spouse means only the one to whom You are lawfully married on the date of Your death. Except in the case of legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

The beneficiary designated may be changed in accordance with the Change of Beneficiary provision. Any change of beneficiary is subject to the laws in Your state of residence.

CHANGE OF BENEFICIARY: You may change the beneficiary at any time by writing to Us at Our Administrative Office. Once We record the change, it will take effect as of the day You signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable.

DISABILITY BENEFIT

We will pay the Disability Monthly Benefit if You provide satisfactory proof of Disability and You are eligible for benefits.

DATE OF LOSS means the date You become Disabled.

DISABILITY / DISABLED means that You are not able to perform each and every major duty of Your occupation because of sickness or accidental injury, as determined by Your Physician, and You are not receiving Full-Time Employment Income.

PRE-EXISTING MEDICAL CONDITION means an Injury sustained or a Sickness for which You were medically treated or advised by a Physician within the six months immediately prior to Your Effective Date of Coverage under this Certificate.

To be eligible for benefits, You must be receiving Full-Time Employment Income while coverage is in effect for at least 90 consecutive days immediately prior to the Date of Loss. We will pay the Disability Monthly Benefit shown in the Schedule of Insurance if You file written proof that Your loss of Full-Time Employment Income began after the Effective Date of coverage and continued for more than 30 consecutive days. A Disability resulting from a Pre-existing Condition will not be covered for six consecutive months after the Effective Date. Benefits will be paid beginning on the 31st day following the Date of Loss. If a benefit is payable for a period of less than one month, it will be paid at a daily rate of 1/30 of the Disability Monthly Benefit.

We will pay the Disability Monthly Benefit shown in the Schedule of Insurance if:

1. You are insured on the Date of Loss; and
2. You are Disabled for more than 30 days; and
3. You are under the regular care of a licensed Physician, other than Yourself or a Family Member; for sickness or accidental injury which caused Your Disability; and
4. You are not receiving Involuntary Loss of Employment Benefits.

PROOF OF DISABILITY: You must have Your attending Physician submit a statement that You were Disabled because of a described disability. We may require ongoing proof that You remain so Disabled.

RECURRENT DISABILITY: If You have been paid benefits for Disability, and You later become Disabled, Your later disability will be considered a continuation of the earlier one if (1) less than 90 days separate the two periods of disability; and (2) the two periods are the result of the same sickness or accidental injury.

RE-ELIGIBILITY: You are re-eligible for Disability benefits if:

1. You are completely recovered from the sickness or accidental injury for which We have already paid benefits; and
2. You meet the eligibility requirements for a new period of Disability as stated above; and
3. Your new Disability is not the result of the same sickness or accidental injury for which We have already paid benefits; and
4. at least 6 consecutive months separate the disability periods.

While You are receiving Disability benefits, We will pay the insurance premium charges for this coverage.

The payment of Disability benefits will stop on the earliest of the following:

1. when You are no longer Disabled; or
2. when the Disability Maximum Number of Payments shown in the Schedule of Insurance have been reached.

INVOLUNTARY LOSS OF EMPLOYMENT BENEFIT

We will pay benefits for Involuntary Loss of Employment if You provide satisfactory proof of Involuntary Loss of Employment and proof that You are eligible for Benefits. You can not collect Involuntary Loss of Employment benefits within the first 60 days after the Effective Date.

DATE OF LOSS means the first date of Involuntary Unemployment for which You receive state unemployment benefits.

INVOLUNTARY LOSS OF EMPLOYMENT means You qualify for, continue to qualify for, and are receiving state unemployment benefits.

We will pay the Involuntary Loss of Employment Monthly Benefit shown in the Schedule of Insurance if:

1. You are insured on the Date of Loss; and
2. You have been gainfully employed for wages or profit for 30 hours or more a week for at least 90 consecutive days immediately prior to the Date of Loss; and
3. You remain so unemployed for more than 30 consecutive days; and
4. You are not receiving Disability Benefits.

After You have been involuntarily unemployed for 30 consecutive days, benefits will be paid beginning with the thirty first day following the Date of Loss. If a benefit is payable for a period of less than one month, it will be paid at a daily rate of 1/30 of the Involuntary Loss of Employment Monthly Benefit.

The payment of Involuntary Loss of Employment benefits will stop on the earliest of the following:

1. when You begin receiving Full-Time Employment Income; or
2. when You are no longer actively seeking employment; or
3. when the Involuntary Loss of Employment Maximum Number of Payments shown in the Schedule of Insurance have been reached.

PROOF OF UNEMPLOYMENT: You must provide proof that You are receiving state unemployment benefits. We may require ongoing proof of involuntarily unemployment.

While You are receiving Unemployment benefits, We will pay the insurance premium charges for this coverage.

HOW TO FILE A CLAIM

Notice Of Claim: Written Notice of Claim must be given to Us within 30 days after loss covered under the Policy occurs or as soon as possible thereafter. The notice should give Your name and Certificate number as shown on the Schedule of Insurance. Notice should be mailed to Us at Our Administrative Office.

Claim Forms: When We receive the Notice of Claim, We will send the claimant forms for filing Proof of Loss. If We do not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing Us with a written statement describing what happened. We must receive this statement within the time given for filing Proof of Loss.

Proof Of Loss: Written proof of loss must be given to Us within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

Time Of Payment Of Claims: We will pay all benefits covered by the Certificate as soon as We receive proper written Proof of Loss sufficient to determine liability.

GENERAL PROVISIONS

Entire Contract: The Group Policy, the application for the Group Policy, this Certificate and its riders, if any, are the complete contracts of insurance.

Misstatement of Age: If Your age has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, We accept a premium for any period when coverage would not normally have been in effect, then Our liability for such period shall be a refund, upon request, of all premiums paid for such period.

Physical Exam: We, at Our expense, may have You examined as often as is reasonable while a claim is pending.

Legal Action: No action can be brought to recover on this Certificate for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

Time Limit On Certain Defenses : After 2 years from the Effective Date of Your Certificate, no misstatements, except fraudulent misstatements, made by You in the enrollment form for such Certificate shall be used to void the Certificate or deny a claim for Loss incurred after a 2 year period.

Grace Period: If a premium is not paid when due, the insurance shall be in default. We will allow a 31 day Grace Period to pay each premium after the first one. If a premium is not paid on or before the end of the Grace Period, the insurance shall terminate.

Reinstatement: The Certificate may be put back in force after it has lapsed. The Company will do so subject to all of the following:

1. A written request is received within [5] years of the due date of the unpaid premium;
2. The Policy has not expired;
3. Evidence of insurability is acceptable to Us;
4. All past due premiums are paid; and
5. Interest is paid on all past due premiums with interest at 6% per year, compounded annually.

The reinstated coverage will require satisfaction of a new waiting period of [3 months] during which any Loss incurred due to Involuntary Unemployment will not be eligible for benefits. All benefit payments for any claims incurred prior to the date coverage are reinstated shall be applied towards any benefit maximums in the reinstated coverage.

Conformity with State Statutes: The provisions of this Certificate must conform with the laws of the state in which the Certificate is issued. If any provision does not, they are hereby amended to conform.

Stonebridge Casualty Insurance Company

A STOCK COMPANY

Home Office: Columbus, Ohio

[Administrative Office: 2700 West Plano Parkway, Plano, Texas 75075]

CERTIFICATE OF INSURANCE

Person(s) insured and Schedule of Insurance are shown on the Schedule Page. Place the Schedule Page with Your Certificate for safekeeping.

Stonebridge Casualty Insurance Company (herein called "We," "Us" or "Our") has issued Policy No [25757 GC541] to [Wells Fargo Bank, N.A.] (herein called "Policyholder") which makes available Disability Income and Involuntary Loss of Employment insurance for eligible persons.

We agree to pay the benefits herein provided with respect to the person(s) insured hereunder, subject to all terms of the Policy.

RIGHT TO EXAMINE CERTIFICATE

If You are not satisfied with this insurance, You may void it by returning this Certificate to Our Administrative Office within [30/60/90] days after You receive it. You will receive a full refund of any premium You have paid.

[This Certificate supersedes any Certificate previously issued to You under the Policy [with the Participating Group named on the Schedule Page]. You may qualify under one Certificate only. If any person is insured under more than one Certificate, We will consider that person to be insured under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, We will refund any duplicated payments which may have been made on behalf of that person. The records maintained by the Policyholder shall determine the insurance provided under the Policy for any Insured. Important provisions of the Policy are outlined herein.]



President



Secretary

ACCIDENT ONLY DISABILITY AND INVOLUNTARY LOSS OF EMPLOYMENT

Stonebridge Casualty Insurance Company

SCHEDULE OF INSURANCE

This Schedule of Insurance is part of Your Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. [25757 GC542] to [Wells Fargo Bank, N.A.]

[POLICYHOLDER: Wells Fargo Bank, N.A.]

[GROUP POLICY NUMBER: 25491 GC902]

[CERTIFICATE NUMBER: 123-123-123-123]

[EFFECTIVE DATE: 09/01/02]

[INSURED JOHN DOE]
[1234 EASY STREET]
[ANY CITYDE 12345]

[DATE OF BIRTH: 08/15/67]

[COVERAGE TYPE: JOINT]

[INSURANCE TERMINATION AGE: 71]

[PARTICIPATING GROUP NUMBER: 25451

PARTICIPATING GROUP: XXXXXXXXXX]

[MONTHLY PREMIUM RATE: \$ 4.06]

[For the (1)(2)(3) month(s), Your premium will be paid by the Policyholder / Participating Group.]

	[MONTHLY BENEFIT]	[MAXIMUM NUMBER OF PAYMENTS]
[DISABILITY	\$500	24]
[INVOLUNTARY EMPLOYMENT	LOSS OF \$500	5]

[For questions, service, or to make a claim, call 1-800- 527-9027]

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DEFINITIONS

EFFECTIVE DATE means the date Your coverage begins, as shown on the Schedule of Insurance, provided You are alive on that date.

FAMILY MEMBER means You, Your Spouse, son, daughter or parent.

FULL-TIME EMPLOYMENT INCOME means salary, fees, wages or profit compensated while actively working for one employer at least 30 hours per week in a non-seasonal occupation.

YOU AND YOUR means the Insured only if Single Coverage is indicate on the Schedule of Insurance. If Joint Coverage is indicated You and Your means the Insured and the spouse of the Insured, provided coverage has become effective.

[PARTICIPATING GROUP means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by Us. The name of such group is shown in the Schedule of Insurance Page.]

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat sickness or accidental injury. Such person must be providing services within the scope of his or her license. A Physician may not be You or a Family Member.

WHEN YOUR INSURANCE BEGINS

Insurance starts at 12:01 a.m., Standard Time on the Effective Date as shown in the Schedule of Insurance provided We receive the initial premium [before][within 21 days of] the Effective Date and while You are alive.

WHEN YOUR INSURANCE ENDS

This Certificate may be canceled by:

1. Your giving Us or the Policyholder prior written notice stating when cancellation is to be effective; or
2. Us or the Policyholder by giving You 45 days written notice prior to the renewal date stating when cancellation will be effective.

The mailing of such notice is sufficient proof of notice. Delivery of such notice shall be equivalent to mailing.

The coverage provided by this Certificate will end at 12:01 a.m., Standard Time, on the earliest of the following dates:

1. the first Policy renewal date, on or after the date We receive Your request to end coverage;
2. when the premium is due and unpaid, subject to the 31 day Grace Period; or
3. the first Certificate renewal date on or after You reach the Insurance Termination Age shown in the Schedule of Insurance; or
4. the date of the Insured's death; or
5. the date the Group Policy terminates.

If the Certificate is canceled, such cancellation will not affect any claim then in progress or loss commencing for which We are liable at the time of such cancellation. We will not be liable for losses that begin after the effective date of cancellation.

WHO IS INSURED

You are insured for the terms of this Certificate as of the Effective Date shown in the Schedule of Insurance.

PREMIUMS

Payment Of Premium: All premiums due by the terms of the Policy shall be paid by the [Policyholder / Participating Group] to Our Administrative Office on or prior to the day they are due.

[For the first 30 / 60 / 90 days of coverage, the premium will be paid by the Policyholder / Participating Group.]

You are required to contribute 100 percent of the premium payable under this Certificate [after the 30/60/90 days]. If at any time the [Policyholder / Participating Group] refuses to accept such contributions and pay the premium for You, You may pay such premium directly to Our Administrative Office on or prior to the day it is due.

[If no initial premium is requested by Us with Your enrollment form, You shall have 21 days from the Effective Date shown on the Schedule of Insurance to pay the first premium. If the first premium is not paid within such 21-day period, the Certificate shall be considered void from the beginning and no benefits will be paid for any loss.]

[PAYING YOUR PREMIUMS]

[PREMIUM PAYMENTS: You keep coverage in force by paying the Premiums. Your first Premium is due prior to the Certificate Effective Date. All Premiums after the first Premium must be paid in advance. Three payment methods are available: (1) We bill You directly; (2) You pay by credit card; or (3) You pay by automatic deductions from Your bank account. (NOTE: Credit Card Payment may not be permitted in New Hampshire.)]

1. **[WE BILL YOU:** If We bill You directly, We will send You Premium reminders. Premiums can be paid in advance. All Premiums are payable to Stonebridge Life Insurance Company, at Our Administrative Office. Premiums are also payable to an authorized agent in exchange for an official receipt signed by Our President and Secretary.]
2. **[YOU PAY BY CREDIT CARD:** If credit card payment is used, Our receipt of Your credit card billing authorization is treated as receipt of payment. The credit card company assumes the duty to pay each Premium when due. You are billed by them through the credit card. Premiums are paid for as long as You authorize payment and Your credit card remains in effect. This is subject to the option of the credit card company not to make payment if Your credit card account is over limit or past due. We will bill You directly if payment is not made by the credit card company. (NOTE: Credit Card Payment may not be permitted in New Hampshire.)]
3. **[YOU PAY BY AUTOMATIC BANK ACCOUNT:** If bank account payment is used, Our receipt of Your authorization to deduct premiums from Your bank account is treated as receipt of payment. The bank pays each Premium when due. Premiums are paid for as long as You authorize payment, provided there are enough funds in Your bank account to pay the Premium. We will bill You directly if payment cannot be automatically deducted from Your bank account.]

Premium Change: The premium is subject to change. If We increase the rate, We will give You at least 45 days written notice of any premium change. Premium changes will always be effective on Your Certificate renewal date.

BENEFICIARY

Benefits will be paid on a monthly basis to You, if living. Otherwise

1. to Your beneficiary; or
2. if You do not have one, to Your living spouse; or
3. if You do not have one, in equal shares to Your living, lawful children; or
4. if there are none, in equal shares to Your living, lawful parents; or
5. if there are none, in equal shares to Your living, lawful brothers and sisters; or
6. if there are none, to Your estate.

Spouse means only the one to whom You are lawfully married on the date of Your death. Except in the case of legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

The beneficiary designated may be changed in accordance with the Change of Beneficiary provision. Any change of beneficiary is subject to the laws in Your state of residence.

CHANGE OF BENEFICIARY: You may change the beneficiary at any time by writing to Us at Our Administrative Office. Once We record the change, it will take effect as of the day You signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable.

DISABILITY BENEFIT

We will pay the Disability Monthly Benefit if You provide satisfactory proof of Disability and You are eligible for benefits.

DATE OF LOSS means the date You become Disabled.

INJURY means bodily Injury caused by an accident occurring while the insurance is in force resulting directly and independently of all other causes.

DISABILITY / DISABLED means that You are not able to perform each and every major duty of Your occupation because of accidental Injury, as determined by Your Physician, and You are not receiving Full-Time Employment Income.

To be eligible for benefits, You must be receiving Full-Time Employment Income while coverage is in effect for at least 90 consecutive days immediately prior to the Date of Loss. We will pay the Disability Monthly Benefit shown in the Schedule of Insurance if You file written proof that Your loss of Full-Time Employment Income began after the Effective Date of coverage and continued for more than 30 consecutive days. Benefits will be paid beginning on the 31st day following the Date of Loss. If a benefit is payable for a period of less than one month, it will be paid at a daily rate of 1/30 of the Disability Monthly Benefit.

We will pay the Disability Monthly Benefit shown in the Schedule of Insurance if:

1. You are insured on the Date of Loss; and
2. You are Disabled for more than 30 days; and
3. You are under the regular care of a licensed Physician, other than Yourself or a Family Member; for accidental Injury which caused Your Disability; and
4. You are not receiving Involuntary Loss of Employment Benefits.

PROOF OF DISABILITY: You must have Your attending Physician submit a statement that You were Disabled because of a described disability. We may require ongoing proof that You remain so Disabled.

RECURRENT DISABILITY: If You have been paid benefits for Disability, and You later become Disabled, Your later disability will be considered a continuation of the earlier one if (1) less than 90 days separate the two periods of disability; and (2) the two periods are the result of the same accidental Injury.

RE-ELIGIBILITY: You are re-eligible for Disability benefits if:

1. You are completely recovered from the accidental Injury for which We have already paid benefits; and
2. You meet the eligibility requirements for a new period of Disability as stated above; and
3. Your new Disability is not the result of the same accidental Injury for which We have already paid benefits; and
4. at least 6 consecutive months separate the disability periods.

While You are receiving Disability benefits, We will pay the insurance premium charges for this coverage.

The payment of Disability benefits will stop on the earliest of the following:

1. when You are no longer Disabled; or
2. when the Disability Maximum Number of Payments shown in the Schedule of Insurance have been reached.

INVOLUNTARY LOSS OF EMPLOYMENT BENEFIT

We will pay benefits for Involuntary Loss of Employment if You provide satisfactory proof of Involuntary Loss of Employment and proof that You are eligible for Benefits. You can not collect Involuntary Loss of Employment benefits within the first 60 days after the Effective Date.

DATE OF LOSS means the first date of Involuntary Unemployment for which You receive state unemployment benefits.

INVOLUNTARY LOSS OF EMPLOYMENT means You qualify for, continue to qualify for, and are receiving state unemployment benefits.

We will pay the Involuntary Loss of Employment Monthly Benefit shown in the Schedule of Insurance if:

1. You are insured on the Date of Loss; and
2. You have been gainfully employed for wages or profit for 30 hours or more a week for at least 90 consecutive days immediately prior to the Date of Loss; and
3. You remain so unemployed for more than 30 consecutive days; and
4. You are not receiving Disability Benefits.

After You have been involuntarily unemployed for 30 consecutive days, benefits will be paid beginning with the thirty first day following the Date of Loss. If a benefit is payable for a period of less than one month, it will be paid at a daily rate of 1/30 of the Involuntary Loss of Employment Monthly Benefit.

The payment of Involuntary Loss of Employment benefits will stop on the earliest of the following:

1. when You begin receiving Full-Time Employment Income; or
2. when You are no longer actively seeking employment; or
3. when the Involuntary Loss of Employment Maximum Number of Payments shown in the Schedule of Insurance have been reached.

PROOF OF UNEMPLOYMENT: You must provide proof that You are receiving state unemployment benefits. We may require ongoing proof of involuntarily unemployment.

While You are receiving Unemployment benefits, We will pay the insurance premium charges for this coverage.

HOW TO FILE A CLAIM

Notice Of Claim: Written Notice of Claim must be given to Us within 30 days after loss covered under the Policy occurs or as soon as possible thereafter. The notice should give Your name and Certificate number as shown on the Schedule of Insurance. Notice should be mailed to Us at Our Administrative Office.

Claim Forms: When We receive the Notice of Claim, We will send the claimant forms for filing Proof of Loss. If We do not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing Us with a written statement describing what happened. We must receive this statement within the time given for filing Proof of Loss.

Proof Of Loss: Written proof of loss must be given to Us within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

Time Of Payment Of Claims: We will pay all benefits covered by the Certificate as soon as We receive proper written Proof of Loss sufficient to determine liability.

GENERAL PROVISIONS

Entire Contract: The Group Policy, the application for the Group Policy, this Certificate and its riders, if any, are the complete contracts of insurance.

Misstatement of Age: If Your age has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, We accept a premium for any period when coverage would not normally have been in effect, then Our liability for such period shall be a refund, upon request, of all premiums paid for such period.

Physical Exam: We, at Our expense, may have You examined as often as is reasonable while a claim is pending.

Legal Action: No action can be brought to recover on this Certificate for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

Time Limit On Certain Defenses : After 2 years from the Effective Date of Your Certificate, no misstatements, except fraudulent misstatements, made by You in the enrollment form for such Certificate shall be used to void the Certificate or deny a claim for Loss incurred after a 2 year period.

Grace Period: If a premium is not paid when due, the insurance shall be in default. We will allow a 31 day Grace Period to pay each premium after the first one. If a premium is not paid on or before the end of the Grace Period, the insurance shall terminate.

Reinstatement: The Certificate may be put back in force after it has lapsed. The Company will do so subject to all of the following:

1. A written request is received within [5] years of the due date of the unpaid premium;
2. The Policy has not expired;
3. Evidence of insurability is acceptable to Us;
4. All past due premiums are paid; and
5. Interest is paid on all past due premiums with interest at 6% per year, compounded annually.

The reinstated coverage will require satisfaction of a new waiting period of [3 months] during which any Loss incurred due to Involuntary Unemployment will not be eligible for benefits. All benefit payments for any claims incurred prior to the date coverage are reinstated shall be applied towards any benefit maximums in the reinstated coverage.

Conformity with State Statutes: The provisions of this Certificate must conform with the laws of the state in which the Certificate is issued. If any provision does not, they are hereby amended to conform.

Stonebridge Casualty Insurance Company

[Administrative Office: 2700 West Plano Parkway, Plano, Texas 75075]

GROUP ACCIDENT HOSPITAL INDEMNITY CONFINEMENT BENEFIT RIDER

LIMITED BENEFIT, PLEASE READ CAREFULLY

BENEFIT SCHEDULE

[INSURED:]

JOHN J. DOE
345 MAIN STREET
ANYTOWN, USA 12345

[ATTACHED TO CERTIFICATE NO. 74L0012345]

[AGE AT ISSUE: 45]

[GENDER: MALE]

[COVERAGE TYPE: JOINT]

[ACCIDENT HOSPITAL INDEMNITY]
[BENEFIT AMOUNT: \$500.00 PER COVERED INJURY]

[EFFECTIVE DATE OF COVERAGE: 09/01/2003]

[TERMINATION AGE: 71]

[HOSPITAL BENEFIT QUALIFYING PERIOD: 48 HOURS]

[Total Additional Premium:]

[\$2.82 per month]

The consideration for this Rider is (1) receipt and approval of the signed enrollment form, if required, and (2) payment of the premium. The additional premium is listed above in the Benefit Schedule. Premiums are to be paid in the same manner and at the same time as the Certificate.

DEFINITIONS

HOSPITAL means an institution which meets the following requirements:

1. It is operated pursuant to law; and
2. It is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a prearranged basis and under supervision of a staff of one or more duly licensed Physicians, medical, diagnostic, and major surgery facilities for medical care and treatment of sick and Injured persons on an inpatient basis; and
3. It provides 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.).

HOSPITAL does not include an institution operated primarily as:

1. a convalescent home, convalescent, rest, or nursing facility; or
2. a facility primarily affording custodial or educational care; or
3. a facility for the aged, drug addicts, or alcoholics.

HOSPITAL also does not include that part of an institution operated primarily as:

1. a convalescent home, convalescent, rest, or nursing facility; or
2. a facility primarily affording custodial or educational care; or
3. a facility for the aged.

HOSPITAL CONFINEMENT/CONFINEMENT/CONFINED means being an inpatient in a Hospital for the necessary care and treatment of an Injury. Such confinement must be prescribed by a Physician.

Confinement does not include Outpatient care and treatment, including Outpatient surgery or Outpatient observation received in a Hospital.

INJURY/INJURED for which benefits are provided, means bodily injury caused by an accident which occurs while this Rider is in force. The Injury must be the direct cause of loss, independent of disease or bodily infirmity.

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment or service or expense in connection therewith, which is experimental in nature, is considered Necessary Treatment.

We may use Peer Review Organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

If services do not meet these criteria, expenses related to those services will not be deemed Necessary Treatment

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Necessary Treatment or covered by the Group Policy.

BENEFIT FOR ACCIDENTAL HOSPITAL CONFINEMENT

We will pay the Accident Hospital Confinement Benefit stated in the Benefits Schedule of this Rider provided:

1. the Confinement is for the Necessary Treatment of a covered Injury;
2. You are under the professional care of a Physician;
3. such Confinement occurs while this Rider is in force; and
4. the Confinement begins within [90] days of the accident causing the Injury.

You must be Confined in a Hospital as a result of accidental bodily injury and shall remain Confined for more than 48 hours.

EXCLUSIONS

No benefit shall be paid for Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane;
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. You taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a physician;
4. Your blood alcohol level being [.08] percent weight by volume or higher;
5. You operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. You committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. disease, bodily infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. Your voluntary gas inhalation or poison voluntarily taken, administered or inhaled; or
9. You taking alcohol in combination with any drug, medication or sedative.

GENERAL PROVISIONS

TERMINATION

This Rider shall terminate for the following reasons:

1. non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
2. the date the Certificate terminates; or
3. the date the Rider terminates; or
4. You cancel this Rider by giving Us notice. Notice is deemed to be due or given when made in writing or communicated verbally by telephone, in person, or by any other means acceptable to Us.

This Rider takes effect on the date entered hereon after receipt and approval of the signed enrollment form, if required. This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Casualty Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

Stonebridge Casualty Insurance Company

[Administrative Office: 2700 West Plano Parkway, Plano, Texas 75075]

GROUP ACCIDENTAL DEATH BENEFIT RIDER

LIMITED BENEFIT, PLEASE READ CAREFULLY

BENEFIT SCHEDULE

[INSURED:]

[ATTACHED TO CERTIFICATE NO. 74L0012345]

[JOHN J. DOE]
[12345 MAIN STREET]
[ANYTOWN, USA 12345]

[TYPE COVERAGE: JOINT]

[ACCIDENTAL DEATH BENEFIT:\$XX,XXX]

[EFFECTIVE DATE OF COVERAGE 10/01/2002]

[Total Additional Premium:]
[\$X.XX A MONTH]

The consideration for this Rider is (1) receipt and approval of the signed enrollment form, if required, and (2) payment of the premium. The additional premium is listed above in the Benefit Schedule. Premiums are to be paid in the same manner and at the same time as the Certificate.

ACCIDENTAL DEATH BENEFIT

We will pay to the beneficiary an Accidental Death Benefit in the amount shown in the Benefit Schedule upon receipt at Our Administrative Office of due proof of Your death. Your death must have resulted directly and independently from accidental bodily injury. The accident causing such Injury must occur after the Effective Date of Coverage shown in the Benefit Schedule. Death must occur within 90 days following the date of the accident which caused such Injury.

DEFINITIONS

INJURY means bodily Injury caused by an accident which occurs while this Rider is in force. The Injury must be the direct cause of loss, independent of disease or bodily infirmity.

EXCLUSIONS

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane;
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. You taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. Your blood alcohol level being [.08] percent weight by volume or higher;
5. You operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. You committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. disease, bodily infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. Your voluntary gas inhalation or poison voluntarily taken, administered or inhaled; or
9. You taking alcohol in combination with any drug, medication or sedative.

GENERAL PROVISIONS

AUTOPSY

At Our own expense, We may have an autopsy done where it is not forbidden by law.

TERMINATION

This Rider shall terminate for the following reasons:

1. non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
2. the date the Certificate terminates; or
3. the date the Rider terminates; or
4. You cancel this Rider by giving Us notice. Notice is deemed to be due or given when made in writing or communicated verbally by telephone, in person, or by any other means acceptable to Us.

This Rider takes effect on the date entered hereon after receipt and approval of the signed enrollment form, if required. This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Casualty Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

Stonebridge Casualty Insurance Company

Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075]

FAMILY LEAVE BENEFIT RIDER

BENEFIT SCHEDULE

[INSURED:]

[ATTACHED TO CERTIFICATE NO. 74L0012345]

[AGE AT ISSUE: 45]

[GENDER: MALE]

[JOHN J. DOE]

[12345 MAIN STREET]

[ANYTOWN, USA 12345]

[COVERAGE TYPE: JOINT]

[MONTHLY BENEFIT: \$500.00]

[MAXIMUM NUMBER OF PAYMENTS: 2]

[RIDER EFFECTIVE DATE: 10/01/2004]

[TERMINATION AGE: 71]

[Termination of this Rider does not affect any claim which began while the coverage was in force.]

[Total Additional Premium:]

[\$X.XX per month]

The consideration for this Rider is (1) receipt and approval of the signed enrollment form, if required, and (2) payment of the premium. The additional premium is listed above in the Benefit Schedule. Premiums are to be paid in the same manner and at the same time as the Certificate.

DEFINITIONS

FAMILY LEAVE means Your unpaid absence from Your full-time employment:

1. while caring for Your Family Member who has a Serious Health Condition;
2. because of a Serious Health Condition;
3. after the birth of Your son or daughter, and to care for Your newborn child; or,
4. during placement of Your son or daughter for adoption or to care for a newly placed child.

SERIOUS HEALTH CONDITION means a sickness or accidental bodily injury which is not a Pre-Existing Health Condition that renders an individual unable to care for himself or herself and requires, as determined by a Physician, the continuing care by another.

PRE-EXISTING MEDICAL CONDITION means a condition for which You or Your Family Member saw, or were under treatment by, a Physician within the 6 months before the Effective Date shown in the Schedule of Insurance.

BENEFIT

We will pay benefits subject to the terms and conditions of this Rider because of Your loss of Full-Time Employment Income due to Family Leave if:

1. You are insured on the Date of Loss;
2. You have no other claim in progress under this Certificate;
3. Your loss of Full-Time Employment Income is the result of a Family Leave.

We will pay the Family Leave Monthly Benefit shown in the Schedule of Insurance if:

1. You file written Proof of Loss that Your loss of Full-Time Employment Income began after the Effective Date; and
2. Your loss of Full-Time Employment Income continues for more than 30 consecutive days; and
3. You provide proof from Your employer of a covered unpaid Family Leave .

After You have been on Family Leave for 30 consecutive days, benefits will be paid beginning with the [31st day] of Family Leave. If a benefit is payable for a period of less than one month, it will be paid at a daily rate of 1/30 of the Family Leave Monthly Benefit.

The payment of Family Leave benefits will stop on the earliest of the following:

1. upon Your return to full-time employment; or
2. when Your Family Member no longer requires Your care; or
3. when the Family Leave Maximum Number of Payments shown in the Schedule of Insurance has been reached.

Re-Eligibility: You may file a new claim for Family Leave benefits only after You have returned to full-time employment for one year after You have stopped receiving benefits. If You have not satisfied the one-year re-eligibility requirement at the time of a later Family Leave, it will be a continuation of the prior Family Leave.

We will not pay benefits for Family Leave:

1. for more than one unpaid leave of absence claim to care for the same Family Member in any 12 month period as defined by Your employer;
2. resulting from Your loss of Full-Time Employment Income within 6 months after the Effective Date as a result of a Pre-Existing Medical Condition.

While You are receiving Family Leave benefits, We will pay the insurance premium charges for this coverage.

GENERAL PROVISIONS

TERMINATION

This Rider shall terminate for the following reasons:

1. non-payment of any premium for the Certificate or this Rider on or before the due date, except as provided in the Grace Period; or
2. the date the Certificate terminates; or
3. the date the Rider terminates; or
4. You cancel this Rider by giving Us notice. Notice is deemed to be due or given when made in writing or communicated verbally by telephone, in person, or by any other means acceptable to Us.

This Rider takes effect on the date entered hereon after receipt and approval of the signed enrollment form, if required. This Rider is subject to all of the Certificate provisions, definitions, conditions, exclusions, limitations, exceptions, and reductions not in conflict herewith.

The Stonebridge Casualty Insurance Company has caused this Rider to be signed by its President and Secretary.



President



Secretary

ENROLLMENT FORM

Yes! Please enroll me and my spouse (if selected) in the [cash benefit insurance plan.]

[AF301]

Applicant

[67C01/ADB]

[AF301]

Spouse

[67C01/ADB]

[Full Name]

[Full Name]

[Address]

[Address]

[City/State/ZIP]

[City/State/ZIP]

()

()

[Telephone]

[Telephone]

____ / ____ / ____ [Male] [Female]
[MO DAY YR]
[Date of Birth]

____ / ____ / ____ [Male] [Female]
[MO DAY YR]
[Date of Birth]

[Will this coverage replace, discontinue, or change an existing policy or contract? Yes No]

[Will this coverage replace, discontinue, or change an existing policy or contract? Yes No]

I understand that in order to enroll for this coverage, I must be [a Wells Fargo N.A. Accountholder age 18-64 and residing in a state in which this coverage may legally be offered. The first two months' coverage will be provided at no cost to me and] I may discontinue my coverage at any time. [I also understand that this coverage terminates automatically when I reach age 71.] My coverage will become effective on the date stated on my Certificate Schedule Page. [I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

[By signing below I certify that I am not currently eligible for Medicare.]

[Beneficiary Designation for each applicant: Unless specified below, any other benefit will be paid to your then-living, lawful spouse; otherwise equally to your then-living lawful children; if any; otherwise equally to your then-living lawful parents or parent; otherwise equally to your then-living lawful brothers and sisters; otherwise to your estate.]

X

Applicant's Signature

Date

X

Spouse's Signature

Date

GGA285

For Company Use Only
Licensed Agent

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

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

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

Residents of KENTUCKY: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

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

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

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

Residents of NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

ENROLLMENT FORM

Yes! Please enroll me and my spouse (if selected) in the [cash benefit insurance plan.]

[AF301]

Applicant

[67C01/ADB]

[AF301]

Spouse

[67C01/ADB]

[Full Name]

[Full Name]

[Address]

[Address]

[City/State/ZIP]

[City/State/ZIP]

()

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[Telephone]

[Telephone]

____ / ____ / ____ [Male Female]
[MO] [DAY] [YR]
[Date of Birth]

____ / ____ / ____ [Male Female]
[MO] [DAY] [YR]
[Date of Birth]

[Will this coverage replace, discontinue, or change an existing policy or contract? Yes No]

[Will this coverage replace, discontinue, or change an existing policy or contract? Yes No]

I understand that in order to enroll for this coverage, I must be [a Wells Fargo N.A. Accountholder age 18-64 and residing in a state in which this coverage may legally be offered. The first two months' coverage will be provided at no cost to me and] I may discontinue my coverage at any time. [I also understand that this coverage terminates automatically when I reach age 71.] My coverage will become effective on the date stated on my Certificate Schedule Page. [I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

[By signing below I certify that I am currently eligible to receive Medicare benefits and have received the special notice regarding this product and Medicare benefits.]

[Beneficiary Designation for each applicant: Unless specified below, any other benefit will be paid to your then-living, lawful spouse; otherwise equally to your then-living lawful children; if any; otherwise equally to your then-living lawful parents or parent; otherwise equally to your then-living lawful brothers and sisters; otherwise to your estate.]

X

Applicant's Signature

Date

X

Spouse's Signature

Date

GGA286

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Licensed Agent

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

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

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

Residents of KENTUCKY: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

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

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

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

Residents of NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

**GROUP MASTER POLICY
MONTHLY PREMIUM**

Stonebridge Casualty Insurance Company

A Stock Company
Home Office: Columbus, Ohio
Administrative Office: [2700 W. Plano Parkway, Plano, Texas 75075]

As You read through this policy, the words "We," "Us," and "Our" refer to the Stonebridge Casualty Insurance Company. "You" and "Your" mean the Policyholder named in the Application-Schedule page. "He," "Him" or "His" refer to your Insured Certificate Holder who has been issued a Certificate of Insurance, regardless of sex. This policy and its Application-Schedule page contain all agreements between You and Us. The Certificate(s) of Insurance shown in the Application-Schedule are made part of this policy and contain Our agreements as to the insurance protection provided under this policy. For service or information on this policy, contact the agent who sold the policy or our Administrative Office.

WHO IS ELIGIBLE FOR A CERTIFICATE OF INSURANCE

To be eligible for insurance an individual must have an Account as defined in the Application-Schedule in good standing with You. The individual must be a natural person. He must not be over the maximum age stated in the Application-Schedule. Only one individual may be issued a Certificate of Insurance on an Account. The individual billed on an Account shall be the Insured Certificate Holder.

EFFECTIVE DATE

The Effective date of each Certificate of Insurance shall be the date You process each eligible individual's completed enrollment form.

A Certificate of Insurance will be issued to each eligible individual within 30 days of Your receipt of his completed enrollment form.

CLAIM INFORMATION

You must provide Us with the Account information necessary to process a claim.

TYPE OF INSURANCE AND PREMIUM

This insurance is Monthly Premium - Monthly Renewable Disability Income and Involuntary Unemployment Insurance. The monthly insurance charges are computed pursuant to the Certificate of Insurance attached hereto. The premium will be paid monthly. All amounts charged by You may not exceed the premium rates established by Us. They must be in accordance with the methods we have set forth.

Payment of Premiums - All premiums due by the terms of this Policy shall be paid by the Policyholder to the Administrative Office of the Company on or prior to the day they are due.

Insureds are required to contribute 100 percent of the premium payable under this Policy for their Certificates [after the first 30 / 60 / 90 days]. If at any time the Policyholder refuses to accept such contributions and pay the premium for the Insured, the Insured may pay such premium directly to the Administrative Office of the Company on or prior to the day it is due.

If no initial premium is requested by the Company with the Insured's enrollment form, the Insured shall have 21 days from the Effective Date shown on the Certificate Schedule Page to pay the first premium. If the first premium is not paid within such 21-day period, the Certificate shall be considered void from the beginning and no benefits will be paid for any Loss.

Grace Period - Thirty-one days of grace without interest charge will be allowed for the payment of every premium after the first. The benefits shall continue in force during the grace period.

CANCELLATION OF POLICY

You or We can cancel this policy by giving the other party at least 90 days written notice prior to the premium due date. This policy shall stop as to individual Certificates of Insurance on the Insured Certificate Holder's third billing date after notice of cancellation is received by You or Us unless this policy is replaced. If this policy is replaced coverage shall stop on individual Certificates of Insurance on the Insured Certificate Holder's first billing date after notice is received that the policy is cancelled.

GENERAL PROVISIONS

- A. Data Required** - On or before the 15th day of each policy month You must supply Us with the requested information. We will supply You with the necessary forms.
- B. Clerical Error** - We cannot cancel the Insured Certificate Holder's insurance if, through clerical error, You:
1. Fail to furnish the required insurance information.
 2. Fail to make the required insurance payment.
 3. Report a false termination.
- C. Policy Conformed to Statute** - Any terms of this policy which are in conflict with the statutes of the state where issued are amended to conform to the minimum requirements of the statutes.
- D. Bankruptcy of Insured Certificate Holder** - Bankruptcy or insolvency of any Insured Certificate Holder shall not relieve Us of Our obligation.
- F. Changes of Contract** - This policy cannot be changed in any way except by a written agreement signed by an officer of our Company.
- G. Examination of Records** - All Your records containing information to the insurance under this policy must be available to Us during the policy term. It must also be available within one year after the termination of this policy.

IN WITNESS WHEREOF, **Stonebridge Casualty Insurance Company** has caused this contract to be signed by its President and Secretary.



President



Secretary

GROUP MASTER POLICY
MONTHLY PREMIUM

Stonebridge Casualty Insurance Company

A Stock Company
Home Office: Columbus, Ohio
Administrative Office: [2700 W. Plano Parkway, Plano, Texas 75075]

APPLICATION - SCHEDULE

Name of Policyholder: [Wells Fargo, N.A.]
[1234 Easy Street]
[Any Town, WY 999999]

Group Policy No: [XXXX GC998]

Effective Date of policy: [May 1, 2007] at 12:01 AM Standard Time at the Policyholder's Address

Premium Due Date: .[15th day of each month]

Eligibility: [Each natural person age 18 through 64 who is an account holder (or the spouse of an account holder age 18 through 64) of Wells Fargo Bank, N.A. or its affiliates is eligible to become an insured if that person resides in a state in which the insurance coverage may legally be offered.]

[No person shall be covered under more than one Certificate of Insurance under this Policy. If a person is recorded by the Company as an Insured under more than one Certificate, such person shall be deemed to be insured only under the Certificate which affords that person the greatest amount of coverage. Upon discovery of the duplication of coverage, any premium for the duplication coverage made by, or on behalf of, the Insured will be refunded.

[In no event will a corporation, partnership, or business entity, other than a natural person, be eligible for Insurance.]

This policy provides insurance covering Insured Certificate Holders on the Account(s) in accordance with the provisions of the Certificate(s) of Insurance attached hereto.

The maximum Monthly Benefit is \$ [1000.00]._____ per Covered Insured.

[The Maximum Number of Payments is [24].]

No individual can become insured on or after his _____ [64th] birthday.

[For the first (1)(2)(3) month(s) the premium will be paid by the Policyholder. Thereafter, premiums paid by the Covered Certificate Holder are included on the attached rate sheet.]

This policy is subject to the following endorsements, riders, and Certificate(s) of Insurance:

[GC541]

Dated at _____

Full or Corporate Name of Policyholder

This _____ day of _____, 20_____

Signature and Title

Signature of Licensed Resident Agent (if required)

SERFF Tracking Number: *AEXX-125445397* *State:* *Arkansas*
Filing Company: *Stonebridge Casualty Insurance Company* *State Tracking Number:* *#7210030970 \$50*
Company Tracking Number: *OC AR0003823F01*
TOI: *33.0 Other Lines of Business* *Sub-TOI:* *33.0001 Other Personal Lines*
Product Name: *Other Personal Liability*
Project Name/Number: *Other Personal Liability/OC AR0003823F01*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AEXX-125445397 State: Arkansas
Filing Company: Stonebridge Casualty Insurance Company State Tracking Number: #7210030970 \$50
Company Tracking Number: OC AR0003823F01
TOI: 33.0 Other Lines of Business Sub-TOI: 33.0001 Other Personal Lines
Product Name: Other Personal Liability
Project Name/Number: Other Personal Liability/OC AR0003823F01

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty

Review Status:

Approved

02/07/2008

Comments:

Attachment:

AR - NAIC P&C TRANSMITTAL DOCUMENT.PDF

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

3. Group Name	Group NAIC #			
	468			
4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Stonebridge Casualty Insurance Company	OH	10952	31-4423946	

5. Company Tracking Number	OC AR0003823F01
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Cindy K. Hammonds, FLMI, CCP, AIRC, ACS 2700 W. Plano Pkwy Plano TX 75075	Senior Contract Analyst	877-527-6444 Ext. 6783	972-881-4097	chammon1@aegonusa.com
7.	Signature of authorized filer		<i>Cindy Hammonds</i>		
8.	Please print name of authorized filer		Cindy K. Hammonds, FLMI, CCP, AIRC, ACS		

Filing Information (see General Instructions for descriptions of these fields)

9.	Type of Insurance (TOI)	33.0 Other Lines of Business
10.	Sub-Type of Insurance (Sub-TOI)	33.0001 Other Personal Lines
11.	State Specific Product code(s) (if applicable) [See State Specific Requirements]	
12.	Company Program Title (Marketing Title)	Cash Benefit
13.	Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14.	Effective Date(s) Requested	New: Upon Approval Renewal:
15.	Reference Filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Reference Organization (if applicable)	
17.	Reference Organization # & Title	
18.	Company's Date of Filing	
19.	Status of filing in domicile	<input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document

20.	This filing transmittal is part of Company Tracking #	OC AR0003823F01
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21.	Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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Attached for your review and approval are new forms. These forms do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion and variable information is printed in red and bracketed. An effective date coinciding with your date of approval is requested.

GC541 offers Disability Income as a result of a covered accident or sickness and Involuntary Unemployment . Coverage terminates on the Insured's 71st birthday. Single and Joint coverage is available.

GC542 offers Disability Income as a result of a covered accident only and Involuntary Unemployment. Coverage terminates on the Insured's 71st birthday. Single and Joint coverage is available.

GR924 provides a hospital benefit if the insured is confined for at least 48 hours for the necessary treatment of a covered injury. The confinement must begin within a specified number of days of the accident causing the injury.

GR925 provides an accidental death benefit for the covered person when death results directly from a covered injury. Death must occur 90 days from the date of the accident.

GR926 offers Family Leave coverage if the insured takes the Family Leave benefit from their place of employment. Coverage terminates on the Insured's 71st birthday. Single and Joint coverage is available.

These riders will be used at-issue as well as an add-on and will be used with these and other similar products as your Department approves them.

GGA285 and GGA286 are the enrollment forms that will be used to solicit this coverage.

MPCAS001 is the Master Policy under which these certificates will be issued. MACAS001 is the Group Master Policy Application that will be used with Master Policy MPCAS001.

The Flesch scores for GC541 and GC542 are 46.8 and 47.1 respectively. The Flesch scores for GR924, GR925 and GR926 are 40, 44.3 and 43.6 respectively. Microsoft Word was used to obtain these scores.

This product will be mass marketed by direct response and possibly on the Internet through our website. This form may be used in other media formats including translations into Spanish, Chinese, Korean, Vietnamese, Polish, etc, but such case, we certify that content will not change.

We plan to issue a master policy to a group consisting of Wells Fargo, N.A. Account holders. For solicitation of Wells Fargo, N.A., the group is defined as the following:

Each natural person age 18 through 64 who is an account holder (or the spouse of an account holder age 18 through 64) of Wells Fargo Bank, N.A. or its affiliates is eligible to become an insured if that person resides in a state in which the insurance coverage may legally be offered.

The group policy is also contemplated for issue to various discretionary groups that are situated in your state. We certify: (1) the issuance of the group policy is not contrary to the best interest of the public; (2) the issuance of the group policy would be actuarially sound; (3) the issuance of the group policy would result in economies of acquisition or administration; and (4) the benefits are reasonable in relation to the premium charged.

This product will be marketed without an illustration.

I respectfully request your favorable review and approval. We appreciate your consideration of these forms. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6783 or contact me by e-mail at chammon1@aegonusa.com.

22.	Filing Fees (Filer must provide check # and fee amount if applicable.) [If a state requires you to show how you calculated your filing fees, place that calculation below]
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Check #: 7210030970
Amount: \$50.00

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**