

SERFF Tracking Number: ARKS-125608986 State: Arkansas
Filing Company: 26581 - Independence American Insurance Company State Tracking Number: #4514 \$20
Company Tracking Number: SL2004-APP-IAIC-AR
TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0000 Other Liability Sub-TOI Combinations
Product Name: n/a
Project Name/Number: /

Filing at a Glance

Company: 26581 - Independence American Insurance Company

Product Name: n/a

SERFF Tr Num: ARKS-125608986 State: Arkansas

TOI: 17.0 Other Liability - Claims
Made/Occurrence

SERFF Status: Closed

State Tr Num: #4514 \$20

Sub-TOI: 17.0000 Other Liability Sub-TOI
Combinations

Co Tr Num: SL2004-APP-IAIC-AR

State Status: Fees verified and
received

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi, Edith
Roberts, Brittany Yielding

Author:

Disposition Date: 04/30/2008

Date Submitted: 04/14/2008

Disposition Status: Approved

Effective Date Requested (New):

Effective Date (New):

Effective Date Requested (Renewal):

Effective Date (Renewal):

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 04/30/2008

State Status Changed: 04/30/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Company and Contact

Filing Contact Information

NA NA,

NA@NA.com

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Product Name: n/a
Project Name/Number: /

NA (123) 555-4567 [Phone]

NA, AR 00000

Filing Company Information

26581 - Independence American Insurance CoCode: 26581 State of Domicile: Delaware
Company
485 Madison Avenue Group Code: 450 Company Type: Property &
Casualty
New York, NY 10022-5872 Group Name: State ID Number:
(212) 355-4141 ext. 3019[Phone] FEIN Number: 74-1746542

SERFF Tracking Number: ARKS-125608986 State: Arkansas
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Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	04/30/2008	04/30/2008

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Product Name: n/a
Project Name/Number: /

Disposition

Disposition Date: 04/30/2008

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ARKS-125608986 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	ARKS-125608986		Yes

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Product Name: n/a
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Rate Information

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Product Name: n/a
Project Name/Number: /

Supporting Document Schedules

Review Status:

Satisfied -Name: ARKS-125608986

05/01/2008

Comments:

Attachment:

ARKS-125608986.pdf



ARKS-12560898# 4519
20.00

Approved until withdrawn
or revoked

April 10, 2008

APR 14 2008

Arkansas Insurance Department
By: *EW*

NAIC Company #: 26581
NAIC Group #: 0450
FEIN#: 74-1746542

Ms. Edith Roberts
Policy & Other Form Filings
Arkansas Insurance Department
1200 W. Third Street
Little Rock, Arkansas 72201-1904

RE: Independence American Insurance Company

Bulletin No: 6-2008
Form #: SL2004-APP-IAIC-AR **Application**

Dear Ms. Roberts :

Enclosed for your review and approval, please find duplicate copies of the captioned form. On August 17, 2004, your Department approved our stop loss application form number SL2004-APP-IAIC. In compliance with Bulletin No. 6-2008, please find a revised application incorporating the required notice as indicated in the attached bulletin. We have revised the footer number to indicate that a change has been made. No other changes have been made to the application.

Also enclosed please find a Certification and a postage-paid self-addressed envelope for your use in returning a stamped-approved copy of the form.

If you have any questions concerning this submission, please do not hesitate to contact me direct at 212-355-4141, ext. 3019, e-mail at lparrilla@sslicny.com or via facsimile at (212) 754-3346. I look forward to hearing from you.

Very truly yours,

Lizza Parrilla
Legal/Compliance

Encls.

RECEIVED

1 APR 14 2008

PROPERTY AND CASUALTY DIVISION
ARKANSAS INSURANCE DEPARTMENT

Independence American Insurance Company
485 Madison Avenue New York, NY 10022-5872 Telephone: (212) 355-4141 Fax: (212) 308-7679

Arkansas Insurance Department

Mike Beebe
Governor



Julie Benafield Bowman
Commissioner

BULLETIN NO. 6-2008

TO: ALL LICENSED INSURANCE COMPANIES, HEALTH MAINTENANCE ORGANIZATIONS, HOSPITAL MEDICAL SERVICE CORPORATIONS, RATE SERVICE OR ADVISORY ORGANIZATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: APPLICATIONS FOR STOP LOSS INSURANCE POLICIES

EFFECTIVE DATE: June 1, 2008

DATE: April 3, 2008

The Arkansas Insurance Department ("Department") is issuing this Bulletin on applications for stop loss insurance policies to set forth the Department's position regarding Ark. Code Ann. §23-62-111. It is the Department's position that a disclosure to policyholders is needed to inform the employer/applicant that the purchase of stop loss coverage does not fully relieve the employer of all potential risks. This Bulletin shall apply to all applications used by all insurance companies selling stop loss policies to self-funded medical plans.

Accordingly, the Department will require the following notice to be added to all applications for stop loss insurance. This requirement will apply to stop loss policies written by accident and health carriers as well as casualty carriers that are writing this type of policy.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

To comply with this requirement:

1. Carriers may add this notice to their stop loss applications and file the applications with the Department for approval. If the amended application is filed electronically with a certification that the only change is the addition of above Notice along with the \$20 filing fee, the Insurance Department will process the filing within two business days; or
2. If after the effective date of this Bulletin any carrier has not filed an amended application for approval, carriers should deliver a copy of the required disclosure notice with their stop loss applications including a signature section whereby the applicant acknowledges the receipt of the disclosure notice.
3. All stop loss applications used in this State after December 31, 2008 must include the required Notice.

Questions concerning this Bulletin should be directed to the Arkansas Insurance Department Legal Division at 501-371-2820 or by e-mail to legal.division@arkansas.gov.

(signed by Julie Benafield Bowman)

JULIE BENAFIELD BOWMAN
INSURANCE COMMISSIONER
STATE OF ARKANSAS

INDEPENDENCE AMERICAN INSURANCE COMPANY

CERTIFICATION

Arkansas Insurance Department

Date: 4/10/08

Insurance Company Name: Independence American Insurance Company

Insurance Company NAIC Number: 26581

Filing ID Number: SL2004-APP-IAIC-AR

RE: Bulletin No.: 6-2008 (Arkansas Insurance Department)

On August 17, 2004, your Department approved our stop loss application form number SL2004-APP-IAIC. In compliance with Bulletin No. 6-2008, I certify that the only change being made to our filed and approved application is the addition of the required Notice as indicated in the attached bulletin. We have changed the footer on the application to indicate that a change has been made. No other changes have been made to the application.

Filing Analyst Name: Lizza Parrilla

Filing Analyst Signature: 

Responsible Officer's Name: Thomas A. Gibbons
Vice President - Legal & Compliance



485 Madison Avenue
New York, NY 10022
(212) 355-4141

APPLICATION FOR EXCESS LOSS INSURANCE

1. Name of Applicant: [ABC Corp.]
Address (Street, City, State, Zip) : [Any City, Any State]
2. Industry/Business Type and Description: [Widget Manufacturing]
3. Name and Addresses of Subsidiaries to be covered (attach additional pages if necessary):

Name	Address (City, State, Zip)
<u>[None]</u>	
4. Number of Employees at all Locations listed above:
Single: [XXX] Family: [XXX] Composite: [XXX]
COBRA Continuees: [XXX] Retirees: [XXX]
5. Name of Administrator: [Any TPA]
Address (Street, City, State, Zip): [Any City, Any State]
6. Proposed Effective Date of the Policy: [01/01/XX]

A. AGGREGATE EXCESS LOSS INSURANCE

7. Benefits Covered
 Medical Dental Weekly Income Vision Prescription Drug Card
 Other: _____
8. Benefit Period
[[covered subsidiary or class (additional as needed):]
Eligible Expenses incurred from _____ through _____; and
Eligible Expenses paid from _____ through _____.]

The applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the applicant may experience losses that are not covered under the policy, when issued, or under any such prior or subsequent coverage.

9. Minimum Aggregate Attachment Point [\$XXX,XXX.XX]
10. Aggregate Loss Limit (per person) [\$XXX,XXX.XX]
11. Aggregate Benefit Percentage [100%]
12. Maximum Aggregate Benefit [\$XXX,XXX.XX]

13. [Run-In/Run-out] Limit: [\$XXX,XXX.XX]

14. Monthly Aggregate Factors/Enrollment:

[[covered subsidiary or class (additional as needed):]

FACTORS:

Single/Employee: [\$XX.XX]

Family/Dependent: [\$XX.XX]

Composite: [\$XX.XX]

COVERED UNITS/ENROLLMENT:

Single/Employee: [XXX]

Family/Dependent: [XXX]

Composite: [XXX]

15. Aggregate Premium (Annual / Per Employee Per Month) [\$XXX,XXX.XX]

16. Minimum Aggregate Premium (Annual / Monthly) [\$XXX,XXX.XX]

17. Premium Payment Mode [Monthly]

B. SPECIFIC EXCESS LOSS INSURANCE

18. Benefits Covered: Medical Prescription Drug Card

19. Benefit Period:

[[covered subsidiary or class (additional as needed):]

Eligible Expenses Incurred from [01/01/XX] through [12/31/XX]; and

Eligible Expenses Paid from [01/01/XX] through [12/31/XX].]

The applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the applicant may experience losses that are not covered under the policy, when issued, or under any such prior or subsequent coverage.

20. Deductible (per covered person) [\$XXX,XXX.XX]

[Except for the following:

a. [John Doe]: [\$XXX,XXX.XX]

b. [Jane Doe]: [\$XXX,XXX.XX]

c. []: \$]

21. Specific Benefit Percentage..... [100%]

22. Specific Benefit Limit (per lifetime, per person)..... [\$XXX,XXX.XX]

23. [Run-In/Run-Out] Limit:

a. [John Doe]: [\$XXX,XXX.XX]

b. [Jane Doe]: [\$XXX,XXX.XX]

c. []: \$]

24. Monthly Specific Premium Rate/Enrollment:

[[covered subsidiary or class (additional as needed):]

RATE:

Single/Employee: [\$XXX,XXX.XX]

Family/Dependent: [\$XXX,XXX.XX]

Composite: [\$XXX,XXX.XX]

COVERED UNITS/ENROLLMENT:

Single/Employee: [XXX]

Family/Dependent: [XXX]

Composite: [XXX]

25. Minimum Specific Premium (Annual / Monthly)..... [\$XXX,XXX.XX]

26. A deposit of [\$XXX,XXX.XX] is enclosed to apply to the first payment under the Policy, if issued, subject to the requirements below. If the Application is not accepted, the deposit will be returned.

C. OPTIONS REQUESTED*

- | | |
|--|---|
| <input checked="" type="checkbox"/> Waiver of Actively at Work | <input type="checkbox"/> Aggregating Specific Rider |
| <input checked="" type="checkbox"/> Advanced Funding | <input type="checkbox"/> Aggregate Monthly Cumulative Accommodation |
| <input checked="" type="checkbox"/> Retiree Expenses Included in Coverage
[Limited to: _____] | <input type="checkbox"/> Aggregate Excess Loss Terminal Liability |
| | <input type="checkbox"/> Specific Excess Loss Terminal Liability |

* Approval of request subject to underwriting review.]

It is understood and agreed that as a condition precedent to the approval of the Application that:

- a) **Any Excess Loss Insurance resulting from this Application shall be as described in and shall be subject to the terms and provisions of the Policy, when issued.** Such Policy shall become effective on the date specified in this Application; provided that, including, without limitation: (1) a true and correct Disclosure Statement has been received, (2) the underwriting requirements have been satisfied, (3) the required premiums have been paid, and (4) a copy of the executed Plan is received and acceptable to the Company pursuant to paragraph b below. If any of these requirements are not satisfied within [90] days from the proposed effective date indicated in this Application, all premium will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- b) The Applicant shall furnish to [MGU NAME ("MGU") or] Independence American Insurance Company (the "Company") a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of [MGU or] the Company. No Policy will be released nor claim reimbursed until such time as acceptable Plan is received and accepted by the Company. If in the sole judgment of [MGU or] the Company there is a material variance between the provisions of the Plan received by [MGU or] the Company, and the Plan provisions upon which the terms and rates of the aggregate and specific excess coverage were based, [MGU or] the Company may, at its option, notify the Applicant of such variances and decline to release the Policy until such time as an amended Plan is received and accepted. If such amended Plan is not received and accepted by [MGU or] the Company within [30] days of such notice, all premium will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- c) The Applicant will provide or employ supervision and claim administration facilities acceptable to [MGU or] the Company to administer the Plan and to process and pay claims according to the Plan.
- d) The receipt by the Company of the deposit listed above and the deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event that the Company does not approve this Application, its sole obligation shall be to refund the deposit to the Applicant.
- e) The Applicant represents that the statements and declarations made in this Application, the Disclosure Statement, and in the Plan referred to in this Application are true and complete and that the Policy, when issued, will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this Application, the Policy, and the Plan shall embody all agreements existing between the Applicant and the Company, or any of their respective agents, relating to this Excess Loss Insurance for which this Application is being made.

The Applicant represents that it, directly or through its authorized agent, has read this Application in its entirety and has been given the opportunity to ask any questions it may have. The Applicant further understands that the insurance requested does not start unless this Application is approved and accepted by [MGU NAME or] the Company.

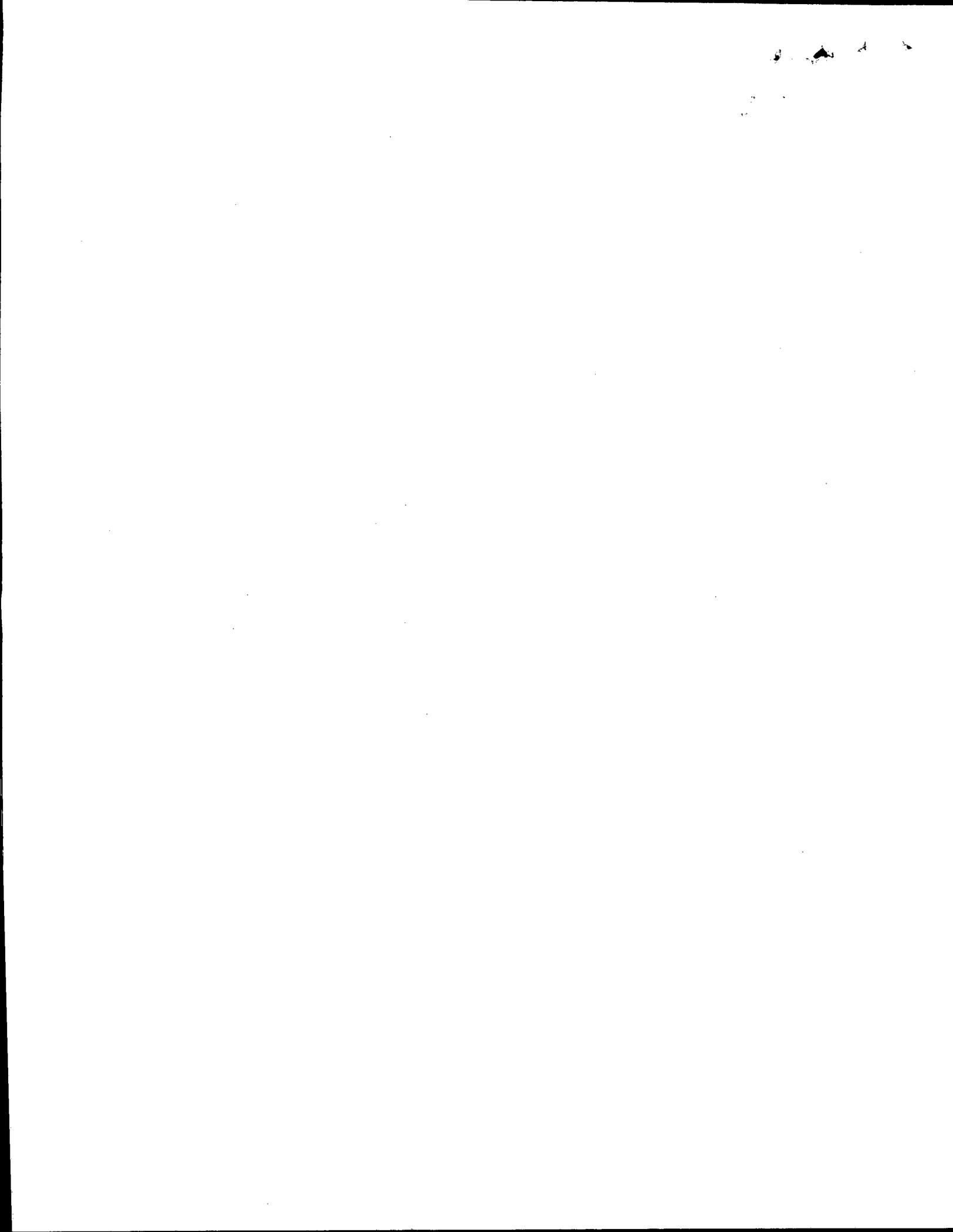
NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

Applicant: _____
 Signature: _____
 Print Name: _____
 Title: _____
 Date: _____

 Licensed Agent's Signature
 Print Name _____
 Date: _____

4-11-68

100



FRAUD WARNING NOTICES: (Please review notice that applies in your state)

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.

For applicants in ALASKA, DELAWARE, IDAHO, INDIANA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For applicants in CALIFORNIA: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For applicants in ARKANSAS: 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.

For applicants in COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in DISTRICT OF COLUMBIA: **WARNING:** It is a crime to provide false or misleading information to an insurer for 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 application.

For applicants in 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.

For applicants in KENTUCKY, NEW HAMPSHIRE, NEW MEXICO, NORTH DAKOTA, OHIO and 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.

For applicants in MINNESOTA: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, is guilty of a crime.

For applicants in OKLAHOMA: **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claims for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For applicants in OREGON: 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 may be a crime.

For applicants in MAINE, TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, 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.

For applicants in 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.