

SERFF Tracking Number: BFLI-125630644 State: Arkansas
Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 38897
Company Tracking Number: AR B 9200 PRF AP2008
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
Standard Plans
Product Name: Medicare Supplement Application
Project Name/Number: /

Filing at a Glance

Company: Bankers Fidelity Life Insurance Company

Product Name: Medicare Supplement SERFF Tr Num: BFLI-125630644 State: ArkansasLH

Application

TOI: MS051 Individual Medicare Supplement - SERFF Status: Closed State Tr Num: 38897

Standard Plans

Sub-TOI: MS051.001 Plan A Co Tr Num: AR B 9200 PRF State Status: Under Review

AP2008

Filing Type: Form

Co Status:

Reviewer(s): Stephanie Fowler

Authors: Jill Jones, Tina

Disposition Date: 05/27/2008

Cunningham

Date Submitted: 05/07/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: paper filing mailed to GA 05-01-2008

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/27/2008

State Status Changed: 05/23/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

These applications will be used to solicit our Medicare Supplement products, which have been or will have been previously approved by your department; a representative sample of the plans to be offered is shown in the selection area. Solicitation will be performed by personally producing, licensed and contracted agents and brokers.

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 Standard Plans
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Company and Contact

Filing Contact Information

Tina Cunningham, Compliance Analyst L1 tcunningham@atlam.com
 4370 Peachtree Road NE (404) 266-5723 [Phone]
 Atlanta, GA 30319 (404) 926-4092[FAX]

Filing Company Information

Bankers Fidelity Life Insurance Company CoCode: 61239 State of Domicile: Georgia
 4370 Peachtree Rd NE Group Code: 587 Company Type: Life & Health
 Atlanta, GA 30319 Group Name: 61239 State ID Number:
 (404) 266-5600 ext. [Phone] FEIN Number: 58-0658963

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Bankers Fidelity Life Insurance Company	\$50.00	05/07/2008	20143374

SERFF Tracking Number: BFLI-125630644 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	05/27/2008	05/27/2008

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Disposition

Disposition Date: 05/27/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved	No
Supporting Document	Application	Approved	No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Cover letter	Approved	No
Form	Application for Medicare Supplement Insurance	Approved	No
Form	Application for Medicare Supplement Insurance	Approved	No

SERFF Tracking Number: BFLI-125630644 State: Arkansas
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Form Schedule

Lead Form Number: B 9200 PRF AP2008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	B 9200 PRF AP2008	Application/ Enrollment Form	Application for Medicare Supplement Insurance	Initial		51	B 9200 PRF AP2008 john doe.pdf
Approved	B 9200 STND AP2008	Application/ Enrollment Form	Application for Medicare Supplement Insurance	Initial		55	B 9200 STND AP2008 john doe.pdf

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, GA 30348-5146

APPLICATION FOR INSURANCE PREFERRED UNDERWRITING CLASS

PLEASE PRINT

Agent/Broker Name <u>Joe Agent</u>	Agent # <u>00001</u>
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Proposed Insured <u>John D. Doe</u>	Social Security No. <u>0000000001</u>	Sex <u>M</u>	Place (State) of Birth <u>GA</u>	Age <u>68</u>	Born			Height & Weight		
					Mo. <u>01</u>	Day <u>01</u>	Yr. <u>48</u>	Ft. <u>6</u>	In. <u>2</u>	Lbs. <u>180</u>
Residence Address (Street or Route & Box No.) <u>#1 Main St</u>		City <u>City</u>	County <u>County</u>	State <u>ST</u>	Zip Code <u>30000-0000</u>					
Telephone Number <u>(404) 123 4567</u>	Best Time to Call: <u>8:00</u> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	Proposed Insured E-mail Address: <u>john.doe@email.com</u>			Mail Policy To: <input checked="" type="checkbox"/> Insured <input type="checkbox"/> Agent					

PRINT—To whom should premium notices be sent? Same address as Proposed Insured, or:
 Payor name _____ Phone number () _____
 Complete Address: _____

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

MEDICARE SUPPLEMENT PLANS*: A B C D E F High Ded. F G

*Some plans not available in all states. Refer to rate sheet for availability.

Open Enrollment:

- (a) Is the Proposed Insured eligible for coverage under the "Open Enrollment" period (the six month period beginning with the first month in which the Proposed Insured is both age 65 or older and enrolled in Medicare Part B)? Yes No
- (b) Is the Proposed Insured eligible for coverage under the 63-day (90-day in WY only) "guaranty issue" period? If "Yes," proof must be submitted. Yes No

REQUESTED EFFECTIVE DATE: <u>05-01-08</u>	PREMIUM MODE: <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Direct <input type="checkbox"/> Monthly Bank Draft* <input type="checkbox"/> Monthly Credit Card* *Requested Draft Date _____	PREMIUM CLASS: <input checked="" type="checkbox"/> Non-Tobacco* <input type="checkbox"/> Tobacco *Has not used any tobacco product in the last 3 years. Applicants qualified for Open Enrollment will automatically be given Non-tobacco rates. BILLING TYPE: <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Family* *Complete Family Billing Form B 0129 FB/LB	MODAL PREMIUM COMPUTATION: Total Amount Paid \$ <u>xxx xx</u> <input checked="" type="checkbox"/> Check/money order included. <input type="checkbox"/> Charge credit card for initial premium. <input type="checkbox"/> Draft initial premium* *Initial Draft Date _____
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INSURANCE INFORMATION

1. (a) Medicare claim number 000-00-0001-00 (Record full, complete number from Medicare card.)
- (b) Is the Proposed Insured covered under Medicare Part A? Yes No If "Yes," effective date 01-01-2005
- (c) Is the Proposed Insured covered under Medicare Part B? Yes No If "Yes," effective date 01-01-2005
- (d) Is the Proposed Insured covered under Social Security Disability? Yes No If "Yes," effective date _____
2. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.
- (A) Did you turn age 65 in the last 6 months? Yes No
- (B) Did you enroll in Medicare Part B in the last 6 months? Yes No
- (C) If yes, what is the effective date? _____
- (D) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) Yes No
- (a) If yes, will Medicaid pay your premiums for this Medicare supplement policy? Yes No
- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No
- (E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start date _____ End Date _____
- (a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No
- (b) Was this your first time in this type of Medicare plan? Yes No
- (c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No
- (F) Do you have another Medicare supplement policy in force? Yes No
- (a) If so, with what company, and what plan do you have? _____
- (b) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No
- (G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan) Yes No
- (a) If so, with what company and what kind of policy? _____
- (b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.
Start date _____ End Date _____

IF THE ANSWER TO ANY PART OF QUESTION 3 THROUGH 5 IS "YES," COVERAGE IS NOT AVAILABLE. IF ELIGIBLE FOR OPEN ENROLLMENT OR 63-DAY (90 DAY IN WY ONLY) GUARANTY ISSUE, QUESTIONS 3 THROUGH 7 DO NOT HAVE TO BE ANSWERED.

3. In the last 5 years, has the Proposed Insured had or been medically diagnosed with or treated for:
- (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
 - (b) any lipidosis, including Gaucher's or Tay-Sachs or Wolman's? Yes No
4. In the past year, has the Proposed Insured been:
- (a) confined to a hospital 2 or more times or to a nursing facility or to a wheelchair, or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring or toileting? Yes No
 - (b) medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? Yes No
5. In the last 3 years has the Proposed Insured had, been medically diagnosed with or treated for:
- (a) heart attack, stroke of any kind, congestive heart failure or surgery for transplanting any organ or tissue (excluding corneal transplants) or amputation due to disease? Yes No
 - (b) emphysema, chronic obstructive pulmonary disease (COPD), or used supplemental oxygen, inhalers or puffers for any of these conditions? Yes No
 - (c) kidney/renal failure, cirrhosis, liver disease, or hepatitis (excluding Type A)? Yes No
 - (d) internal cancer, leukemia, malignant melanoma or Hodgkin's disease? Yes No
 - (e) Alzheimer's disease, dementia, organic brain syndrome, schizophrenia or psychotic disorder, alcoholism or drug addiction or diabetes requiring insulin? Yes No
 - (f) Parkinson's or Huntington's disease, Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig's disease (ALS), Systemic Lupus or sickle cell anemia? Yes No

6. List all prescription drugs the Proposed Insured is currently taking or has been medically advised to take:

(If "None," so state; if additional space is needed attach separate page and have Proposed Insured sign and date.)

Medication	Amount	Condition for Which Prescribed	Currently Taking?
NONE			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

7. Please provide complete name, address and telephone number of the Proposed Insured's primary care physician:

Physician's name: Dr. Bob Physician Telephone number 404-234-5678
 Physician's address: #1 Physician Ct City ST 30000

8. NOTICE TO THE PROPOSED INSURED: (a) You do not need more than one Medicare supplement policy. (b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (d) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

9. I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein. I have received an outline of coverage and a "Guide To Health Insurance For People With Medicare."

The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" and/or "Time Limit On Certain Defenses" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy.

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Dated at, on City ST (City and State) 05-01-08 X (Month, Day, Year) John Doe Proposed Insured's signature. Please read item 9 before signing.
X Joe Agent Agent's signature 00001 Agent's number

Is any of this insurance being purchased to replace or change any existing insurance? Yes No

Complete Replacement Notice(s) as required.

I have sold the following Medicare supplement policies to the Proposed Insured which are still in force: NONE

I have sold the following Medicare supplement policies to the Proposed Insured within the past 5 years which are no longer in force:

NONE

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare."

I certify that to the best of my knowledge and belief the Medicare Supplement coverage applied for herein does not duplicate coverage the Proposed Insured currently has in force.

Is the Proposed Insured related to you? Yes No If "Yes," explain relationship: Self _____

If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identity as required by the USA Patriot Act (PL 107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:

Drivers License Passport Government-issued identification card Other _____

Dated at City ST , on 05-01-08 X Joe Agent Agent's signature 00001 Agent's number
X _____ Co-signature (if required)

WRITING AGENT COMPLETE

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, GA 30348-5146

APPLICATION FOR INSURANCE STANDARD UNDERWRITING CLASS

PLEASE PRINT

Agent/Broker Name <u>Joe Agent</u>	Agent # <u>00001</u>
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Proposed Insured <u>John D. Doe</u>		Social Security No. <u>000 000001</u>		Sex <u>M</u>	Place (State) of Birth <u>GA</u>	Age <u>68</u>	Born Mo. <u>01</u> Day <u>01</u> Yr. <u>48</u>			Height & Weight Ft. <u>6</u> In. <u>2</u> Lbs. <u>180</u>		
Residence Address (Street or Route & Box No.) <u>#1 Main St</u>				City <u>City</u>	County <u>Count</u>	State <u>ST</u>	Zip Code <u>30000-0000</u>					
Telephone Number <u>(404) 123 4567</u>	Best Time to Call: <u>8</u> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		Proposed Insured E-mail Address: <u>johnddoe@email.com</u>				Mail Policy To: <input checked="" type="checkbox"/> Insured <input type="checkbox"/> Agent					

PRINT—To whom should premium notices be sent? Same address as Proposed Insured, or:

Payor name _____ Phone number () _____
Complete Address: _____

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

MEDICARE SUPPLEMENT PLANS*: A B C D E F High Ded. F G

*Some plans not available in all states. Refer to rate sheet for availability.

Open Enrollment:

- (a) Is the Proposed Insured eligible for coverage under the "Open Enrollment" period (the six month period beginning with the first month in which the Proposed Insured is both age 65 or older and enrolled in Medicare Part B)? Yes No
- (b) Is the Proposed Insured eligible for coverage under the 63-day (90-day in WY only) "guaranty issue" period? If "Yes," proof must be submitted. Yes No

REQUESTED EFFECTIVE DATE: <u>05-01-08</u>	PREMIUM MODE: <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Direct <input type="checkbox"/> Monthly Bank Draft* <input type="checkbox"/> Monthly Credit Card* *Requested Draft Date _____	BILLING TYPE: <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Family* *Complete Family Billing Form B 0129 FB/LB	MODAL PREMIUM COMPUTATION: Total Amount Paid\$ <u>444.22</u> <input checked="" type="checkbox"/> Check/money order included. <input type="checkbox"/> Charge credit card for initial premium. <input type="checkbox"/> Draft initial premium* *Initial Draft Date _____
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INSURANCE INFORMATION

- (a) Medicare claim number 0000-00-00001-00 (Record full, complete number from Medicare card.)

(b) Is the Proposed Insured covered under Medicare Part A? Yes No If "Yes," effective date 01-01-05

(c) Is the Proposed Insured covered under Medicare Part B? Yes No If "Yes," effective date 01-01-05

(d) Is the Proposed Insured covered under Social Security Disability? Yes No If "Yes," effective date _____
- If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.

(A) Did you turn age 65 in the last 6 months? Yes No

(B) Did you enroll in Medicare Part B in the last 6 months? Yes No

(C) If yes, what is the effective date? _____

(D) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) Yes No

(a) If yes, will Medicaid pay your premiums for this Medicare supplement policy? Yes No

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

(E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start date _____ End Date _____

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No

(b) Was this your first time in this type of Medicare plan? Yes No

(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No

(F) Do you have another Medicare supplement policy in force? Yes No

(a) If so, with what company, and what plan do you have? _____

(b) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

(G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan) Yes No

(a) If so, with what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.
Start date _____ End Date _____

IF THE ANSWER TO ANY PART OF QUESTION 3 THROUGH 5 IS "YES," COVERAGE IS NOT AVAILABLE. IF ELIGIBLE FOR OPEN ENROLLMENT OR 63-DAY (90 DAY IN WY ONLY) GUARANTY ISSUE, QUESTIONS 3 THROUGH 5 DO NOT HAVE TO BE ANSWERED.

3. In the last 5 years, has the Proposed Insured had or been medically diagnosed with or treated for:
- (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)?..... Yes No
 - (b) any lipidosis, including Gaucher's or Tay-Sachs or Wolman's?..... Yes No
4. In the past year, has the Proposed Insured been:
- (a) confined to a hospital 3 or more times or to a nursing facility or to a wheelchair or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring or toileting?..... Yes No
 - (b) medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so?..... Yes No
5. In the last 2 years has the Proposed Insured had, been medically diagnosed with or treated for:
- (a) heart attack, stroke (excluding transient ischemic attack (TIA) or mini stroke), congestive heart failure or surgery for transplanting any organ or tissue (excluding corneal transplants) or amputation due to disease? Yes No
 - (b) emphysema, chronic obstructive pulmonary disease (COPD), or used supplemental oxygen, inhalers or puffers for any of these conditions? Yes No
 - (c) kidney/renal failure, cirrhosis, liver disease, or hepatitis (excluding Type A)? Yes No
 - (d) internal cancer, leukemia, malignant melanoma or Hodgkin's disease? Yes No
 - (e) Alzheimer's disease, dementia, organic brain syndrome, schizophrenia or psychotic disorder, alcoholism or drug addiction or diabetes requiring insulin?..... Yes No
 - (f) Parkinson's or Huntington's disease, Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig's disease (ALS), Systemic Lupus or sickle cell anemia?..... Yes No
 - (g) diabetic coma, insulin shock or taking 70 or more units of insulin daily? Yes No

6. NOTICE TO THE PROPOSED INSURED: (a) You do not need more than one Medicare supplement policy. (b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (d) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(Application continued)

7. I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein. I have received an outline of coverage and a "Guide To Health Insurance For People With Medicare."

The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" and/or "Time Limit On Certain Defenses" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy.

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Dated at, on City ST (City and State) 05-01-08 (Month, Day, Year) John Doe Proposed Insured's signature. Please read item 7 before signing.
X Joe Agent Agent's signature 00001 Agent's number

Is any of this insurance being purchased to replace or change any existing insurance? Yes No
Complete Replacement Notice(s) as required.

I have sold the following Medicare supplement policies to the Proposed Insured which are still in force: NONE

I have sold the following Medicare supplement policies to the Proposed Insured within the past 5 years which are no longer in force: NONE

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare."

I certify that to the best of my knowledge and belief the Medicare Supplement coverage applied for herein does not duplicate coverage the Proposed Insured currently has in force.

Is the Proposed Insured related to you? Yes No If "Yes," explain relationship: Self _____
If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identity as required by the USA Patriot Act (PL 107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:

Drivers License Passport Government-issued identification card Other _____

Dated at City ST City and State, on 05-01-08 Month, Day, Year X Joe Agent Agent's signature 00001 Agent's number
X _____ Co-signature (if required)

WRITING AGENT COMPLETE

SERFF Tracking Number: BFLI-125630644 State: Arkansas
Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 38897
Company Tracking Number: AR B 9200 PRF AP2008
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
Standard Plans
Product Name: Medicare Supplement Application
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: BFLI-125630644 State: Arkansas
 Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 38897
 Company Tracking Number: AR B 9200 PRF AP2008
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
 Standard Plans
 Product Name: Medicare Supplement Application
 Project Name/Number: /

Supporting Document Schedules

<p>Satisfied -Name: Certification/Notice Comments: Attachment: B 9200 PRF STND AP2008 Flesch Cert.pdf</p>	<p>Review Status: Approved 05/27/2008</p>
<p>Satisfied -Name: Application Comments: Applications for B 9200 PRF AP2008 and B 9200 STND AP2008 Attachments: B 9200 PRF AP2008 john doe.pdf B 9200 STND AP2008 john doe.pdf</p>	<p>Review Status: Approved 05/27/2008</p>
<p>Bypassed -Name: Health - Actuarial Justification Bypass Reason: N/A as this filing is for a application Comments:</p>	<p>Review Status: 05/27/2008</p>
<p>Bypassed -Name: Outline of Coverage Bypass Reason: N/A as this filing is for a application Comments:</p>	<p>Review Status: 05/27/2008</p>
<p>Satisfied -Name: Cover letter Comments: Attachment: AR B 9200 PRF AP2008 cvr ltr 5-7-08.pdf</p>	<p>Review Status: Approved 05/27/2008</p>

BANKERS FIDELITY LIFE INSURANCE COMPANY
Atlanta, Georgia

FLESCH SCORE CERTIFICATION

B 9200 PRF AP2008 - Application

Words: 280
Sentences: 18
Syllables: 464
Score: 50.85

B 9200 STND AP2008 - Application

Words: 250
Sentences: 17
Syllables: 404
Score: 55.19

I hereby certify that the Flesch reading ease score of the above forms is as shown.



Sharon A. Busch
Vice President; Legal/Compliance



Date

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, GA 30348-5146

APPLICATION FOR INSURANCE PREFERRED UNDERWRITING CLASS

PLEASE PRINT

Agent/Broker Name <u>Joe Agent</u>	Agent # <u>00001</u>
---------------------------------------	-------------------------

Proposed Insured <u>John D. Doe</u>	Social Security No. <u>0000000001</u>	Sex <u>M</u>	Place (State) of Birth <u>GA</u>	Age <u>68</u>	Born			Height & Weight		
					Mo. <u>01</u>	Day <u>01</u>	Yr. <u>48</u>	Ft. <u>6</u>	In. <u>2</u>	Lbs. <u>180</u>
Residence Address (Street or Route & Box No.) <u>#1 Main St</u>		City <u>City</u>	County <u>County</u>	State <u>ST</u>	Zip Code <u>30000-0000</u>					
Telephone Number <u>(404) 123 4567</u>	Best Time to Call: <u>8:00</u> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	Proposed Insured E-mail Address: <u>john.doe@email.com</u>			Mail Policy To: <input checked="" type="checkbox"/> Insured <input type="checkbox"/> Agent					

PRINT—To whom should premium notices be sent? Same address as Proposed Insured, or:
 Payor name _____ Phone number () _____
 Complete Address: _____

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

MEDICARE SUPPLEMENT PLANS*: A B C D E F High Ded. F G

*Some plans not available in all states. Refer to rate sheet for availability.

Open Enrollment:
 (a) Is the Proposed Insured eligible for coverage under the "Open Enrollment" period (the six month period beginning with the first month in which the Proposed Insured is both age 65 or older and enrolled in Medicare Part B)? Yes No
 (b) Is the Proposed Insured eligible for coverage under the 63-day (90-day in WY only) "guaranty issue" period? If "Yes," proof must be submitted. Yes No

REQUESTED EFFECTIVE DATE: <u>05-01-08</u>	PREMIUM MODE: <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Direct <input type="checkbox"/> Monthly Bank Draft* <input type="checkbox"/> Monthly Credit Card* *Requested Draft Date _____	PREMIUM CLASS: <input checked="" type="checkbox"/> Non-Tobacco* <input type="checkbox"/> Tobacco <small>*Has not used any tobacco product in the last 3 years. Applicants qualified for Open Enrollment will automatically be given Non-tobacco rates.</small>	MODAL PREMIUM COMPUTATION: Total Amount Paid \$ <u>xxx xx</u> <input checked="" type="checkbox"/> Check/money order included. <input type="checkbox"/> Charge credit card for initial premium. <input type="checkbox"/> Draft initial premium* *Initial Draft Date _____
	BILLING TYPE: <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Family* <small>*Complete Family Billing Form B 0129 FB/LB</small>		

INSURANCE INFORMATION

- (a) Medicare claim number 000-00-0001-00 (Record full, complete number from Medicare card.)

(b) Is the Proposed Insured covered under Medicare Part A? Yes No If "Yes," effective date 01-01-2005

(c) Is the Proposed Insured covered under Medicare Part B? Yes No If "Yes," effective date 01-01-2005

(d) Is the Proposed Insured covered under Social Security Disability? Yes No If "Yes," effective date _____
- If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.

(A) Did you turn age 65 in the last 6 months? Yes No

(B) Did you enroll in Medicare Part B in the last 6 months? Yes No

(C) If yes, what is the effective date? _____

(D) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) Yes No

(a) If yes, will Medicaid pay your premiums for this Medicare supplement policy? Yes No

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

(E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start date _____ End Date _____

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No

(b) Was this your first time in this type of Medicare plan? Yes No

(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No

(F) Do you have another Medicare supplement policy in force? Yes No

(a) If so, with what company, and what plan do you have? _____

(b) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

(G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan) Yes No

(a) If so, with what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.
 Start date _____ End Date _____

IF THE ANSWER TO ANY PART OF QUESTION 3 THROUGH 5 IS "YES," COVERAGE IS NOT AVAILABLE. IF ELIGIBLE FOR OPEN ENROLLMENT OR 63-DAY (90 DAY IN WY ONLY) GUARANTY ISSUE, QUESTIONS 3 THROUGH 7 DO NOT HAVE TO BE ANSWERED.

3. In the last 5 years, has the Proposed Insured had or been medically diagnosed with or treated for:
- (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
 - (b) any lipidosis, including Gaucher's or Tay-Sachs or Wolman's? Yes No
4. In the past year, has the Proposed Insured been:
- (a) confined to a hospital 2 or more times or to a nursing facility or to a wheelchair, or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring or toileting? Yes No
 - (b) medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? Yes No
5. In the last 3 years has the Proposed Insured had, been medically diagnosed with or treated for:
- (a) heart attack, stroke of any kind, congestive heart failure or surgery for transplanting any organ or tissue (excluding corneal transplants) or amputation due to disease? Yes No
 - (b) emphysema, chronic obstructive pulmonary disease (COPD), or used supplemental oxygen, inhalers or puffers for any of these conditions? Yes No
 - (c) kidney/renal failure, cirrhosis, liver disease, or hepatitis (excluding Type A)? Yes No
 - (d) internal cancer, leukemia, malignant melanoma or Hodgkin's disease? Yes No
 - (e) Alzheimer's disease, dementia, organic brain syndrome, schizophrenia or psychotic disorder, alcoholism or drug addiction or diabetes requiring insulin? Yes No
 - (f) Parkinson's or Huntington's disease, Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig's disease (ALS), Systemic Lupus or sickle cell anemia? Yes No

6. List all prescription drugs the Proposed Insured is currently taking or has been medically advised to take:

(If "None," so state; if additional space is needed attach separate page and have Proposed Insured sign and date.)

Medication	Amount	Condition for Which Prescribed	Currently Taking?
NONE			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

7. Please provide complete name, address and telephone number of the Proposed Insured's primary care physician:

Physician's name: Dr. Bob Physician Telephone number 404-234-5678
 Physician's address: #1 Physician Ct City ST 30000

8. NOTICE TO THE PROPOSED INSURED: (a) You do not need more than one Medicare supplement policy. (b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (d) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

9. I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein. I have received an outline of coverage and a "Guide To Health Insurance For People With Medicare."

The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" and/or "Time Limit On Certain Defenses" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy.

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Dated at, on City ST (City and State) 05-01-08 X (Month, Day, Year) John Doe Proposed Insured's signature. Please read item 9 before signing.
X Joe Agent Agent's signature 00001 Agent's number

Is any of this insurance being purchased to replace or change any existing insurance? Yes No

Complete Replacement Notice(s) as required.

I have sold the following Medicare supplement policies to the Proposed Insured which are still in force: NONE

I have sold the following Medicare supplement policies to the Proposed Insured within the past 5 years which are no longer in force:

NONE

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare."

I certify that to the best of my knowledge and belief the Medicare Supplement coverage applied for herein does not duplicate coverage the Proposed Insured currently has in force.

Is the Proposed Insured related to you? Yes No If "Yes," explain relationship: Self _____

If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identity as required by the USA Patriot Act (PL 107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:

Drivers License Passport Government-issued identification card Other _____

Dated at City ST , on 05-01-08 X Joe Agent Agent's signature 00001 Agent's number
X _____ Co-signature (if required)

WRITING AGENT COMPLETE

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, GA 30348-5146

APPLICATION FOR INSURANCE STANDARD UNDERWRITING CLASS

PLEASE PRINT

Agent/Broker Name <u>Joe Agent</u>	Agent # <u>00001</u>
---------------------------------------	-------------------------

Proposed Insured <u>John D. Doe</u>		Social Security No. <u>000 000001</u>		Sex <u>M</u>	Place (State) of Birth <u>GA</u>	Age <u>68</u>	Born Mo. <u>01</u> Day <u>01</u> Yr. <u>48</u>			Height & Weight Ft. <u>6</u> In. <u>2</u> Lbs. <u>180</u>		
Residence Address (Street or Route & Box No.) <u>#1 Main St</u>				City <u>City</u>	County <u>Count</u>	State <u>ST</u>	Zip Code <u>30000-0000</u>					
Telephone Number <u>(404) 123 4567</u>	Best Time to Call: <u>8</u> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		Proposed Insured E-mail Address: <u>johnddoe@email.com</u>				Mail Policy To: <input checked="" type="checkbox"/> Insured <input type="checkbox"/> Agent					

PRINT—To whom should premium notices be sent? Same address as Proposed Insured, or:

Payor name _____ Phone number () _____
Complete Address: _____

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

MEDICARE SUPPLEMENT PLANS*: A B C D E F High Ded. F G
*Some plans not available in all states. Refer to rate sheet for availability.

Open Enrollment:

- (a) Is the Proposed Insured eligible for coverage under the "Open Enrollment" period (the six month period beginning with the first month in which the Proposed Insured is both age 65 or older and enrolled in Medicare Part B)? Yes No
- (b) Is the Proposed Insured eligible for coverage under the 63-day (90-day in WY only) "guaranty issue" period? If "Yes," proof must be submitted. Yes No

REQUESTED EFFECTIVE DATE: <u>05-01-08</u>	PREMIUM MODE: <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Direct <input type="checkbox"/> Monthly Bank Draft* <input type="checkbox"/> Monthly Credit Card* *Requested Draft Date _____	BILLING TYPE: <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Family* *Complete Family Billing Form B 0129 FB/LB	MODAL PREMIUM COMPUTATION: Total Amount Paid\$ <u>444.22</u> <input checked="" type="checkbox"/> Check/money order included. <input type="checkbox"/> Charge credit card for initial premium. <input type="checkbox"/> Draft initial premium* *Initial Draft Date _____
--	--	--	--

INSURANCE INFORMATION

1. (a) Medicare claim number 000-00-0001-00 (Record full, complete number from Medicare card.)
- (b) Is the Proposed Insured covered under Medicare Part A? Yes No If "Yes," effective date 01-01-05
- (c) Is the Proposed Insured covered under Medicare Part B? Yes No If "Yes," effective date 01-01-05
- (d) Is the Proposed Insured covered under Social Security Disability? Yes No If "Yes," effective date _____
2. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.
- (A) Did you turn age 65 in the last 6 months? Yes No
- (B) Did you enroll in Medicare Part B in the last 6 months? Yes No
- (C) If yes, what is the effective date? _____
- (D) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) Yes No
- (a) If yes, will Medicaid pay your premiums for this Medicare supplement policy? Yes No
- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No
- (E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start date _____ End Date _____
- (a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No
- (b) Was this your first time in this type of Medicare plan? Yes No
- (c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No
- (F) Do you have another Medicare supplement policy in force? Yes No
- (a) If so, with what company, and what plan do you have? _____
- (b) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No
- (G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan) Yes No
- (a) If so, with what company and what kind of policy? _____
- (b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.
Start date _____ End Date _____

IF THE ANSWER TO ANY PART OF QUESTION 3 THROUGH 5 IS "YES," COVERAGE IS NOT AVAILABLE. IF ELIGIBLE FOR OPEN ENROLLMENT OR 63-DAY (90 DAY IN WY ONLY) GUARANTY ISSUE, QUESTIONS 3 THROUGH 5 DO NOT HAVE TO BE ANSWERED.

3. In the last 5 years, has the Proposed Insured had or been medically diagnosed with or treated for:
- (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
 - (b) any lipidosis, including Gaucher's or Tay-Sachs or Wolman's? Yes No
4. In the past year, has the Proposed Insured been:
- (a) confined to a hospital 3 or more times or to a nursing facility or to a wheelchair or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring or toileting? Yes No
 - (b) medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? Yes No
5. In the last 2 years has the Proposed Insured had, been medically diagnosed with or treated for:
- (a) heart attack, stroke (excluding transient ischemic attack (TIA) or mini stroke), congestive heart failure or surgery for transplanting any organ or tissue (excluding corneal transplants) or amputation due to disease? Yes No
 - (b) emphysema, chronic obstructive pulmonary disease (COPD), or used supplemental oxygen, inhalers or puffers for any of these conditions? Yes No
 - (c) kidney/renal failure, cirrhosis, liver disease, or hepatitis (excluding Type A)? Yes No
 - (d) internal cancer, leukemia, malignant melanoma or Hodgkin's disease? Yes No
 - (e) Alzheimer's disease, dementia, organic brain syndrome, schizophrenia or psychotic disorder, alcoholism or drug addiction or diabetes requiring insulin? Yes No
 - (f) Parkinson's or Huntington's disease, Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig's disease (ALS), Systemic Lupus or sickle cell anemia? Yes No
 - (g) diabetic coma, insulin shock or taking 70 or more units of insulin daily? Yes No

6. NOTICE TO THE PROPOSED INSURED: (a) You do not need more than one Medicare supplement policy. (b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (d) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(Application continued)

7. I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein. I have received an outline of coverage and a "Guide To Health Insurance For People With Medicare."

The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" and/or "Time Limit On Certain Defenses" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy.

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Dated at, on City ST (City and State) 05-01-08 (Month, Day, Year) John Doe Proposed Insured's signature. Please read item 7 before signing.
X Joe Agent Agent's signature 00001 Agent's number

Is any of this insurance being purchased to replace or change any existing insurance? Yes No
Complete Replacement Notice(s) as required.

I have sold the following Medicare supplement policies to the Proposed Insured which are still in force: NONE

I have sold the following Medicare supplement policies to the Proposed Insured within the past 5 years which are no longer in force:
NONE

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare."

I certify that to the best of my knowledge and belief the Medicare Supplement coverage applied for herein does not duplicate coverage the Proposed Insured currently has in force.

Is the Proposed Insured related to you? Yes No If "Yes," explain relationship: Self _____
If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identity as required by the USA Patriot Act (PL 107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:

Drivers License Passport Government-issued identification card Other _____

Dated at City ST City and State, on 05-01-08 Month, Day, Year X Joe Agent Agent's signature 00001 Agent's number
X _____ Co-signature (if required)

WRITING AGENT COMPLETE



May 07, 2008

Mr. Joe Musgrove
Department of Insurance
1200 W Third Street
Little Rock, AR 72201-1904

RE: Bankers Fidelity Life Insurance Company NAIC # 587-61239 FEIN # 58-0658963
New Forms: B 9200 PRF AP2008 - Application for Medicare Supplement Insurance - Preferred
B 9200 STND AP2008 - Application for Medicare Supplement Insurance - Standard

Dear Mr. Musgrove:

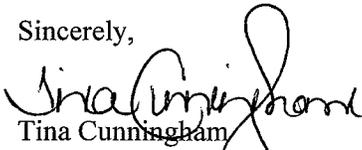
The enclosed forms are being submitted to your department for formal review and approval and will replace the following previously approved forms as indicated:

<u>New Form</u>	<u>Replaced Form</u>	<u>Approval Date</u>
B 9200 PRF AP2008	B 9200 PRF AP2006	02-15-2006
B 9200 STND AP2008	B 9200 STND AP2006	02-15-2006

These applications will be used to solicit our Medicare Supplement products, which have been or will have been previously approved by your department; a representative sample of the plans to be offered is shown in the selection area. Solicitation will be performed by personally producing, licensed and contracted agents and brokers.

Thank you for your time in review of this filing. If you have any questions, or need additional information, please contact me at: direct 404-266-5723; toll-free 1-800-241-1439, ext. 5723; fax 404-926-4092 or email tcunningham@atlam.com.

Sincerely,


Tina Cunningham
Compliance Analyst I
Legal/Compliance