

SERFF Tracking Number: RNIC-125618714 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number: 38772
Company Tracking Number:
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
Product Name: MCO-HO-1 AR
Project Name/Number: Application for Medicare Supplement Policy/

Filing at a Glance

Company: Reserve National Insurance Company

Product Name: MCO-HO-1 AR SERFF Tr Num: RNIC-125618714 State: ArkansasLH
TOI: MS06 Medicare Supplement - Other SERFF Status: Closed State Tr Num: 38772
Sub-TOI: MS06.000 Medicare Supplement - Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Stephanie Fowler
Authors: Kyle Conrad, Brenda Ingram Disposition Date: 05/19/2008
Date Submitted: 04/22/2008 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Application for Medicare Supplement Policy
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 05/19/2008
State Status Changed: 05/19/2008
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 04/04/2008
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:

Deemer Date:

Filing Description:

Ms. Rosalind D. Minor
Certified Rate and Form Analyst
Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

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RE: Reserve National Insurance Company – NAIC #68462
Form MCO-HO-1 AR – Application for Medicare Supplement Policy
Form RP-MCS-HO – Notice to Applicant Regarding Replacement

Dear Mr. Wilder:

Enclosed are copies of the above-referenced forms, which we request you consider for approval. This is a new filing not previously submitted.

Form MCO-HO-1 AR will be used as the application when an existing Reserve National insured contacts our home office and requests a Reserve National Medicare supplement policy. Form MCO-HO-1 AR will be used only upon the insured's direct request to our home office and without the involvement of an agent. Form MCO-HO-1 AR will not be used as the application taken by an agent for a Medicare supplement policy.

Since this application will not be used by an agent, Form MCO-HO-1 AR does not include: "Agents shall list any other health insurance policies they have sold to the applicant; (1) List policies sold which are still in force; and (2) List policies sold in the past five (5) years which are no longer in force." If these provisions are required to be included in Form MCO-HO-1 AR, please let us know.

In some cases, the existing Reserve National insured may want to "convert" his or her current Reserve National policy (either a Medicare supplement policy or other accident/health policy) to a new Reserve National Medicare supplement policy.

In all situations where Form MCO-HO-1 AR is used, the Medicare supplement policy will cover pre-existing conditions immediately with no waiting period.

Form RP-MCS-HO will be used when an existing Reserve National insured is changing from one Reserve National Medicare supplement policy to a new Reserve National Medicare supplement policy.

Thank you for your consideration. If there are any questions, you may contact me by telephone at (800) 874-1431, by fax at (405) 840-3426 or by e-mail at kconrad@unitrin.com.

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Sincerely,

Kyle D. Conrad
 Vice President and
 Associate Corporate Counsel
 KDC:bdi

Company and Contact

Filing Contact Information

Kyle Conrad, Vice President & Associate Corporate Counsel
 kconrad@unitrin.com
 6100 N. W. Grand Blvd (800) 874-1431 [Phone]
 Oklahoma City, OK 73118

Filing Company Information

Reserve National Insurance Company CoCode: 68462 State of Domicile: Oklahoma
 6100 N.W. Grand Boulevard Group Code: 215 Company Type: Life and Health
 Oklahoma City, OK 73118 Group Name: Reserve National State ID Number:
 (405) 848-7931 ext. 549[Phone] FEIN Number: 73-0661453

Filing Fees

Fee Required? Yes
 Fee Amount: \$25.00
 Retaliatory? Yes
 Fee Explanation: \$25.00 per form filing
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	\$25.00	04/22/2008	19813900

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	05/19/2008	05/19/2008

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Disposition

Disposition Date: 05/19/2008

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		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Application for Medicare Supplement Policy	Approved	Yes
Form	Notice to Applicant Regarding Replacement of Medicare Supplement Insurance	Approved	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved	MCO-HO-1 AR	Application/ Enrollment Form Supplement Policy	Initial			MCO-HO-1 AR.pdf
Approved	RP-MCS-HO	Policy/Cont ract/Fratern al Replacement of Certificate: Medicare Amendmen t, Insert Insurance Page, Endorseme nt or Rider	Initial			RP-MCS-HO.pdf



<i>FOR HOME OFFICE USE ONLY</i>					
POLICY NUMBER(S):		EFFECTIVE DATE			
		<table border="1"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> </tr> </table>	Month	Day	Year
Month	Day	Year			

APPLICATION FOR MEDICARE SUPPLEMENT POLICY

Name: _____

I hereby apply for Reserve National's Medicare Supplement Policy Form MCS _____ (Enter standardized plan selected.)

Will the new Medicare Supplement Policy replace existing Medicare Supplement coverage? Yes No

I request the following changes to my other Reserve National policies in connection with the issuance of the new Medicare supplement policy [list policy number(s) and requested change(s), including requested effective date of change(s)]. _____

My smoking status is (check one):

Smoker (Used tobacco within the past year.) Non-smoker

A. Statements:

- (1) You do not need more than one Medicare supplement policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (4) 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 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 suspension.
- (5) 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 circumstance, 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 ninety (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.
- (6) 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).

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.

D. To the best of your knowledge:

- (1) (a) Did you turn 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 so, what is the effective date? _____
- (2) Are you covered for medical assistance through the state Medicaid program? Yes No
 [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.] If YES:
 - (a) 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
- (3) (a) 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 ___/___/___ END ___/___/___
 - (b) 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
 - (c) Was this your first time in this type of Medicare plan? Yes No
 - (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No
- (4) (a) Do you have another Medicare supplement policy in force? Yes No
 - (b) If so, with what company, and what plan do you have? _____
 - (c) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No
- (5) 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?..... START ___/___/___ END ___/___/___
 (If you are still covered under the other policy, leave "END" blank.)

REQUESTED EFFECTIVE DATE OF NEW MEDICARE SUPPLEMENT POLICY: _____

If the new Reserve National Medicare Supplement Policy will replace a current Reserve National policy, coverage under the current policy will be terminated the day before the effective date of the new Medicare supplement policy and any premium paid for your coverage under your current Reserve National policy beyond the date of termination will be (check one if applicable):

Refunded **Applied to the new Medicare Supplement Policy**

Premium mode selected (check one):

Monthly Quarterly Semi-Annual Annual

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED ON THIS FORM ARE TRUE AND CORRECT AND THAT (check one): I am currently covered by Medicare Parts A and B or I will be covered by Medicare Parts A and B upon my eligibility thereunder. I understand that (1) this application will be attached to and made a part of the new Medicare supplement policy and (2) the new Medicare supplement policy will cover all existing health conditions with no waiting periods.

I acknowledge receipt of an outline of coverage for the Medicare supplement policy and a "Guide to Health Insurance for People with Medicare."

NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. 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.

Date

Signature of Applicant/Current Reserve National Policyholder



**NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!**

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Reserve National Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER:

We have reviewed your current medical or health insurance coverage. To the best of our knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
 - No change in benefits, but lower premiums.
 - Fewer benefits and lower premiums.
 - My plan has outpatient prescription drug coverage and I am enrolling in Part D.
 - Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
-
- Other. (please specify) _____
-

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Date)

(Applicant's Signature)

Reserve National Insurance Company Home Office:
6100 Northwest Grand Blvd.
Oklahoma City, Oklahoma 73118-1082

(Applicant's Name Printed)

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Supporting Document Schedules

Review Status:
Bypassed -Name: Certification/Notice 05/19/2008
Bypass Reason: Not Applicable
Comments:

Review Status:
Bypassed -Name: Application 05/19/2008
Bypass Reason: Not Applicable.
Comments:

Review Status:
Bypassed -Name: Health - Actuarial Justification 05/19/2008
Bypass Reason: Not Applicable
Comments:

Review Status:
Bypassed -Name: Outline of Coverage 05/19/2008
Bypass Reason: Not Applicable
Comments: