

SERFF Tracking Number: RNIC-125646329 State: Arkansas  
Filing Company: Reserve National Insurance Company State Tracking Number: 38990  
Company Tracking Number:  
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
Product Name: MCO-AGT (5/08) AR  
Project Name/Number: Application for Medicare Supplement Policy/

## Filing at a Glance

Company: Reserve National Insurance Company

Product Name: MCO-AGT (5/08) AR

TOI: MS06 Medicare Supplement - Other

Sub-TOI: MS06.000 Medicare Supplement -  
Other

Filing Type: Form

SERFF Tr Num: RNIC-125646329

SERFF Status: Closed

Co Tr Num:

Co Status:

Authors: Kyle Conrad, Brenda  
Ingram

Date Submitted: 05/14/2008

State: ArkansasLH

State Tr Num: 38990

State Status: Approved-Closed

Reviewer(s): Stephanie Fowler

Disposition Date: 05/29/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

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: 05/29/2008

State Status Changed: 05/29/2008

Corresponding Filing Tracking Number:

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

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 05/05/2008

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

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RE: Reserve National Insurance Company – NAIC #68462  
Form MCO-AGT (5/08) AR – Application for Medicare Supplement Policy

Dear Ms. Minor:

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

Form MCO-AGT (5/08) AR will be used as the application when an existing Reserve National insured wishes to apply for a Reserve National Medicare supplement policy.

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-AGT (5/08) AR is used, the Medicare supplement policy will cover pre-existing conditions immediately with no waiting period.

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](mailto:kconrad@unitrin.com).

Sincerely,

Kyle D. Conrad  
Senior Vice President  
and Associate Corporate Counsel

KDC:bdi

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## Company and Contact

### Filing Contact Information

Kyle Conrad, Vice President & Associate kconrad@unitrin.com  
 Corporate Counsel  
 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  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$25.00  
 Retaliatory? Yes  
 Fee Explanation: 1 Form = \$25.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	\$25.00	05/14/2008	20317212

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	05/29/2008	05/29/2008

*SERFF Tracking Number:*      *RNIC-125646329*                      *State:*                      *Arkansas*  
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## **Disposition**

Disposition Date: 05/29/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved	Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Health - Actuarial Justification		Yes
<b>Supporting Document</b>	Outline of Coverage		Yes
<b>Form</b>	Application for Medicare Supplement Policy	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-AGT (5/08) AR	Application/ Enrollment Form	Application for Medicare Supplement Policy	Initial		68	MCO-AGT (5.08) AR.pdf



<b>FOR HOME OFFICE USE ONLY</b>					
POLICY NUMBER(S):		<b>EFFECTIVE DATE</b>			
		<table border="1"> <tr> <td style="width: 33%;">Month</td> <td style="width: 33%;">Day</td> <td style="width: 33%;">Year</td> </tr> </table>	Month	Day	Year
Month	Day	Year			

## APPLICATION FOR MEDICARE SUPPLEMENT POLICY

Name: \_\_\_\_\_ Medicare HIC Number \_\_\_\_\_

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.**

**B. 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.)

C. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

\_\_\_\_\_  
 (2) List policies sold in the past five (5) years which are no longer in force.

**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

I CERTIFY THAT I ASKED EACH QUESTION OF THE APPLICANT PERSONALLY AND THE ANSWERS HAVE BEEN ACCURATELY RECORDED HEREON.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Agent

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## **Rate Information**

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## Supporting Document Schedules

<b>Bypassed -Name:</b> Certification/Notice	<b>Review Status:</b> Approved	05/29/2008
<b>Bypass Reason:</b> Not Applicable.		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Application	<b>Review Status:</b>	05/14/2008
<b>Bypass Reason:</b> Not Applicable.		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Health - Actuarial Justification	<b>Review Status:</b>	05/14/2008
<b>Bypass Reason:</b> Not Applicable.		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Outline of Coverage	<b>Review Status:</b>	05/14/2008
<b>Bypass Reason:</b> Not Applicable.		
<b>Comments:</b>		