

SERFF Tracking Number: ETPF-126388436 State: Arkansas
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 44133
 Company Tracking Number: HNL-RA-2009
 TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
 Product Name: Medicare Supplement
 Project Name/Number: HNL-RA-2009/HNL-RA-2009

Filing at a Glance

Company: Heartland National Life Insurance Company

Product Name: Medicare Supplement SERFF Tr Num: ETPF-126388436 State: Arkansas
 TOI: MS06 Medicare Supplement - Other SERFF Status: Closed-Approved- State Tr Num: 44133
 Closed

Sub-TOI: MS06.000 Medicare Supplement - Other Co Tr Num: HNL-RA-2009 State Status: Approved-Closed
 Other

Filing Type: Form Reviewer(s): Stephanie Fowler
 Disposition Date: 12/17/2009

Authors: Mark Banks, Jana Peterson, Kathy Foster

Date Submitted: 11/19/2009

Disposition Status: Approved-Closed

Implementation Date Requested: 12/15/2009

Implementation Date:

State Filing Description:

General Information

Project Name: HNL-RA-2009

Status of Filing in Domicile: Pending

Project Number: HNL-RA-2009

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 12/17/2009

Explanation for Other Group Market Type:

State Status Changed: 12/17/2009

Deemer Date:

Created By: Jana Peterson

Submitted By: Jana Peterson

Corresponding Filing Tracking Number:

Filing Description:

Submitted for your review is Heartland National Life Insurance Company's form for Reinstatement of Insurance. This is a new form, and does not replace any form previously filed with the Arkansas Insurance Department ("Department"). This form will be used with all products approved for use by Heartland in your state, and will be sent to the applicant upon request when a policy has lapsed.

We look forward to hearing from you soon.

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Company and Contact

Filing Contact Information

Jana Peterson, Senior Compliance Specialist Jana.Peterson@Equilife.com
 3 Triad Center Suite 200 877-579-3782 [Phone]
 Salt Lake City, UT 84180 801-579-3471 [FAX]

Filing Company Information

(This filing was made by a third party - equitablelifecasualtytpf)

Heartland National Life Insurance Company	CoCode: 66214	State of Domicile: Indiana
P O Box 2878	Group Code:	Company Type: Life & Health
Salt Lake City, UK 84110	Group Name:	State ID Number:
(866) 916-7971 ext. [Phone]	FEIN Number: 64-0431935	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Heartland National Life Insurance Company	\$20.00	11/19/2009	32160114

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	12/17/2009	12/17/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Application	Jana Peterson	11/19/2009	11/19/2009

SERFF Tracking Number: *ETPF-126388436* *State:* *Arkansas*
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Product Name: *Medicare Supplement*
Project Name/Number: *HNL-RA-2009/HNL-RA-2009*

Disposition

Disposition Date: 12/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document (revised)	Application	Approved	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Third Party Authorization	Accepted for Informational Purposes	Yes

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Amendment Letter

Submitted Date: 11/19/2009

Comments:

My humble apologies - I inadvertently attached the wrong application to this filing. Please consider this new one for approval.

Thank you.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Application

Comment:

generic HNL-Reinstatement app.pdf

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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification Bypass Reason: Not required Comments:		
Satisfied - Item: Application Comments: Attachment: generic HNL-Reinstatement app.pdf	Approved	12/17/2009
Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not being submitted Comments:		
Bypassed - Item: Outline of Coverage Bypass Reason: Not being submitted Comments:		
Satisfied - Item: Third Party Authorization Comments: Attachment: Authorization, November 2009.pdf	Accepted for Informational Purposes	12/17/2009

APPLICATION FOR REINSTATEMENT

Insured's Name (Last, First, MI): _____

Address: _____ Telephone: (____) _____

City, State, Zip: _____

Policy No. _____ Premium Submitted \$ _____

*Please answer all questions. If any answer is "Yes" **circle** the condition and give details in the space below.* **Yes No**

1. Do you need assistance with activities of daily living such as transferring, bathing, toileting, eating dressing or continence?
2. In the past 5 years, have you received medical treatment, had surgery or taken medication for any of the following medical conditions:
 - a. Parkinson's disease, myasthenia gravis, multiple or amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer's disease, dementia or memory loss?
 - b. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?
 - c. Insulin dependent diabetes, uncontrolled diabetes or diabetes with complications such as eye disease, neuropathy or kidney problems?
 - d. Emphysema or COPD, or other chronic pulmonary condition requiring oxygen use?
 - e. Internal cancer, leukemia, lymphoma or malignant melanoma?
 - f. Osteoporosis with related fractures or kidney failure?
3. In the past two years, have you:
 - a. Required the use of a wheelchair, been hospitalized, been confined to a nursing facility or received home health care?
 - b. Had or been treated for heart surgery, congestive heart failure, heart attack, peripheral vascular disease, arrhythmia, stroke or transient ischemic attack?
 - c. Had or been treated for cirrhosis of the liver, chronic hepatitis, alcohol or drug abuse?
 - d. Had or been treated for amputation due to disease, mental or nervous disorder requiring psychiatric care or disabling, crippling or rheumatoid arthritis?

Question #	Condition	Treatment or Medication	Name / Address Of Physician

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete. I certify that I have read or had read to me the completed application and I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

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

Signed at (City, ST) _____ Date _____

Insured's Signature: _____

To complete the Application for Reinstatement, please sign, date and return the attached Health Information Authorization.

HNL-RA-2009

Home Office Use Only		
Reinstated <input type="checkbox"/>	Declined <input type="checkbox"/>	Date: _____

HEARTLAND NATIONAL

P.O. Box 2878, Salt Lake City
Utah 84110-2878



Life Insurance Company

November 1, 2009

RE: Form Filing Authorization

This letter will serve as authorization from Heartland National Life Insurance Company ("Heartland") for Equitable Life & Casualty Insurance Company to file all rates, policies and related forms on Heartland's behalf, and to respond to all inquiries regarding such filings with all state insurance departments and jurisdictions.

This authorization shall be valid until revoked by Heartland.

Sincerely,

Christopher M. McDaniel
President, Chief Executive Officer & Chairman of the Board
Heartland National Life Insurance Company

cc: Robert E. Anderson, Chief Operating Officer, Equitable Life & Casualty Insurance Company
Kendall R. Surfass, Vice President, Secretary and General Counsel, Equitable Life & Casualty Insurance Company

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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/18/2009		Supporting Application Document	11/19/2009	HNL-RA-2009.pdf (Superseded)

APPLICATION FOR REINSTATEMENT

Insured's Name (Last, First, MI): _____

Address: _____ Telephone: (____) _____

City, State, Zip: _____

Policy No. _____ Premium Submitted \$ _____

*Please answer all questions. If any answer is "Yes" **circle** the condition and give details in the space below.* **Yes No**

1. Do you need assistance with activities of daily living such as transferring, bathing, toileting, eating dressing or continence?
2. In the past 5 years, have you received medical treatment, had surgery or taken medication for any of the following medical conditions:
 - a. Parkinson's disease, myasthenia gravis, multiple or amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer's disease, dementia or memory loss?
 - b. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?
 - c. Insulin dependent diabetes, uncontrolled diabetes or diabetes with complications such as eye disease, neuropathy or kidney problems?
 - d. Emphysema or COPD, or other chronic pulmonary condition requiring oxygen use?
 - e. Internal cancer, leukemia, lymphoma or malignant melanoma?
 - f. Osteoporosis with related fractures or kidney failure?
3. In the past two years, have you:
 - a. Required the use of a wheelchair, been hospitalized, been confined to a nursing facility or received home health care?
 - b. Had or been treated for heart surgery, congestive heart failure, heart attack, peripheral vascular disease, arrhythmia, stroke or transient ischemic attack?
 - c. Had or been treated for cirrhosis of the liver, chronic hepatitis, alcohol or drug abuse?
 - d. Had or been treated for amputation due to disease, mental or nervous disorder requiring psychiatric care or disabling, crippling or rheumatoid arthritis?

Question #	Condition	Treatment or Medication	Name / Address Of Physician

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete. I certify that I have read or had read to me the completed application and I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

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

Signed at (City, ST) _____ Date _____

Insured's Signature: _____

To complete the Application for Reinstatement, please sign, date and return the attached Health Information Authorization.

HNL-RA-2009 CO

Home Office Use Only		
Reinstated <input type="checkbox"/>	Declined <input type="checkbox"/>	Date: _____