

SERFF Tracking Number: SKML-126058735 State: Arkansas
 Filing Company: Marquette National Life Insurance Company State Tracking Number: 41755
 Company Tracking Number: MNLIC EAPP
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
 Standard Plans
 Product Name: MNLIC Medicare Supplement
 Project Name/Number: Med Supp E App/MN-MSUPP-EAPP-4/09

Filing at a Glance

Company: Marquette National Life Insurance Company

Product Name: MNLIC Medicare Supplement SERFF Tr Num: SKML-126058735 State: ArkansasLH

TOI: MS051 Individual Medicare Supplement - SERFF Status: Closed State Tr Num: 41755

Standard Plans

Sub-TOI: MS051.001 Plan A

Co Tr Num: MNLIC EAPP

State Status: Filed-Closed

Filing Type: Form

Co Status:

Reviewer(s): Stephanie Fowler

Authors: Alvah Shelton, Pamela Kelly

Disposition Date: 03/12/2009

Date Submitted: 03/10/2009

Disposition Status: Filed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Med Supp E App

Status of Filing in Domicile: Pending

Project Number: MN-MSUPP-EAPP-4/09

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: All States Filed Concurrently

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/12/2009

Explanation for Other Group Market Type:

State Status Changed: 03/12/2009

Deemer Date:

Corresponding Filing Tracking Number: MNLIC EAPP

Filing Description:

Form No. MN-MSUPP-EAPP-4/09 AR Medicare Supplement Application

Form No. MN-GI-EAPP-4/09 AR Guarantee Issue Application

The enclosed forms are being submitted on behalf of Marquette National Life Insurance Company. These applications

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are new forms and will not replace any forms on file with your department.

These applications will be used with Marquette National Life Insurance Company's Medicare Supplement Policies as listed below:

MMSI-06 Plan A AR Approved 12/9/06
MMSI-06 Plan D AR Approved 12/9/06
MMSI-06 Plan F AR Approved 12/9/06
MMSI-06 Plan G AR Approved 12/9/06
MMSI-06 Plan J AR Approved 12/9/06

These applications are virtually similar to the following application forms, which were also approved for use with this Medicare Supplement Policy:

Application Form MN-SUP-APP (1/06) AR Approved 12/9/06
Application Form MN-GI 1/06 AR Approved 12/9/06

The only difference between the approved applications and the presently submitted applications is the form number and a few formatting changes. For example we have changed from using check boxes to using radio dots and removing the "X" which denoted the signature line. The new applications have been altered for electronic use. Therefore, the applicant will apply for coverage under this Medicare Supplement Program via electronic application.

The Company reserves the right to alter the pagination, layout, type and font of the printed application as it may change according to the web program utilized to view and complete the form. Therefore, for filing purposes, the submitted forms are in landscape format, but will actually print in portrait format when computer-generated.

Company and Contact

Filing Contact Information

(This filing was made by a third party - sandrakmeltzerandassociates)
Alvah Shelton, Policy Analyst alvah@skminc.com

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1925 Century Blvd (404) 633-5353 [Phone]
Atlanta, GA 30345 (404) 633-6301[FAX]

Filing Company Information

Marquette National Life Insurance Company CoCode: 71072 State of Domicile: Texas
1001 Heathrow Park Lane Group Code: 953 Company Type: Life & Health
Lake Mary, FL 32746 Group Name: State ID Number:
(407) 995-8000 ext. 8350[Phone] FEIN Number: 36-2641398

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Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: The retaliatory fee is \$100 as the state of domicile is Texas. The filing fee of \$100 is submitted concurrently with this submission via EFT.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Marquette National Life Insurance Company	\$100.00	03/10/2009	26279322

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	03/12/2009	03/12/2009

SERFF Tracking Number: SKML-126058735 *State:* Arkansas
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Disposition

Disposition Date: 03/12/2009

Implementation Date:

Status: Filed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Authorization Letter	Accepted for Informational Purposes	Yes
Form	Application For Medicare Supplement Insurance	Filed	Yes
Form	Medicare Supplement Guaranteed Issue Determination Application	Filed	Yes

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Form Schedule

Lead Form Number: MN-MSUPP-EAPP-4/09 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed	MN-MSUPP-EAPP-4/09 AR	Application/ Enrollment Form	Application For Medicare Supplement Insurance	Initial		42	MQ AR MS App - Landscape.pdf
Filed	MN-EAPP-GI-4/09 AR	Application/ Enrollment Form	Application/ Medicare Supplement Guaranteed Issue Determination Application	Initial		50	MQ AR MS GI App - Landscape.pdf

MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas **Administrative Office:** P. O. Box 13547, Pensacola, Florida 32591-3547 **Phone:** (800) 934-8203

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

PART I: APPLICANT INFORMATION

Proposed Insured	Spouse
Name: <input style="width: 90%;" type="text"/>	Name: <input style="width: 90%;" type="text"/>
Address: <input style="width: 90%;" type="text"/>	Address: <input style="width: 90%;" type="text"/>
City: <input style="width: 15%;" type="text"/> State: <input style="width: 15%;" type="text"/> Zip: <input style="width: 20%;" type="text"/>	City: <input style="width: 15%;" type="text"/> State: <input style="width: 15%;" type="text"/> Zip: <input style="width: 20%;" type="text"/>
Phone#: <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> Best time to call: <input style="width: 10%;" type="text"/> : <input style="width: 10%;" type="text"/> AM <input style="width: 10%;" type="text"/>	Phone#: <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> Best time to call: <input style="width: 10%;" type="text"/> : <input style="width: 10%;" type="text"/> AM <input style="width: 10%;" type="text"/>
Social Security #: <input style="width: 10%;" type="text"/> - <input style="width: 10%;" type="text"/> - <input style="width: 10%;" type="text"/> DOB: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>	Social Security #: <input style="width: 10%;" type="text"/> - <input style="width: 10%;" type="text"/> - <input style="width: 10%;" type="text"/> DOB: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>
Medicare #: <input style="width: 20%;" type="text"/>	Medicare #: <input style="width: 20%;" type="text"/>
Height: <input style="width: 10%;" type="text"/> Weight: <input style="width: 10%;" type="text"/> Sex: <input style="width: 10%;" type="text"/> Age: <input style="width: 10%;" type="text"/>	Height: <input style="width: 10%;" type="text"/> Weight: <input style="width: 10%;" type="text"/> Sex: <input style="width: 10%;" type="text"/> Age: <input style="width: 10%;" type="text"/>
Have you used tobacco within the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you used tobacco within the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO
Name & Address of family doctor: <div style="border: 1px solid gray; height: 100px; width: 150px; margin-left: 10px;"></div>	Name & Address of family doctor: <div style="border: 1px solid gray; height: 100px; width: 150px; margin-left: 10px;"></div>

Beneficiary: <input type="text"/>	Beneficiary: <input type="text"/>
Relationship: <input type="text"/>	Relationship: <input type="text"/>
Proposed Effective Date: <input type="text"/> / <input type="text"/> / <input type="text"/>	Proposed Effective Date: <input type="text"/> / <input type="text"/> / <input type="text"/>

PART II: COVERAGE APPLIED FOR

MEDICARE SUPPLEMENT PLAN		MEDICARE SELECT PLAN	
PROPOSED INSURED	SPOUSE	PROPOSED INSURED	SPOUSE
Plan <input type="text"/> Premium <input type="text"/>			
Class <input type="text"/>	Class <input type="text"/>	Class <input type="text"/>	Class <input type="text"/>

PART III: MEDICAL & GENERAL (A telephone interview with the applicant(s) may be conducted to verify application)

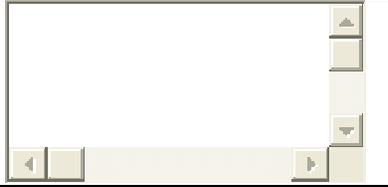
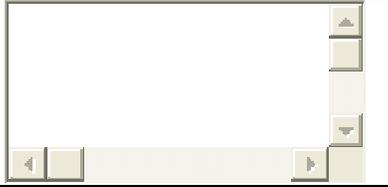
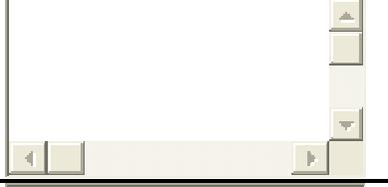
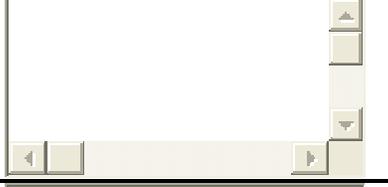
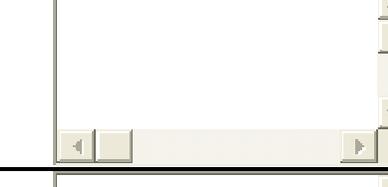
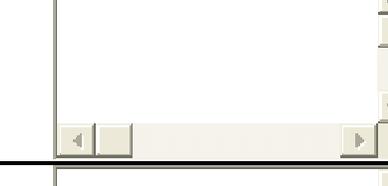
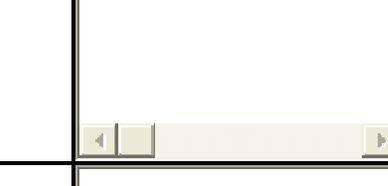
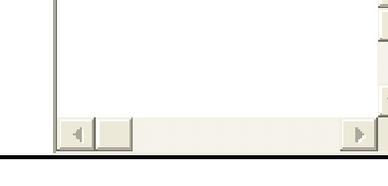
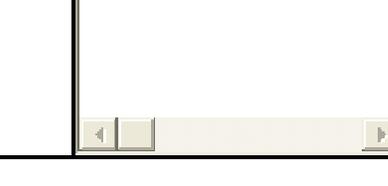
Basic Questions (Answer for both Insureds)		
If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be 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.		
To the best of your knowledge:	Proposed Insured	Spouse
1. Did you turn age 65 in the last 6 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. Did you enroll in Medicare Part B in the last 6 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. If yes, what is the effective date? Insured <input type="text"/> / <input type="text"/> / <input type="text"/> Spouse <input type="text"/> / <input type="text"/> / <input type="text"/>		
2. Are you covered for medical assistance through the state Medicaid program? (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,	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

a. Will Medicaid pay your premiums for this Medicare supplement policy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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. Insured: START <input type="text"/> / <input type="text"/> / <input type="text"/> END <input type="text"/> / <input type="text"/> / <input type="text"/> Spouse: START <input type="text"/> / <input type="text"/> / <input type="text"/> END <input type="text"/> / <input type="text"/> / <input type="text"/>		
b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. Was this your first time in this type of Medicare plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. a. Do you have another Medicare supplement policy in force?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. If so, with what company? Insured: <input type="text"/> Spouse: <input type="text"/> c. What plan do you have? Insured: <input type="text"/> Spouse: <input type="text"/>		
d. If so, do you intend to replace your current Medicare supplement policy with this policy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. If so, with what company?		

Insured: <input type="text"/> Spouse: <input type="text"/> b. What kind of policy? Insured: <input type="text"/> Spouse: <input type="text"/> c. What are your dates of coverage under the other policy? Insured: START <input type="text"/> / <input type="text"/> / <input type="text"/> END <input type="text"/> / <input type="text"/> / <input type="text"/> Spouse: START <input type="text"/> / <input type="text"/> / <input type="text"/> END <input type="text"/> / <input type="text"/> / <input type="text"/> (If you are still covered under the other policy, leave "END" blank.)		
Health Questions (Answer for both Insureds)	Proposed Insured	Spouse
Do not answer questions 1-9 if you are applying for this coverage within 6 months of obtaining Medicare Part B, or under guaranteed issue status.		
IF THE ANSWER TO ANY OF QUESTIONS 2-8 IS "YES" FOR EITHER APPLICANT, THEN THAT APPLICANT IS NOT ELIGIBLE FOR COVERAGE AND HIS OR HER APPLICATION SHOULD NOT BE SUBMITTED.		
1. Have you used tobacco within the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Is any person to be insured currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, received home health care in the past 90 days; or has any such care been medically advised?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Has any person to be insured been diagnosed, treated or been advised by a physician that they have Alzheimer's Disease, Senile Dementia, Organic Brain Disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Muscular Dystrophy or paralysis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Has any person to be insured tested positive for exposure to the HIV infection or been diagnosed and advised by a physician that they have Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Has any person to be insured been diagnosed with Diabetes requiring the use of Insulin, Kidney Disease requiring dialysis, received or is awaiting an organ transplant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Within the past two years has any person to be insured had, been treated for or been advised by a physician to have treatment for:		
a. Congestive Heart Failure, Heart Attack, Angina (chest pain), Coronary Artery Disease, Cardiomyopathy, Stroke (CVA), Transient Ischemic Attack (TIA), Heart Rhythm Disorders requiring pacemaker or defibrillator?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

b. Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. Cancer (except skin cancer), Melanoma, Hodgkin's Disease or Leukemia?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
e. Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
f. Emphysema, Chronic Obstructive Pulmonary or Lung Disease, or use of Oxygen?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Has any person to be insured been hospitalized two or more times within the past 24 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Has any person to be insured been advised to have surgery, medical tests or treatment that has not been performed or have they had medical test(s) for which they have not received the results?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Has any person to be insured taken any prescription medications within the past 12 months? . . If yes provide details (attach a separate sheet if necessary):	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Proposed Insured	Spouse	Medication	Dosage	List Condition & Reason for Medication	How long
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				

undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that he realized 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.

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, The Medical Information Bureau, Pharmaceutical Database, other organization, institution or person, that has any records or knowledge of me, or my health, to give Marquette National Life Insurance Company or its reinsurer(s) any such information. A photographic copy of this authorization shall be as valid as the original. **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.**

I acknowledge receiving: (a) "A Guide to Health Insurance for People With Medicare"; (b) Outline of Coverage; (c) Investigative Consumer Report Notice; and (d) Medical Information Bureau (MIB) Disclosure Notice.

Signed at City: State: Date: / /

Applicant's Signature :
Spouse's Signature if applying for coverage:

PART VI - AGENT CERTIFICATION

The undersigned Agent certifies that the Applicant(s) has read, or had read to him/her, the completed application and that the Applicant(s) realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.
AGENT COMPLETES (attach separate sheet, if necessary.)

TO AGENT: List all Health Insurance Policies sold to the applicant(s) which are still in force.

COMPANY	TYPE

List all Health Insurance Policies sold to the applicant(s) within the past 5 years which are no longer in force.

COMPANY	TYPE	
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I certify: (1) I have accurately recorded the information supplied by the Applicant(s); and (2) I have given an outline of coverage for the policy applied for and a "A Guide to Health Insurance for People With Medicare" to the Applicant(s).

Licensed Agent's Signature	<input type="text"/>	Agent Code	<input type="text"/>	Off. Code	<input type="text"/>	%	<input type="text"/>	Print Agent's Name	<input type="text"/>	Agent's State Identification
Secondary Agent's Signature	<input type="text"/>	Secondary Agent Code	<input type="text"/>	Off. Code	<input type="text"/>	%	<input type="text"/>	Secondary Agent Print Name	<input type="text"/>	Secondary Agent Identification

Send Policy to: Agent Insured

SUPPLEMENT TO APPLICATION MN-MSUPP-EAPP 4/09 AR

PLEASE PRINT

Proposed Insured (if applying for coverage) <input type="text"/> Beneficiary <input type="text"/> Relationship <input type="text"/> Automatic Premium Loan <input type="checkbox"/> YES <input type="checkbox"/> NO	Spouse (if applying for coverage) <input type="text"/> Beneficiary <input type="text"/> Relationship <input type="text"/> Automatic Premium Loan <input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

If you are in open enrollment or eligible for guaranteed issue for a Medicare Supplement/Select policy and are applying for life insurance, you must answer questions 1 through 9 on this application.

Issue ages 65-79 Primary Insured - Face Amount \$2,500 \$5,000 \$7,500 \$10,000 Others *

Spouse -

Face Amount

\$2,500 \$5,000 \$7,500 \$10,000 Others *

* Amount must be between \$2,500 and \$10,000.

Is any insurance applied for intended to replace any life insurance or annuity currently in force?

PROPOSED INSURED

SPOUSE

YES NO

YES NO

If "Yes" complete and attach the appropriate replacement forms (if applicable).

Proposed Insured Company:

Proposed Insured Policy Number:

Spouse Company:

Spouse Policy Number:

I hereby apply for life insurance as shown above based on my attached application. The answers are, to the best of my knowledge and belief, true. I agree any policy shall not be effective until it has actually been issued.

Date: / / Signature of Proposed Insured: (if applying for coverage)

Date: / / Signature of Spouse: (if applying for coverage)

PREMIUM MODE:

DIRECT

CREDIT CARD

Annual

Annual

Semi Annual

Semi Annual

Quarterly

Quarterly

Monthly PAC

Monthly

PREMIUM

Insured

Spouse

Medicare Supplement

\$ \$

Life Insurance

\$ \$

TOTAL AMOUNT COLLECTED

\$ \$

MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas **Administrative Office:** P. O. Box 13547, Pensacola, Florida 32591-3547

Phone: (800) 934-8203

MEDICARE SUPPLEMENT GUARANTEED ISSUE DETERMINATION APPLICATION
COMPLETE ONLY IF APPLYING FOR A MEDICARE SUPPLEMENT POLICY ON A GUARANTEED
ISSUE BASIS

For any applicant to be considered eligible for a Medicare Supplement policy on a guaranteed issue basis, *other than during an open enrollment period*, the following information and appropriate documentation must be provided in addition to completion of the application for Medicare Supplement insurance.

If you are issued a Medicare Supplement policy on a guaranteed issue basis we will waive any pre-existing condition limitation.

Prior Coverage - Employee Welfare Benefit Plan

Within the last 63 days, did your employee welfare benefit plan terminate or cease to provide some or all health benefits supplementing Medicare?

Proposed Insured: YES NO Spouse: YES NO

Within the last 63 days, did your employee welfare benefit plan that was primary to Medicare terminate or cease to provide some or all health benefits supplementing Medicare or did you leave the plan, whether the plan was primary or secondary to Medicare?

Proposed Insured: YES NO Spouse: YES NO

If you answer "yes", you are eligible for Medicare Supplement Plans A or F on a guaranteed issue basis.

Prior Coverage – Enrolled in a Medicare Advantage (formerly Medicare+Choice) Plan or With a PACE Provider That Had Been Elected Upon First Becoming Enrolled for Benefits Under Medicare Part A

Within the last 63 days, did you terminate enrollment from a Medicare Advantage (formerly Medicare+Choice) plan or a Program of All-Inclusive Care for the Elderly (PACE), having enrolled in such plan upon first becoming enrolled for benefits under Medicare Part A, and subsequently disenrolled within 12 months of enrollment?

Proposed Insured: YES NO Spouse: YES NO

If you answer "yes", you are eligible for any Medicare Supplement policy offered by the company on a guaranteed issue basis.

Prior Coverage - First time Enrollment in Medicare Select Policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or with a PACE Provider After

Termination of Medicare Supplement Coverage

1. Within the last 12 months, did you terminate Medicare Supplement coverage to enroll for the first time in a Medicare Select Plan, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or a Program of All-Inclusive Care for the Elderly (PACE)?

Proposed Insured: YES NO Spouse: YES NO

If "yes", with what Company? Policy Number:

2. Within the past 63 days, did you terminate enrollment in such plan?

Proposed Insured: YES NO Spouse: YES NO

If you answer "yes" to questions 1. and 2., you are eligible for the same Medicare Supplement plan, on a guaranteed issue basis, that you had prior to the election of the coverage that most recently terminated. However, application must be made to the same insurer that provided the Medicare Supplement coverage. If that insurer does not have that plan available, then you are eligible for a Medicare Supplement Plan A or F from this company on a guaranteed issue basis.

Company: Policy Number:

Prior Coverage - Medicare Select Policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or You Are 65 Years of Age or Older and Enrolled With a PACE Provider

Within the last 63 days, did you discontinue enrollment in a Medicare Select policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or you are 65 years of age or older and discontinued enrollment in a Program of All-Inclusive Care for the Elderly (PACE) because:

a. the plan's certification was terminated or the plan was discontinued in the area in which you live?

Proposed Insured: YES NO Spouse: YES NO

b. you changed your place of residence or there was another change in circumstance (other than nonpayment of premium) which made you ineligible for the plan?

Proposed Insured: YES NO Spouse: YES NO

c. you have satisfactorily demonstrated that the organization substantially violated a material provision of the plan with respect to your care?

Proposed Insured: YES NO Spouse: YES NO

d. you have satisfactorily demonstrated that the organization, agent or other entity acting on the plan's behalf, materially misrepresented the plan's provision in the marketing of the plan to

you?

Proposed Insured: YES NO Spouse: YES NO

If you answer "yes" to any questions a.- d., you are eligible for Medicare Supplement Plans A or F on a guaranteed issue basis.

Prior Coverage - Medicare Supplement Policy

Within the last 63 days, did your Medicare Supplement policy terminate because:

a. the insurer went bankrupt, became insolvent, or involuntarily terminated the plan and there is no state law or regulation for continuation or conversion of such coverage?

Proposed Insured: YES NO Spouse: YES NO

b. you have satisfactorily demonstrated that the insurer substantially violated a material provision of the policy with respect to your care?

Proposed Insured: YES NO Spouse: YES NO

c. you have satisfactorily demonstrated that the insurer, agent or entity acting on the company's behalf materially misrepresented the policy's provisions in marketing the plan to you?

Proposed Insured: YES NO Spouse: YES NO

If you answer "yes" to any question you are eligible for Medicare Supplement Plans A or F on a guaranteed issue basis.

Prior Coverage – Medicare Supplement Policy with Outpatient Prescription Drug Benefits

Did you enroll in a Medicare Part D plan during the initial enrollment period (November 15, 2005 to May 15, 2006), and at the time were you enrolled under a Medicare supplement policy that covers outpatient prescription drugs?

Proposed Insured: YES NO Spouse: YES NO

Effective date of your coverage under Medicare Part D:
Proposed Insured: / /

Spouse: / /

(The guaranteed issue period ends 63 days after the effective date of your coverage under Medicare Part D.)

Did you subsequently terminate your Medicare supplement policy?

Proposed Insured: YES NO Spouse: YES NO

If you answer "yes" to both questions, you are eligible for Medicare Supplement Plans A or F on a guaranteed issue basis.

If you are eligible for a Medicare Supplement policy on a guaranteed issue basis, you must provide appropriate documentation of your termination of or disenrollment from coverage or Medicare Part D enrollment along with your application for the Medicare Supplement policy. Appropriate documentation includes written information that identifies the plan of coverage, the date of the termination of or disenrollment from coverage and the reason for termination.

To the best of my knowledge and belief, the information provided above is true and correct. I understand that this application will become part of my application for coverage, and thus part of the policy. The company may investigate my responses to the questions, and the documentation that I have provided.

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.

Signed City: State: Date: / /
at

Proposed Insured's Signature:

Spouse's Signature, if applying for coverage:

Licensed Agent's Signature:

Agent's Code:

Print Agent's Name:

Agent's State Ins. Lic #:

Date: / /

SERFF Tracking Number: SKML-126058735 *State:* Arkansas
Filing Company: Marquette National Life Insurance Company *State Tracking Number:* 41755
Company Tracking Number: MNLIC EAPP
TOI: MS051 Individual Medicare Supplement - *Sub-TOI:* MS051.001 Plan A
Standard Plans
Product Name: MNLIC Medicare Supplement
Project Name/Number: Med Supp E App/MN-MSUPP-EAPP-4/09

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: SKML-126058735 State: Arkansas
Filing Company: Marquette National Life Insurance Company State Tracking Number: 41755
Company Tracking Number: MNLIC EAPP
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Standard Plans
Product Name: MNLIC Medicare Supplement
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Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Accepted for Informational 03/12/2009
Purposes

Comments:

Attachment:

FLESCHE-MNLIC-EAPP-MSUPP.pdf

Bypassed -Name: Application **Review Status:** 03/03/2009

Bypass Reason: This filing is intended to obtain approval to use the submitted applications, which are virtually similar to the previously approved versions, in an electronic format. Please review the General Information section for specific approval and form information.

Comments:

Bypassed -Name: Health - Actuarial Justification **Review Status:** 03/03/2009

Bypass Reason: This requirement does not apply to this submission. This filing is intended to obtain approval to use a previously approved application in an electronic format. The electronic version has been given a new form number and attached to the Forms Schedule.

Comments:

Bypassed -Name: Outline of Coverage **Review Status:** 03/03/2009

Bypass Reason: This requirement does not apply to this submission.

Comments:

Satisfied -Name: Authorization Letter **Review Status:** Accepted for Informational 03/12/2009
Purposes

Comments:

Attachment:

Authorizarion Letter.pdf

FLESCH CERTIFICATION

RE: Marquette National Life Insurance Company
(Company Name)

This is to certify that the form(s) referenced below (as well as any state variation) is/are in compliance with the readability requirements of your state.

The Flesch Reading Ease Test was applied to each form in its entirety. All titles, major headings and subheadings, and tables were excluded.

<u>Form Number</u>	<u>Flesch Score</u>
MN-MSUPP-EAPP-4/09	42.4
MN-EAPP-GI-4/09	49.8



BY: _____
(Signature of Company Officer)

Michelle Doherty, ACS, AIAA, AIRC, ALHC, CCP, HIA, MHP
Vice President, Product Filing & Compliance
(Type Name & Title of Person Signing)

February 27, 2009

RE: Letter of Authorization

Dear State Regulator:

We hereby authorize:

Sandra K. Meltzer & Associates, Inc.
1925 Century Boulevard, Suite 1
Atlanta, Georgia 30345

to carry out the state filings (including the District of Columbia) on behalf of Marquette National Life Insurance Company. This authorization is to be used with the filing of application form(s) MN-MSUPP-EAPP-4/09 (and state variations thereof) and associated forms required to secure approval of the application.

Sincerely,



Michelle Doherty
ACS, AIAA, AIRC, ALHC, CCP, HIA, MHP
Vice President, Product Filing & Compliance