

SERFF Tracking Number: WAKE-126035625 State: Arkansas  
Filing Company: Family Life Insurance Company State Tracking Number: 41563  
Company Tracking Number:  
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
Product Name: FLIC Revised Application  
Project Name/Number: Family Life/022009

## Filing at a Glance

Company: Family Life Insurance Company

Product Name: FLIC Revised Application

TOI: MS06 Medicare Supplement - Other

Sub-TOI: MS06.000 Medicare Supplement - Other

Filing Type: Form

SERFF Tr Num: WAKE-126035625 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 41563

Co Tr Num:

State Status: Approved-Closed

Co Status:

Author: Jennifer Snell

Date Submitted: 02/16/2009

Reviewer(s): Stephanie Fowler

Disposition Date: 03/05/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Family Life

Project Number: 022009

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: This filing is currently pending in the home domicile state of Texas.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/05/2009

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 03/05/2009

Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

SUBMISSION

Medicare Supplement Insurance Policies

Application - Form Number MSAPP200810 AR

To be used with the following Medicare Supplement Policy Forms

SERFF Tracking Number: WAKE-126035625 State: Arkansas  
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Plan A – Form Number MSAAA200810 AR  
Plan B – Form Number MSAAB200810 AR  
Plan C – Form Number MSAAC200810 AR  
Plan D – Form Number MSAAD200810 AR  
Plan E – Form Number MSAAE200810 AR  
Plan F – Form Number MSAAF200810 AR  
Plan G – Form Number MSAAG200810 AR

Wakely Actuarial Services, Inc. is filing the above-captioned form on behalf of Family Life Insurance Company. A letter of authorization is included for reference. We are requesting the Department's review and approval of this filing.

The above noted application will replace application form number MSAPP200811 AR which was approved by your Department on January 13, 2009. The new application will be used with the above noted policy forms which were also approved by your Department on January 13, 2009 under SERFF filing number WAKE-125907794.

Please note the changes to the application.

1. An area has been added to the cover page so that the applicant can include their spouse's name and Medicare Claim Number if applicable.
2. Under the listing of prescription medications on the second page of the application, the header Diagnosis/Condition has been changed to Condition/Onset Date.
3. New language has been added to the first paragraph of the Authorization and Certification section on page five.

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration in the review of this filing for Family Life Insurance Company.

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - WAS01)

Jennifer Snell, Compliance Analyst  
34125 US Highway N  
Palm Harbor, FL 34684

jennifer.snell@wakelyactuarial.com  
(727) 373-4558 [Phone]  
(727) 373-4559[FAX]

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**Filing Company Information**

Family Life Insurance Company  
P.O. Box 924408  
Houston, TX 77292-4408  
(800) 877-7705 ext. [Phone]

CoCode: 63053  
Group Code:  
Group Name:  
FEIN Number: 91-0550883  
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State of Domicile: Texas  
Company Type: Life and Health  
State ID Number:

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? Yes  
 Fee Explanation: \$20.00 per a form other than policy times one form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Life Insurance Company	\$0.00	02/16/2009	
Family Life Insurance Company	\$20.00	03/03/2009	26082774

SERFF Tracking Number: WAKE-126035625 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	03/05/2009	03/05/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	03/03/2009	03/03/2009	Jennifer Snell	03/04/2009	03/04/2009

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
Medicare Supplement Application	Form	Jennifer Snell	02/16/2009	02/16/2009

*SERFF Tracking Number:* WAKE-126035625      *State:* Arkansas  
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## **Disposition**

Disposition Date: 03/05/2009

Implementation Date:

Status: Approved-Closed

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>	Flesch Certification	Accepted for Informational Purposes	Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Health - Actuarial Justification		Yes
<b>Supporting Document</b>	Outline of Coverage		Yes
<b>Supporting Document</b>	Authorization Letter	Accepted for Informational Purposes	Yes
<b>Form (revised)</b>	Medicare Supplement Application	Approved	Yes
<b>Form</b>	Medicare Supplement Application		Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 03/03/2009  
Submitted Date 03/03/2009  
Respond By Date 03/16/2009

Dear Jennifer Snell,

This will acknowledge receipt of the captioned filing. With that being said, please forward the appropriate filing fees.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 03/04/2009  
Submitted Date 03/04/2009

Dear Stephanie Fowler,

### Comments:

The required filing fee was submitted via EFT on March 3, 2009.

### Response 1

Comments: The total filing fee submitted was \$20.00.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Feel free to contact me should further information be needed.

Thank you

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Sincerely,  
Jennifer Snell

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**Amendment Letter**

Amendment Date:  
 Submitted Date: 02/16/2009

**Comments:**

Attached you will find a revised application. A typographical error was found in the initial application submitted.  
 Thank you

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
MSAPP200902 AR	Application/Enrollment Form	EMedicare Supplement Application	Revised		WAKE-125907794	MSAPP20084211 AR		MSAPP200902 AR.pdf

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## Form Schedule

**Lead Form Number:** MSAPP200902 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	MSAPP200902 AR	Application/ Medicare Enrollment Form	Supplement Application	Revised	Replaced Form #: MSAPP200811 AR Previous Filing #: WAKE-125907794	42	MSAPP200902 AR.pdf

**FAMILY LIFE INSURANCE COMPANY**

Home Office: Houston, TX

Medicare Supplement Administrative Office: P. O. Box 924408, Houston, TX 77292-4408

**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE**

**APPLICATION #:** \_\_\_\_\_

**APPLICANT**

*Last* \_\_\_\_\_ *First* \_\_\_\_\_ *MI* \_\_\_\_\_

**Check the Medicare Supplement Plan You Prefer:**

- |  |  |
|--|--|
| <input type="checkbox"/> Standardized Plan A | <input type="checkbox"/> Standardized Plan E |
| <input type="checkbox"/> Standardized Plan B | <input type="checkbox"/> Standardized Plan F |
| <input type="checkbox"/> Standardized Plan C | <input type="checkbox"/> Standardized Plan G |
| <input type="checkbox"/> Standardized Plan D |  |

**RESIDENCE ADDRESS**

*Street:* \_\_\_\_\_

*City:* \_\_\_\_\_

*State:* \_\_\_\_\_

*Zip Code:* \_\_\_\_\_

**MEDICARE INFORMATION**

**Date first enrolled in Medicare Part B:** \_\_\_\_\_

**Medicare Claim Number:** \_\_\_\_\_

**MAILING ADDRESS**

*Street:* \_\_\_\_\_

*City:* \_\_\_\_\_

*State:* \_\_\_\_\_

*Zip Code:* \_\_\_\_\_

AGE	DATE OF BIRTH			SEX
	<i>Month</i>	<i>Day</i>	<i>Year</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female
SOCIAL SECURITY NUMBER				
_____				

AREA CODE	TELEPHONE NUMBER	
	_____	
HEIGHT		WEIGHT
<i>Feet</i>	<i>Inches</i>	<i>Lbs.</i>
_____	_____	_____

**Effective Date:** \_\_\_\_\_

**Special Requests:** \_\_\_\_\_

**SPOUSE**

*Last* \_\_\_\_\_ *First* \_\_\_\_\_ *MI* \_\_\_\_\_

**Spouse's Medicare Claim Number:** \_\_\_\_\_

**UNDERWRITING RISK CLASSIFICATION QUESTION**

Have you used any form of tobacco in the past five years?

- Yes       No

*(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)*

**MODAL PREMIUM:** \$ \_\_\_\_\_

**SPOUSAL DISCOUNT:** \$ \_\_\_\_\_  
(IF APPLICABLE)

**POLICY FEE:** \$ \_\_\_\_\_

**TOTAL INITIAL PREMIUM:** \$ \_\_\_\_\_

**PLEASE SELECT THE METHOD OF PAYMENT YOU WANT**

- Bank Draft     Annual     Semiannual     Quarterly     Monthly Bank Draft

**PART I – HEALTH QUESTIONS**

**YOU ARE NOT REQUIRED TO ANSWER HEALTH QUESTIONS 1-14 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.**

**IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-14, YOU MAY NOT BE ELIGIBLE FOR COVERAGE.**

- |    |  |                              |                             |
|----|--|------------------------------|-----------------------------|
| 1. | Are you bedridden or confined to a wheelchair or require the assistance of a motorized mobility aid; or in the past two years have you suffered two or more falls within a six month period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | In the past two years, has surgery or tests been advised by a physician but not performed?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Is surgery anticipated in the next twelve months?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Within the past two years have you had an amputation caused by disease?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**PART I – HEALTH QUESTIONS CONTINUED**

6. Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:
- a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, or any other cognitive disorder?  Yes  No
  - b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?  Yes  No
  - c. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis?  Yes  No
  - d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?  Yes  No
  - e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?  Yes  No
  - f. Congestive Heart Failure (CHF), heart attack, Coronary or Carotid Artery Disease, Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA)?  Yes  No
7. Within the past two years have you had atrial fibrillation, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?  Yes  No
8. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus?  Yes  No
9. Have you had an organ transplant or been advised to have an organ transplant?  Yes  No
10. Are you currently using the services of a home health care agency?  Yes  No
11. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?  Yes  No
12. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis?  Yes  No
13. Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture?  Yes  No
14. Are you diabetic, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with two or more medications?  Yes  No

Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary.  Yes  No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	Condition/Onset Date

**Primary Physician Information**

**Name:**

**Address:**

**Telephone:**

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

Did you enroll in Medicare Part B in the last 6 months?  Yes  No If yes, what is the effective date? \_\_\_\_\_

## PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

**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 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 our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."**

To the best of your knowledge:

1. 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 payment toward your Medicare Part B premium?  Yes  No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. 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 plan to enroll in the Medicare plan?  Yes  No

3. (a) Do you have another Medicare Supplement policy in force?  Yes  No

(b) If so, with which company: \_\_\_\_\_  
with which plan: \_\_\_\_\_  
and what paid-to-date do you have? \_\_\_\_\_

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

4. 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 yes, with what company, what kind of policy and reason for termination?

\_\_\_\_\_  
(b) What are your dates of coverage under the other policy? START END  
/ / / /

## IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

- (1) You do not need more than one Medicare Supplement Insurance 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 Insurance Policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 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 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 suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

## OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-14 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:** The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- (a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or
- (g) Lost eligibility for health benefits under Medicaid.

**Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.**

## AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Family Life Insurance Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Family Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Family Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Family Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Family Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Family Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes 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.

**WARNING: 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) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: \_\_\_\_\_  
(City /State)

Dated: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_  
(Month/Day/Year)

**AGENT'S CERTIFICATION**

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

**TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)**

1. List any other health insurance policy you have sold to the Applicant that is still in force.

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2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

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I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

\_\_\_\_\_  
**Agent's Signature:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Agent's Printed Name:**

\_\_\_\_\_  
**Agent No.:**

AUTHORIZATION	<b>IN FAVOR OF:</b> <b>Family Life Insurance Company</b> <b>Administrative office</b> <b>P.O. Box 924408, Houston, Texas 77292-4408</b>	
	<b>Name of Bank Customer:</b>	<b>Policy Numbers</b>
	<b>Insured's Name:</b>	
	<b>Account Number :</b>	<b>Routing Number:</b>
	<b>To (Name of Bank):</b> _____ <b>Address of Bank:</b> _____	
<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>		
<b>Date</b>	<b>Signature of Depositor</b>	
<b>Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.</b>		
<b>To:    The Bank above</b>		
<p>In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:</p> <ul style="list-style-type: none"> <li>➤ To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.</li> <li>➤ In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.</li> <li>➤ To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.</li> </ul>		

AUTHORIZATION

(Attach Voided Check)

### AUTHORITY TO HONOR PREMIUM CHECKS

*SERFF Tracking Number:*      *WAKE-126035625*                      *State:*                      *Arkansas*  
*Filing Company:*              *Family Life Insurance Company*                      *State Tracking Number:*      *41563*  
*Company Tracking Number:*  
*TOI:*                      *MS06 Medicare Supplement - Other*                      *Sub-TOI:*                      *MS06.000 Medicare Supplement - Other*  
*Product Name:*              *FLIC Revised Application*  
*Project Name/Number:*      *Family Life/022009*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: WAKE-126035625 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 41563  
 Company Tracking Number:  
 TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
 Product Name: FLIC Revised Application  
 Project Name/Number: Family Life/022009

## Supporting Document Schedules

<p><b>Satisfied -Name:</b> Flesch Certification</p> <p><b>Comments:</b></p> <p><b>Attachment:</b> Readability.pdf</p>	<p><b>Review Status:</b> Accepted for Informational Purposes 03/05/2009</p>
<p><b>Bypassed -Name:</b> Application</p> <p><b>Bypass Reason:</b> See Form Schedule</p> <p><b>Comments:</b></p>	<p><b>Review Status:</b> 02/16/2009</p>
<p><b>Bypassed -Name:</b> Health - Actuarial Justification</p> <p><b>Bypass Reason:</b> The changes made to the application do not require a change in rates. The actuarial memorandum that was approved by your Department on January 13, 2009 is still current.</p> <p><b>Comments:</b></p>	<p><b>Review Status:</b> 02/16/2009</p>
<p><b>Bypassed -Name:</b> Outline of Coverage</p> <p><b>Bypass Reason:</b> Not Applicable</p> <p><b>Comments:</b></p>	<p><b>Review Status:</b> 02/16/2009</p>
<p><b>Satisfied -Name:</b> Authorization Letter</p> <p><b>Comments:</b></p> <p><b>Attachment:</b> FLIC Auth Ltr.PDF</p>	<p><b>Review Status:</b> Accepted for Informational Purposes 03/05/2009</p>

# READABILITY COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

**Family Life Insurance Company  
P.O. Box 924408  
Houston, Texas 77292-4408**

I hereby certify that the Flesch Reading Ease Test Score of the listed form is as follows:

<b>Type and/or Title of Form(s)</b>	<b>Form Number(s)</b>	<b>Flesch Score</b>
Application	MSAPP200902 AR	41.6

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Jennifer G. Snell

Name

\_\_\_\_\_  
Compliance Analyst

Title



November 6, 2008

To Whom It May Concern:

The firm of Wakely Actuarial Services, Inc., located at 34125 US Highway 19 North, Suite 310, Palm Harbor, Florida 34684, is hereby authorized to submit form filings for approval on behalf of Family Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Family Life Insurance Company.

Sincerely,

Lee Ann Blakey  
Vice President, Operations



10700 Northwest Freeway  
Houston, TX 77092



800-877-7705



[www.familylifeins.com](http://www.familylifeins.com)

*SERFF Tracking Number:* WAKE-126035625      *State:* Arkansas  
*Filing Company:* Family Life Insurance Company      *State Tracking Number:* 41563  
*Company Tracking Number:*  
*TOI:* MS06 Medicare Supplement - Other      *Sub-TOI:* MS06.000 Medicare Supplement - Other  
*Product Name:* FLIC Revised Application  
*Project Name/Number:* Family Life/022009

## Superseded Attachments

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.

<b>Original Date:</b>	<b>Schedule</b>	<b>Document Name</b>	<b>Replaced Date</b>	<b>Attach Document</b>
No original date	Form	Medicare Supplement Application	02/16/2009	MSAPP200902 AR.pdf

**FAMILY LIFE INSURANCE COMPANY**

Home Office: Houston, TX

Medicare Supplement Administrative Office: P. O. Box 924408, Houston, TX 77292-4408

**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE**

<b>APPLICATION #:</b>	
<b>APPLICANT</b>	<b>RESIDENCE ADDRESS</b>
<i>Last</i> <i>First</i> <i>MI</i>	<i>Street:</i>
<b>Check the Medicare Supplement Plan You Prefer:</b>	<i>City:</i>
<input type="checkbox"/> Standardized Plan A <input type="checkbox"/> Standardized Plan E	<i>State:</i> <i>Zip Code:</i>
<input type="checkbox"/> Standardized Plan B <input type="checkbox"/> Standardized Plan F	
<input type="checkbox"/> Standardized Plan C <input type="checkbox"/> Standardized Plan G	
<input type="checkbox"/> Standardized Plan D	

<b>MEDICARE INFORMATION</b>	<b>MAILING ADDRESS</b>
Date first enrolled in Medicare Part B: _____	<i>Street:</i>
Medicare Claim Number: _____	<i>City:</i>
	<i>State:</i> <i>Zip Code:</i>

<b>AGE</b>	<b>DATE OF BIRTH</b>			<b>SEX</b>		<b>AREA CODE</b>	<b>TELEPHONE NUMBER</b>		
	<i>Month</i>	<i>Day</i>	<i>Year</i>	<input type="checkbox"/> Male	<input type="checkbox"/> Female				
<b>SOCIAL SECURITY NUMBER</b>						<b>HEIGHT</b>		<b>WEIGHT</b>	
						<b>Feet</b>	<b>Inches</b>	<b>Lbs.</b>	

<b>Effective Date:</b>	<b>Special Requests:</b>
------------------------	--------------------------

<b>SPOUSE</b>	<b>Spouse's Medicare Claim Number:</b>
<i>Last</i> <i>First</i> <i>MI</i>	

<b>UNDERWRITING RISK CLASSIFICATION QUESTION</b>	<b>MODAL PREMIUM:</b> \$ _____
Have you used any form of tobacco in the past five years?	<b>SPOUSAL DISCOUNT:</b> \$ _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	(IF APPLICABLE)
<i>(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)</i>	<b>POLICY FEE:</b> \$ <u>25.00</u>
	<b>TOTAL INITIAL PREMIUM:</b> \$ _____

**PLEASE SELECT THE METHOD OF PAYMENT YOU WANT**

Bank Draft       Annual       Semiannual       Quarterly       Monthly Bank Draft

**PART I – HEALTH QUESTIONS**

**YOU ARE NOT REQUIRED TO ANSWER HEALTH QUESTIONS 1-14 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.**

**IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-14, YOU MAY NOT BE ELIGIBLE FOR COVERAGE.**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Are you bedridden or confined to a wheelchair or require the assistance of a motorized mobility aid; or in the past two years have you suffered two or more falls within a six month period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. In the past two years, has surgery or tests been advised by a physician but not performed?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is surgery anticipated in the next twelve months?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Within the past two years have you had an amputation caused by disease?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**PART I – HEALTH QUESTIONS CONTINUED**

6. Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:
- a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, or any other cognitive disorder?  Yes  No
  - b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?  Yes  No
  - c. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis?  Yes  No
  - d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?  Yes  No
  - e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?  Yes  No
  - f. Congestive Heart Failure (CHF), heart attack, Coronary or Carotid Artery Disease, Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA)?  Yes  No
7. Within the past two years have you had atrial fibrillation, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?  Yes  No
8. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus?  Yes  No
9. Have you had an organ transplant or been advised to have an organ transplant?  Yes  No
10. Are you currently using the services of a home health care agency?  Yes  No
11. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?  Yes  No
12. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis?  Yes  No
13. Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture?  Yes  No
14. Are you diabetic, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with two or more medications?  Yes  No

Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary.  Yes  No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	Condition/Onset Date

**Primary Physician Information**

**Name:**

---

**Address:**

---

**Telephone:**

---

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

Did you enroll in Medicare Part B in the last 6 months?  Yes  No If yes, what is the effective date? \_\_\_\_\_

## PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

**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 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 our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."**

To the best of your knowledge:

1. 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 payment toward your Medicare Part B premium?  Yes  No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. 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 plan to enroll in the Medicare plan?  Yes  No

3. (a) Do you have another Medicare Supplement policy in force?  Yes  No

(b) If so, with which company: \_\_\_\_\_  
with which plan: \_\_\_\_\_  
and what paid-to-date do you have? \_\_\_\_\_

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

4. 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 yes, with what company, what kind of policy and reason for termination?

\_\_\_\_\_  
(b) What are your dates of coverage under the other policy? START END  
/ / / /

## IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

- (1) You do not need more than one Medicare Supplement Insurance 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 Insurance Policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 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 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 suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

## OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-14 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:** The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- (a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or
- (g) Lost eligibility for health benefits under Medicaid.

**Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.**

## AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Family Life Insurance Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Family Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Family Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Family Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Family Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Family Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes 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.

**WARNING: 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) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: \_\_\_\_\_  
(City /State)

Dated: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_  
(Month/Day/Year)

**AGENT'S CERTIFICATION**

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

**TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)**

1. List any other health insurance policy you have sold to the Applicant that is still in force.

---

---

---

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

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---

---

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

\_\_\_\_\_  
**Agent's Signature:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Agent's Printed Name:**

\_\_\_\_\_  
**Agent No.:**

AUTHORIZATION	<b>IN FAVOR OF:</b> <b>Family Life Insurance Company</b> <b>Administrative office</b> <b>P.O. Box 924408, Houston, Texas 77292-4408</b>	
	<b>Name of Bank Customer:</b>	<b>Policy Numbers</b>
	<b>Insured's Name:</b>	
	<b>Account Number :</b>	<b>Routing Number:</b>
	<b>To (Name of Bank):</b>	
<b>Address of Bank:</b>		
<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>		
<b>Date</b>	<b>Signature of Depositor</b>	
<b>Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.</b>		
<b>To:    The Bank above</b>		
<p>In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:</p> <ul style="list-style-type: none"> <li>➤ To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.</li> <li>➤ In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.</li> <li>➤ To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.</li> </ul>		

AUTHORIZATION

(Attach Voided Check)

### AUTHORITY TO HONOR PREMIUM CHECKS